Medical Anthropology Quarterly

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Compassion or Corruption? Temporalities of Care and Nationhood in Papua New Guinean Nursing Education

Nurse educators in Papua New Guinea (PNG) must prepare students for often demoralizing working conditions. This article analyzes classroom and practical lessons in a PNG Highlands nursing college. A variety of pedagogical practices, including role plays and other simulation technologies, were used to socialize students to imagine patients' relatives while making clinical decisions, and to contemplate their own relatives and ancestors in reflecting on their moral commitments to health care. Such practices generate a mode of medical citizenship shaped by a regime of biocommunicability in which Christianity and education are thought to transform one's capacity to detach from the emotional appeals of kin. These pedagogies link the individual subjectivities of health workers to a persistent, though fragile, vision of the nation in which transgenerational, urban–rural kinship is a synecdoche for nationhood (and its deferral), despite professional counternarratives that cast these kinship ties as a slippery slope toward "corruption." [medical citizenship, temporalities of care, nursing simulation, nationhood, Papua New Guinea]

Introduction

Health systems in many Pacific Island countries struggle to recruit and retain skilled workers. Low salaries and benefits, poor working conditions, inadequate facilities, and lack of opportunities for career advancement top the list of health workers' concerns (Henderson and Tulloch 2008; World Health Organization 2004). Papua New Guinean health workers share these problems with their colleagues across the region, with additional pressures caused by housing shortages and security issues (Bolger et al. 2005; Razee et al. 2012). With little hope that working conditions will improve any time soon, educators raising the next generation of health workers must set expectations for their students without scaring them away from public service. They must inform them of the challenges they face; they must also give them a sense of moral purpose that will help them persevere despite the difficulties.

MEDICAL ANTHROPOLOGY QUARTERLY, Vol. 37, Issue 1, pp. 42–58, ISSN 0745-5194, online ISSN 1548-1387. DOI: 10.1111/maq.12726

The moral vision taught in Papua New Guinean nursing colleges includes teachings on emotional control and an attunement to the emotional states of others. These teachings are responses to the demoralizing conditions of the workplace, concerns about corruption in the public sector, and the perception that nurses have an "attitude problem" and are unresponsive to patients' suffering (Tantchou 2018). Indeed, on-duty Papua New Guinean hospital nurses, especially the more experienced ones, often perform a studied inattention, refusing the gaze of waiting patients and reacting slowly to incidents around them. This comportment is sometimes misread as rudeness or arrogance (Andersen 2017; Fiti-Sinclair 2002). However, nurses are also taught to be sensitive to the emotional states of others, and to exercise judgment in switching affective styles. This emotional discernment links the individual subjectivities of health workers to a persistent, if fragile, moral vision of the nation.

In this article, I focus on one set of technologies used in the training of Papua New Guinean nurses: the invocation of "relatives" as surveilling presences and moral signposts. Students were reminded constantly to keep patients' relatives in mind, to imagine what they would think and how they might react when making decisions in clinical settings. Just as importantly, they were encouraged to contemplate their own relatives and ancestors, to keep them in mind when interacting with patients. These invocations were materialized through simulation pedagogies like role-playing skits and case studies, sometimes incorporating the use of manikins (Nehring and Lashley 2009). The subjectivity produced through this emotional education is one that holds individualistic and relationalistic values in constant tension, enabling an affective code-switching seen as necessary for ethical practice in a Papua New Guinean context.

I see the contribution of my analysis, then, in amending theories of medical citizenship and biocommunicability with insights from studies of Papua New Guinean nationalism. Medical subjectivity and medical citizenship are underpinned by regimes of biocommunicability that rank citizen–subjects in terms of their relationship to medical knowledge—their capacity to learn, understand, incorporate, and disseminate knowledge about health and illness. Health workers themselves are ranked within this schema, with nurses positioned as "middle figures" (Hunt 1999) who must code-switch across gradients of biocommunicability. They must be able to understand and speak "up" to higher-ranked physicians and administrators, as well as "down" to lower-ranked community health workers, patients, and the general public. As Briggs notes, the subject positions ordered by regimes of biocommunicability include different degrees of agency and "the appropriate type of affect" (Briggs 2011). In the Papua New Guinean context, education has long been seen as heralding a transformation in agency. Because education past the primary level almost always requires moving to town centers, the act of moving away from the village and into the world of cash, work, education, and commodities is believed to transform a person in substantive ways, not least in their ability to disentangle themselves from the desires and concerns of kin. Thus, rural and educated people are seen as possessing different capacities for individual action, efficacy, and responsibility. They are also seen as having different relationships to national progress and development—to temporality—by virtue of these capacities. In this article, I will show how nursing students in the Eastern Highlands are taught to understand their

emotional responses in relation to relatives both real and imagined, their own and others', as part of a wider story of national development.

Care and Temporalities of National Development

This ethnographic case illustrates the imaginative work that goes into shaping the political and ethical subjectivities of health workers. Nurses in the Global South are often positioned as agents of development and national transformation, responsible for both providing frontline care and modeling responsible medical citizenship to the people they serve (Munro 2020; Nading 2013). Papua New Guinean nationalism is overtly Christian in almost all its expressions, though there are competing ideological and theological traditions. In all versions of Papua New Guinean Christian nationalism, a central problematic is how to manage the relationship between the "heathen" indigenous past (which is believed to persist in both cryptic and overt forms) and the enlightened Christian present/future. These temporalities are seen as embodied in types of persons, and educated people often describe themselves as having a relationship to the future that their rural kin, and fellow citizens more broadly, are not yet able to access.

The vision of the nation expressed in nursing education, and the contradictions and tensions that surround it, mirrors larger ideological trends in Papua New Guinean political and social thought. The concept of the Melanesian Way, as outlined by theorist and politician Bernard Narokobi, was influential during the Independence[1] era and remains rhetorically popular with many health professionals (Narokobi 1980). The Melanesian Way has been described as a "hopeful synthesis between diverse indigenous cultures and the positive aspects of Western culture" (Santos da Costa 2021: 902)—namely, Christianity. However, invocations of the Melanesian Way have also become associated with "corrupt practices" that cynically deploy indigenous values of "gift-giving and *wantokism*"[2] (Santos da Costa 2021: 902) in ways that undermine national development. Whichever view of Papua New Guinean nationhood nurses subscribe to, all place differences between educated and rural people at the heart of their concerns about service and duty. These differences are often described in spatial, temporal, and generational terms, rather than class ones. This orientation may be particularly appealing to professionals like nurses because their work requires them to engage daily with people whose ideas about health and illness appear to be grounded in traditional worldviews rather than scientific knowledge or Christian faith.

This means that the temporalities involved in nursing extend beyond the specific moments of caregiving or even the life course of the individual. Theorizations of care in medical anthropology and science and technology studies have highlighted the practical "tinkering" and experimentation with daily routines that make up clinical work (Mol 2008). Illicit, informal, or improvised practices, including practices that are officially deemed "corrupt," must be managed by health workers in some way—either disavowed and rejected, or incorporated and narrated in morally acceptable ways (Praspaliauskiene 2016; Sangaramoorthy 2018). Especially in resource poor or crisis settings, care work also involves "anticipation," as the infrastructural and material conditions cannot be relied on, and constant interruptions are the norm (Tantchou 2018). Because the quotidian, micro temporalities of care are

unpredictable, nurse educators urge students in PNG to focus on the larger narrative temporalities in which their moral labor can actually make a difference.

The simulation of relatives in nursing education calls on powerful moral imaginaries of kinship, in which the relationship between the educated, Christian self and the backward, rural relative is a synecdoche for a grander national story. It calls up a sense of personal indebtedness and compassion (*sore*). However, there is a tension between the moral goad of compassion and professional codes that demand vigilance against the corruption that sore for kin can inspire.

The Educational Context: Becoming a Nurse in the Eastern Highlands

This article draws on data collected through ethnographic research with nursing students in Papua New Guinea's Eastern Highlands in 2011–12. A multicultural, multilinguistic, mixed-gender cohort, the students I worked with were mostly in their late teens and early 20s, with a small handful of older returning students. Their instructors were primarily in their early 40s or older.

Except in special cases, a Grade 12 diploma is required for acceptance to nursing college. This means that simply by entering the program, students are already better credentialed than almost all their fellow citizens, as fewer than 10% of Papua New Guineans complete Grade 12 (National Statistical Office 2011). Students and teachers identify as belonging to an "educated elite" (Kasaipwalova 1976) or "educated working class" (Cox 2014) with a responsibility to improve the nation on behalf of the country's rural majority. The cohort I conducted research with had socioeconomically diverse upbringings. A few were the first in their families to learn to read; others were third-generation health workers. Many had parents with public service or church careers and had spent much of their lives in urban areas, but, like most Papua New Guineans, all felt themselves to be connected in some way to rural kin, even if they had never met them.

Being a nurse in the Eastern Highlands demands social sensitivity and an ability to communicate across cultural and linguistic divides. Papua New Guinean towns and their provincial base hospitals serve both sophisticated urbanites and people from remote areas with little experience of anonymous institutional environments. To assess and treat people of such diverse backgrounds, nurses must tailor their communication strategies and anticipate potential communicative mishaps. For this reason, teachers in the nursing college insisted that students pay attention to social distinctions and be alert to the risks of miscommunication.

Students were taught that they had to learn to be independent, self-directed individuals with a firm sense of professional duty. This lesson was often brought home during their first ward practicums. Even when students wanted to be assessed on their performance, marks were sometimes made up after the fact by busy matrons who barely glanced at them while they worked. Like patients, students sometimes felt that the nurses were neglecting them. They were warned, instead, to focus vigilantly on the presence and power of another group of people: the relatives of patients. "The relatives," tutors warned students, "are always watching how you behave."

Why are nursing students encouraged to remember the relatives? Most obviously, the relatives of patients are physically present, more or less all the time, on the inpatient wards and in waiting areas. Because public hospitals cannot afford to

provide good security, supervision, food, and personal care for inpatients, a designated person will stay full-time with the sick individual as their *wasman* or *wasmeri* (guardian). Guardians sleep on mats beside patients' beds; help patients with toileting and bathing; launder their clothes and bedding; feed them; translate when necessary; and update staff on their condition. Other relatives will come and go during daytime hours, bringing food to supplement the meager or nonexistent meals provided by the hospital. Patients who are not constantly attended by relatives tend to be profoundly socially marginalized. Some hospitals or wards have rules limiting the permitted number of visitors, but in my experience these policies are unpopular and difficult to enforce. A person whose relatives are not watching over them in the hospital is, culturally speaking, barely a person at all.

Beyond the ordinary problems generated by stressed-out people in close quarters, nursing students have some concerns about relatives that are specific to the local context. In the Eastern Highlands, tribal fighting flares up from time to time and health workers are understandably wary of being drawn into these disputes. In matters of tribal conflict or interpersonal violence, hospitals and individual health workers may be asked to provide documentary evidence of death, sickness or injury by kin seeking customary forms of compensation (van Amstel and van der Geest 2004). On rare occasions, health workers are violently attacked in retribution for a patient's death. Highlands peoples are stereotyped as aggressive, and nurses sometimes expect people from certain ethnolinguistic groups to have poor impulse control, especially when feeling concerned about close kin. On a more quotidian level, in understaffed and overcrowded hospitals and health centers, nurses must confront pressure from people seeking treatment for their sick family members. (When the health worker herself is a relative or *wantok* of a sick person, this pressure is even more tangible.) Learning to handle the presence of relatives, then, is an important skill for a nurse to have.

Beyond the practical requirements of the job, the relatives also play a key role in the socialization of affect. Students are taught to pay attention to relatives both as potential sources of trouble and as foils for their own subjective and affective comportment. By invoking the relatives, teachers were encouraging students to reflect on what made them, as educated Christian professionals, different from the country's majority. The fact that traditional Melanesian cultures are kin oriented and relational was consistently emphasized in student training. Educated people were different: While they *had* relatives, they were not *the same as* their relatives. In fact, learning to detach themselves from their relatives was one of the first and hardest lessons of their careers. Too much detachment, however, could be almost as morally perilous as too little. Nursing students had to learn to recognize and modulate an indigenous habitus that emphasized sore to cultivate a professional practice demanding a stable and consistent inner self.

Balancing Compassion and Corruption

In a country and region where talk about corruption is endemic (Larmour 2012), health workers are taught to be vigilant against attempts by others to bribe or otherwise coerce them to break their professional codes of conduct and ethics. Yet they are also socialized, formally and informally, to value sore for patients and their relatives

above all else. Coming from cultural backgrounds that emphasize the importance of emotional responsiveness and empathy, and deeply committed to Christian ideals of charity, nurses sometimes struggle to balance their sense of what is culturally appropriate, what is morally correct, and what is professionally mandated behavior. Corruption is defined by its motivations, not its outcomes: Health workers believe workplace misconduct is caused by selfishness and individualism, not compassion. Nevertheless, they must always prevent the *appearance* of corruption because of how little faith the population has in the public sector and how vulnerable frontline health workers are to retribution. Students learn to act as though they are always being watched by people who would likely misinterpret their behavior. At an interpersonal level, this means avoiding suspicions of wantok preference, and presenting a self that demonstrates an appropriate level of detachment.

It is a cliché that Papua New Guinean government services, businesses, and other enterprises struggle to root out "wantokism." A major survey of health worker retention issues in the Asia-Pacific region argues that the "wontok [sic] system … built on the premise that loyalties to kin supersede all other loyalties" (Henderson and Tulloch 2008) makes it harder for management to fairly monitor, evaluate, and regulate workers in Melanesian countries. Space limitations constrain me from a full discussion of the changing meanings of wantok (Hukula 2017; Schram 2015); literally, it means member of the same language group, but in practice it can also mean kin, neighbor, friend, or peer. Giving preferential treatment to wantoks—e.g., by allowing them to jump queues, waive fees, or see clinicians outside regular hours—is not always considered corrupt, but it is disfavored. In health spaces, concern about potential corruption leads some workers to carefully monitor and discipline their and others' comportment. For example, using one's vernacular language (*tok ples*) with patients could be treated with suspicion.

There was pressure to be vigilant against wantokism in student life as well. While students proudly announced their cultural origins (it is hardly possible to do otherwise in PNG, where one's region of origin is immediately perceptible to all through phenotype, accent, body type, and manner) and often chose to socialize with those from the same province, students who went "too far" were chastised and gossiped about. Students from Enga Province, in particular, were disparagingly said to "*save tok ples tumas*"—habitually use their native language in an exclusionary way. Norms about ethnic solidarity were complicated: While regional and cultural pride were celebrated, a willingness to engage socially across lines of ethnic difference was also positively valued.

Despite the normative rejection of wantok and ethnic preference, the pressure to treat all patients as interchangeable, generic individuals is in tension with other values celebrated by health workers. Nurses see themselves as role models whose mission is to "serve their people" and help them develop. In interviews, many students justified their professional ambitions through the desire to "help my community." While that community could be the entire nation, more frequently it seemed to refer to their communities of origin, the people who had raised them up. Sometimes, specific relatives were singled out as inspirations for their career choices—interviewees would say "I wanted to pay back my paternal kin who paid my school fees"; "I felt sorry for my aunt who looked after me"; "my mother died of cancer and I remembered the nurses who looked after her." Telling the story of how they decided

to become nurses, many students recounted childhood experiences of visiting sick relatives in hospital, and admiring the cleanliness, professionalism, and knowledge of the nurses who treated them. It was morally unspeakable to seek a career for one's own sake; at any rate, nursing could be a thankless and poorly paid profession, and doing it to serve others might have made it feel worth the struggle.

At an emotional level, nurses had to contend with the conflict between professional values of impartiality and neutrality and cultural values of empathy and reciprocity. While there are hundreds of self-defined cultural groups in PNG, there is a broadly shared moral orientation that values deep emotional identification with the suffering of significant others. In Tok Pisin,[3] the emotion word sore is intensely morally charged: Good people feel sore for others who are suffering, while bad people *nogat sore* (have no compassion). Educators are aware of how these values can conflict with professional clinical practices and must teach students to be more reflexive about their emotional reactions. While they are not supposed to totally divest themselves of sore—indeed, Christian values require that they preserve it, in their hearts if not in their outward behavior—they must know when and where it is appropriate to express. Because feelings of sore and *wari* (worry, longing, or anxiety) motivate people to give things to others, health workers have to manage these sentiments in others as well as themselves. Without the goad of compassion, people would never help one another; this powerful force can also be manipulated in ways that cross the line.

A student described the ethical dilemma created by the emotional appeals of others:

> So many patients want to give things to me. They will give me money or give me food. The first time this happened, the ethics class I had just taken had made my thinking very rigid. This old woman I had been working closely with, bathing her, staying with her all the time, her son came—an adult man—he came and said, "Man, I really appreciate how you've been staying close to my mama. I like that." He gave me 20 kina,[4] but I couldn't take it, I ran away into the nursing station. He went and spoke to the nursing officer. … Nurse said, "That's fine, he is forcing the gift on you so you have to take it. If they don't force the gift, or they just show it and you take it right away, that's bad. He forced and pursued you, so take it."

A forced gift was not as potentially corrupting; in this case, it was a token of gratitude, not a bribe. But the nurse still had to learn how to put on an appropriate show of resistance before accepting. There was always a chance that the man who had forced the gift on her might come back in the future, asking her to compromise on something else.

As Alice Street (2014) describes in her ethnography of Madang Hospital, many doctors in Papua New Guinean's public service also begin their careers with hopes of working at the village level and serving their people but tend to end up more firmly ensconced in urban, middle-class lifestyles, separating themselves as much as possible from their rural relations and aspiring to "white people's ways." They do so, Street suggests, to avoid the inevitable proliferation of obligations to a potentially infinite number of relational ties:

> Doctors often talk about the lengths they had to go to in order to avoid relationships with patients. They told me that they avoided eye contact or talking too much with patients because they were concerned that once they had engaged with them patients would start demanding things of them. The slightest gesture, they complain, could be taken as evidence of a relationship, and attendant obligations, having been recognized. (Street 2014: 159)

Unlike doctors, nurses do not have the luxury of being able to ignore relationships. While they, too, aspire to a more modern lifestyle, their role as intermediaries between health care institutions and the general public puts them at the front lines of the divide between the urban and rural social strata. Because of the class position of nurses—those in my study were for the most part one or two generations "out of the village," with more or less ongoing obligations to their rural kin—they are acutely aware of the stakes of PNG's increasingly unequal society. Almost all students had heard stories of health workers who had been violently attacked by patients' relatives. A faded newspaper clipping on the wall of the classroom discussed the murder of a nursing officer by angry relatives. It was often the demands of relatives that pulled supervisors away from their managerial and supervisory roles. In the hospital, the clinic, and most especially the rural health center, nurses could never dependably expect that institutional superiors would be watching them for corrupt or improper behavior. Relatives, however, were always there, in fantasy if not in the flesh.

In the next section of this article, I describe the pedagogical use of simulation activities that invoke "relatives" as imagined figures in clinical interactions. These activities, which involved improvisational and imaginative work, demonstrate the way that nursing students are taught to position themselves as educated people with responsibilities to serve the rural majority.

Simulated Patients and Imagined Relatives

Simulation-based pedagogies are a common feature of nursing education worldwide. These range from role-playing skits and games to realistic manikins, to live actors (Taylor 2011) to sophisticated virtual reality programs. Simulated clinical interactions have been widely adopted as expedient, safe, and efficient ways to provide nurse trainees with the necessary hours of clinical practice (Mills et al. 2014). Papua New Guinean nursing schools lack the resources for the kind of high-fidelity, technologically sophisticated simulation exercises found in wealthier countries. Nevertheless, the pedagogies I describe fit within the rubric of nursing simulation, as this category has always included low-technology options.

Nursing theorists have argued for the benefits of role-play and simulation in cultural competency training as it allows learners to practice interactions and explore their own biases in a safe environment (Roberts et al. 2014). The way that simulation socializes affect is distinct from how this process occurs in clinical practicums. In real clinical interactions, students must immediately scan and interact with whoever is present. Because of the need to make decisions quickly, this can activate unconscious biases. In simulated interactions, students can reflect on their own beliefs, feelings, values, and prejudices in a self-reflexive way through debriefs and other exercises

that follow. They must also confabulate or consciously construct the others with whom they will be interacting. The imagined others that nurse educators and students in Papua New Guinean construct can tell us something about how nurses learn to perform their professional identities, as they conjure recognizable personas and social types that health workers expect to encounter on the job, as well as idealized versions of "how a good nurse should behave."

Before undertaking any practicums on the ward and working with real patients, students learned basic nursing procedures in the classroom, often practicing on a manikin they called "John" or one of his battered companions. Most of the time, John and his plastic mates shared a creaky metal hospital bed in the college's practical room. John's arrival in the classroom signaled to students that they needed to start behaving as though they were being watched by relatives. When students first began interacting in John's presence, they treated him like an object. They quickly learned, however, that when John was in the room they had to treat him like a person. That meant they had to imagine other individuals for whom there were no plastic substitutes: John's relatives and guardian, who would be hovering over John and watching the nurses' every move.

One day, Sister Phillip set John up in the training room to show first year students how to perform a bed-bath. "John," the teacher said kindly to the manikin, "you haven't bathed in a long time. Okay, do you want to pee first?" The students laughed. But, the teacher reminded them, this was part of what they were trying to learn: "Explanation is very important." Speaking properly to the patient was an integral part of the nursing procedure, inseparable from physical assessment and manipulation. Even if a patient was unconscious, their wasman might overhear. Starting with his face and hands, then moving to his limbs, back, and abdomen, the teacher washed, dried, and applied moisturizing lotion to John's body, explaining to him along the way. Once the rest of his body was clean and John's penis was finally uncovered, the students, as a group, burst into loud, embarrassed laughter. "Learn to control yourself," Sister Phillip scolded them. "These are professional procedures that I'm teaching you." She reminded them, "The patient and his wasman are watching how you behave. Don't use bad words. You must use good Tok Pisin. Say, 'I'm going to wash the part I haven't washed yet.' Pay respect to them. Your Tok Pisin must come out properly. It's not funny."

The day that the first-year students learned to perform last offices and the laying out of the dead, Sister Phillip introduced the procedure by telling the class,

> People from the village, they will get scared of the dead body. You as a health worker should not be scared. The relatives will be crying, therefore you have to do it nicely. Let them mourn over the body for one hour or two. This is very important. You must respect their customs and beliefs. Follow relatives' instructions. It's not you that makes a decision, they will make the decision.

Every aspect of the last offices was explained in terms of what the relatives would feel. Orifices were packed with gauze because relatives would get scared if the body started to ooze fluids. The corpse should be spoken to kindly, as though it were a living patient, because the brain can remain alive for up to one week, receptive to the feelings and words of relatives. Sister Phillip explained: "It's not in the textbook,

but they say the brain is not dead. If his brother comes from Port Moresby, the dead man knows that his brother is crying. You are doing the first burial and the relatives will do the second burial."

After she had finished her comments, students set about practicing the procedures, pretending that relatives were standing over their shoulders as they gently cleaned and wrapped the body. One male student playfully impersonated a despondent relative, ripping the bandages off, wailing a lament in a mix of North Fore language and Tok Pisin, aggressively confronting the other students, and blocking his female classmate from finishing the procedure. The other students patiently played along for several minutes, recognizing that this sort of behavior was something they would have to learn to deal with. Eventually, he broke character, looked at me and said with a grin, "That's how relatives act when they come to pick up dead bodies."

Improvised role-plays like this one were opportunities for students to show their cultural fluency and ability to switch between "educated" and "rural" affective styles. The imagined relative this student impersonated embodied many stereotypes about Eastern Highlands cultures. For example, in his wailed lament, he promised John's corpse that he would buy a pair of Stockman boots, sunglasses, and cowboy hat for him to be buried in. This student was himself from a North Fore background, so his performance was that of a knowing insider. He may, indeed, have been lampooning how he had seen his own relatives behave in the past. As an educated person on track to a professional career, he was winking at his own background while demonstrating that he knew better. He was also teaching his ethnically diverse classmates to anticipate certain kinds of disruptive behavior from rural Eastern Highlanders, and to learn patience in the face of it.

When students themselves became teachers, they continued to use kinship imaginaries to transmit moral and behavioral lessons. On a rural experience practicum in a remote part of the province, second-year students developed an educational skit for villagers to increase awareness about tuberculosis and its transmission. Their play, comedic at times, centred around a young girl from town named Julie staying with her *bubu meri* (grandmother) in the village over the school holidays. Joanna, the student playing the grandmother, highlighted some stereotypically rural features in her performance, from her clothes (a checked flannel hooded coat, long skirt, and a netbag hanging from her head) to her manner of speech (with the exaggerated r-sounds of an Eastern Highlands accent) to her affective comportment (weeping loudly while hugging her granddaughter's legs). She mimed sweeping the floor, hunched over at the hips, and pretended to make a fire and peel sweet potatoes. The audience, themselves rural people, laughed at the depiction. The message of the play, in which the schoolgirl from town got TB from sleeping in the same bed and sharing food with her grandmother, was that the intimacies associated with rural kinship could be dangerous. Yet there was a loving familiarity to the depiction of Julie and her bubu meri, and obvious pleasure from the students playing the roles.

In their exploration of medical simulation in London training hospitals, Pelletier and Kneebone note that even high-fidelity, apparently realistic simulations involve a kind of exaggerated "phantasmagoria" in which students and teachers act out their roles with "relish [and] [g]reat pleasure" (Pelletier and Kneebone 2016: 374). By selecting extreme characters like "violent drunk patients, anxious, and unreason-

ing relatives, and confused, demented old ladies" (pp. 372–4), students were tacitly acknowledging that certain things were "not simulatable" or significant enough for representation: "the dissatisfying, limiting aspects of life in hospital" (p. 375). These acts of fantasy and desire thus represent an ideological, cultural imaginary of medicine. The authors suggest that by understanding simulation as ideological, new questions can emerge: "From whose perspective is a scenario represented/enacted? What/whose forms of action and agency does its narrative structure enable and disable?" (p. 281).

In the case of this PNG nursing college, the things that are "enactable" and thus teachable are relatives and their emotions, and the minutiae (including the clothing choices and accent) of how villagers behave. The "not simulatable" are things like drug and equipment shortages, missing supervisors, late paychecks, overcrowded wards, or a lack of clean water in rural areas. Those problems cannot be represented in a role play, and they cannot be solved through individual actions. What *can* be taught is an attentiveness to relatives and a vigilance about one's own affective comportment. Students also learn that while relatives have agency, insofar as they can disrupt professional processes, their beliefs, emotions, and actions should not be challenged. In the face of their overwhelming emotional appeals, the health worker should stand quietly in acceptance, carefully controlling her own responses.

Emotional Discernment and the Professional Self

While students had to learn to pay attention to the sore of relatives, they also had to learn when and where to shut their own emotions off. Nurses had to be selective about how much empathy they allowed themselves to express. Almost every day, while sitting in class, students would hear a sustained wailing from one of the nearby hospital wards. The weeping of the bereaved in the Highlands is highly expressive and overt; besides wailing, weeping, embracing, and addressing the dead, people may show their grief by pulling their own hair out, acting violently, or threatening suicide. Professionals could not allow themselves to be pulled into these displays of sore, even if they were internally devastated. One third-year student, recounting the first time she "lost" a patient, told me in an interview:

> A little girl was looking straight into my eyes and she died. I felt so sore! I went inside the side room and cried really hard. The doctors came and said, "Don't cry over this kind of thing." I saw her die with my own eyes and I just felt really sore. The doctors said, "You must be the kind of woman who cries a lot. It's your first time seeing this, you'll see a lot, so you must be strong." A tutor said, "Don't show your *sore* to [relatives of patients]. They'll be worried about themselves, so don't feel sore."

In teaching students how to manage their feelings, lecturers tried to displace and intellectualize notions of emotional process. In Tok Pisin, emotions are said to come from the *bel* (stomach or innards), an anatomical attribution shared in many indigenous vernaculars. One senior educator said to students, "Where do our fears and emotions come from? We think of feelings as coming from our bel—'*Mi belhat ia!*' [I'm angry; I have a hot stomach]—or from our hearts, but feelings come from

our brain." Displacing emotion from the bel to the brain also limits its vulnerability to influence by others: The bel is susceptible to relationships through the sharing and consumption of food and, by metaphorical extension, the power of gifts more broadly. Instructing students to see their own emotions as intellectual, mental reactions rather than socially reactive and embodied ones was a way of teaching them that they had the option of achieving distance from the intense emotional involvement that characterized indigenous life.

Control over emotional responses was seen as a sign of educated, Christian professionalism. Students sometimes criticized the older generation of less well-credentialed community health workers (CHWs), who they described as lazy, unprofessional, and prone to anger. A 25-year-old male student said during an interview:

> On the maternity ward, I saw another CHW, I don't know the name. This time I went to work there, on several occasions the mothers were sick, and their genitals smelled bad. I don't know, did the CHWs get the same training that we nurses have? Because many times I saw them, and their language [to these mothers] was not gentle. They got really cross. It's mostly the CHWs. Old CHWs. They didn't teach them how to "feel" for the patients, that kind of thing. Empathise or feel for them. Maybe they don't have this kind of thinking or training that we have.

Shame, anger, and disgust—visceral, *bel* feelings—needed to be unlearned before a student could be ready to take up their duties as a nurse. In this case, the better "thinking or training" nurses acquired through their higher diploma program was described as allowing a disembodied form of empathy detached from the senses. Less-educated CHWs were still living in an affective world where the bad smell of women's genitals might harm them, prompting anger.

However, total detachment was neither possible nor desirable. Rural experience excursions, where students lived in village communities for weeks at a time to better understand the challenges of working outside of town centers, were in large part emotional exercises. While learning to deal with the frustrations and uncertainties of working far from the conveniences of town, students reveled in the sights, sounds, smells, and tastes of rural life not as an experience of exotic otherness but as a living reminder of ancestral relationships and connections. During these practicums, students would say things like, "I see this place and I remember my own place, I think about my bubu and I just wari."

Evoking one's own relatives, especially mothers and grandmothers, as intimate but temporally other—as living embodiments of the past—is a common theme in the discourse of educated Papua New Guineans. Becoming a modern, professional person means recognizing the difference between how one's ancestors lived and how one must live today. Importantly, this must be a conscious decision cultivated through education, faith, and humility: As one teacher told students, "My mother had no choice. But you and I, we have to negotiate our life. Decisions we make affect the whole community. And us, the Melanesian way, we cannot privatize our decisions. We don't privatize value."

Medical Citizenship, Ethnographic Citizens, and the "Relative" as Jealous Witness

Care, whatever its material foundations, always involves communicative work to establish "the relational ground upon which care is enacted" (Arnold and Black 2020: 573). This relational ground sets out the roles of individuals in the caring encounter: "who is defined as in need of care, who is seen as capable of providing care, and what attributes are persons occupying each of these roles understood to possess?" (p. 576) In Papua New Guinean nursing education, teachers deploy familiar images and narratives of rural–urban kinship to impart a moral vision on their students, to remind them of the compassion they owe to their fellow citizens. This links their often demoralizing everyday work to a vision of the nation in which people care for one another because they recognize their ongoing ties of nurture and indebtedness.

The concept of medical citizenship describes the ways that health workers are cast as political subjects. The form that health workers' political subjectivity takes will vary depending on the larger political arrangements and ideologies. Under settler colonialism in Indonesian West Papua, for example, medical citizenship is shaped by the fact that indigenous Papuan medical workers "see themselves as part of the same threatened population" (Munro 2020: 635) as the patients they serve. Papua New Guinean nurses, belonging to a nation that was formerly colonized but in which many are ambivalent about independence (Santos da Costa 2021), understand themselves as political subjects on a continuum of "development." One characteristic of being an educated, developed person is a capacity for emotional detachment, necessary to resist the affective and material demands of kin. Medical citizenship in the Papua New Guinean context is always relative: A physician, a nurse, and a community health worker exist at different points on the continuum of education and professional hierarchy and social class, all of which come bundled with ideas about their capacity for detachment.

This is not unique to PNG. In Charles L. Briggs's theorization of biocommunicability, all medical subjects, from medical researchers to patients, are ranked in terms of their ability to understand and incorporate medical knowledge (Briggs 2005), with higher professional status associated with greater objectivity, self-control, and independence. What is unique, perhaps, is the specific form of "double vision" Papua New Guinean nurses must take on in their professional training, in which they must learn for themselves how to resolve the dilemmas created by the imperative to inhabit two incommensurate roles—professional and wantok.

In recent writing on Papua New Guinean national identity and ideologies of nationhood, Ryan Schram has proposed the concept of "ethnographic citizenship" to describe this double vision (Schram 2022). Papua New Guineans understand Papua New Guinean-ness as built on a pre-existing tie to *ples*, a Tok Pisin word meaning "place" or "village" but more broadly indicating an emplaced, indigenous landholding cultural group (McGavin 2016). Yet the cultural characteristics associated with ples life, such as material obligations to extended kin, are thought to preclude full membership in a modern nation-state. Ethnographic citizenship, he writes, "presumes that two orders exist simultaneously in every public space in PNG, yet it does not tell people and communities how they are meant to relate to one another or what to do when they conflict" (Schram 2022: 17). Ethnographic citizens draw on "the

polymorphousness of sociality, its amenability to be accounted in many different narrative frames" (p. 18) in their attempts to resolve this conflict.

Nurses, who work at the nexus of two (nominally) separate cultural orders, manifest an ethnographic perspective on their own practices by narrating relatives as "jealous witnesses" to their care. Here I am indebted to Anthony Pickles's and Priscila Santos da Costa's theorization of the figure of the jealous witness in Papua New Guinean imaginaries of corruption and national identity (Pickles and Santos da Costa 2021). Noting that indigenous epistemologies imagine the archetypical witness not as a disinterested view-from-nowhere, but as embodied and "jealous," they write: "Witnesses are human agents with human interests shaping their perception, never neutral recording devices. Witnesses have no privileged relationship to truth or impartiality, and they are susceptible to coercion through effective use of strategies of inclusion" (2021: 355). A disembodied witness, a person "lacking the appetites of the composite body" (p. 351) who cannot be coerced by gifts, bribes, or emotional appeals, is acknowledged as an impossibility, but remains an aspirational ideal for those who see themselves as Christian professionals with a higher duty to the nation.

The national political imaginary depicts all Papua New Guineans as being, by virtue of their embeddedness in indigenous social worlds, inherently but differently "interested," embodied witnesses of the behavior of political actors, including public servants like doctors and nurses. To become a professional, one must learn to strive for detachment where possible, and learn to see one's behavior as constantly monitored by jealous witnesses—relatives—whose emotions must be managed or deflected to prevent chaos and moral decline. Christianity, in Pickles and da Costa's account, is so central to Papua New Guinean narratives of nationhood because of how it introduces "a potent disembodied witness that scale[s] up the sense of 'oneness' by encompassing the whole country" (2021: 361). The graduated, flexible, ethnographic form of medical citizenship inculcated through Papua New Guinean nursing education allows nurses to manage some of the most challenging dilemmas of their professional role while retaining hope in the possibility of change.

Conclusion

The success of rural health services in PNG has long depended on the resilience and commitment of individual health workers. That commitment, in turn, depends on the continuation of urban–rural kinship imaginaries and Christian ideals of service. With all the frustrations and dangers of nursing work, and as educated urban youth become increasingly alienated from rural life, nursing education must cultivate ethical subjects who feel sore for their imagined clients and identify with them as if they were their own kin. But as professionals whose jobs were essential to the development of the nation, nurses also need to be strong subjects, individuals who can make decisions from a place of emotional detachment and rationality, immune to outside pressures. They need to be able to switch, often quickly, from a stance of deep emotional involvement to a place of disinterest.

When the Papua New Guinean public talks about the country's health workforce, they often describe with anger the detached persona that nursing students learn to take on. A common accusation is that nurses "pretend" not to see them—with the

implication being that they *think* they are "above" their clients (but actually know they aren't). Frustration with the seeming lack of sore among health workers can overshadow the often unbearable working conditions and poor infrastructure they must contend with. On the other hand, health workers in rural areas report hostility and harassment from the communities in which they work (Herbst 2017: 40; Razee et al. 2012; Tynan et al. 2013), increasing their sense of alienation from rural life.

Shih et al. (2017) note the national narratives, shared by many Papua New Guinean health workers, that "economic development and progress has been at the expense of traditional customary values and familial relationships, leading to the widespread decline in moral discipline and social order" (p. 51). At the same time, health workers have a deep ambivalence about traditional customary values and traditional relationships, as they can be incompatible with their own sense of themselves as Christian professionals. The moral persona that nursing students needed to achieve was strong but permeable, connected to place and ancestry but also able to step away from it where necessary. The stories they tell about relatives help produce a form of medical citizenship in which micro negotiations of care and compassion can be, in theory at least, scaled up to encompass the nation.

Notes

Acknowledgments. This research was supported with funding from the U.S. National Science Foundation, the Wenner-Gren Foundation for Anthropological Research, the Social Sciences and Humanities Research Council (Canada), and New York University.
Open access publishing facilitated by Massey University, as part of the Wiley - Massey University agreement via the Council of Australian University Librarians.

1. The two territories that became PNG were administered by Australia from 1902 (Papua) and 1914 (New Guinea) until 1975.
2. The extended meaning of the term wantokism is discussed in a subsequent section.
3. Tok Pisin is the lingua franca of PNG and is commonly used in interactions between health workers and clients. Interviews were conducted primarily in Tok Pisin, translated by the author.
4. Approximately $7 USD.

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