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In the Journals, April 2014 - Part II

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By Melanie Boeckmann

Following in *Anna's* [footsteps](#), here is the second half of this month's **In the Journals**.

The current issue of [Critical Public Health](#) is a special issue on "Schools and public health: critical perspectives." In their [editorial](#), *Michael Gard & Jan Wright* write:

For a field that generates so many research publications, school health is the focus of remarkably little critical scholarly analysis. This is a curious situation for many reasons, not least because so much of what does happen in schools is the subject of heated disagreement. The purpose of schools and the optimal methods for educating children are regularly the context for both healthy public debate and ideological warfare. With the possible exception of sex education, however, the health-related role of schools tends to slip peacefully under the radar. In fact, something of a becalmed consensus seems to pervade school health, leaving its many advocates and practitioners to go about their business largely untroubled by the kinds of probing questions which might seem worth asking.

Research papers of interest:

[Sex, drugs and the honour roll: the perennial challenges of addressing moral purity issues in schools](#)

Kenneth W. Tupper

In the late nineteenth and early twentieth century in North America, public health and social reform advocates were quick to identify and exploit the nascent modern institution of public schools as opportune spaces in which to advance their progressive projects. In particular, psychoactive substance use (at first primarily alcohol drinking) and sexuality were regarded as two domains of morally-charged social activity in which desired attitudinal and behavioural outcomes could be achieved through school-based education. Since the advent of these early public health or 'social

hygiene' efforts in schools, political responses and modern Western cultural norms about both drugs and sexuality have undergone significant transformation over the course of the twentieth century. At the same time, research on purported health or social risks of substance use and sexual activity – and their prevention and mitigation among young people – has burgeoned as a field of professional practice and academic inquiry. This article undertakes a brief comparative review of historical and contemporary approaches to school-based sexuality and drug education in North America. In so doing, it also explores how scientific knowledge about the topics of sex and drugs, and the corollary project of school-based 'prevention' in these domains, has been shaped by evolving ideological and cultural forces. It concludes that the issues of sexuality and drug use – still steeped in conceptions of moral purity and pollution – are likely to remain strongly contested terrain for school-based education.

[Towards an understanding of fidelity within the context of school-based health education](#)

Louise McCuaig & Peter J. Hay

Schools and schooling have long provided a tempting site for the delivery of public health strategies that address and promote young people's current and future health. However, an emerging concern regarding the mobilisation of public health interventions within school settings has been the failure of school teachers to deliver such programs with fidelity. For educators, these notions of fidelity stand in stark contrast to the tenets of student-centred teaching. In seeking to explore these tensions further, this paper draws upon a collaborative health education project conducted with schools and teachers from Queensland, Australia. Findings from this project reveal the complexity associated with curriculum implementation in school settings, where diverse resources including timetable allocations and teacher expertise mitigate the achievement of program fidelity. In our efforts to explain the findings emerging from this project, we have drawn on the conceptual reference points of Basil Bernstein's theory of the pedagogic device to reveal the predictable misalignment of the health and education sectors' expected outcomes of school-based health initiatives. In conclusion, we argue that our exploration of issues pertaining to fidelity demonstrates the need for health and education sectors alike to conduct their work according to a clear articulation of the realistic, educative role that schools can play in promoting healthy living.

[Assembling a health\[y\] subject: risky and shameful pedagogies in health education](#)

Deana Leahy

As a school subject, health education functions as a contemporary apparatus of governmentality by attempting to shape the health[y] conduct of young people. Currently, health education, along with many other institutions and programmes, is heavily shaped by neoliberal logics of risk. This paper is interested in exploring how these tenets shape versions of curriculum and classroom practices. The article draws on ethnographic data and the analytical device of governmental assemblages to consider how governmentalities are brought to life at their point of application; via teacher interviews and classroom practices. Analysis reveals that health education pedagogical assemblages are made up of the usual 'neoliberal suspects': risk discourses and strategies that attempt to individualise and responsabilise. However, accompanying these 'usual suspects' are a raft of melodramatic and affective intensities, including disgust and shame. These affective pedagogical assemblages are significant for scholars interested in understanding the governmental machinery of health education, and public health and health promotion more broadly, and its potential effects.

[Governing bullying through the new public health model: a Foucaultian analysis of a school anti-bullying programme](#)

Tara Galitz & Dominique Robert

Framed as a public health problem, school bullying led public health agencies to design anti-bullying programmes. The public health approach is invested with hope by those who are looking for an alternative to the punitive logic. Using a Foucaultian approach and a discourse analysis method, this research focuses on the way an anti-bullying intervention programme designed by a public health agency governs school bullying. The findings reveal two major logics at play. Firstly, the programme espouses the new public health model and, accordingly, governs bullying as a systemic risk rather than an individual problem. Secondly, the programme is also anchored in the classical punitive rationality. Public health and punitive logics, far from being mutually exclusive, are rather intertwined. This dual logic contributes to the 'dangerization' of school bullying.

[Healthy, happy and ready to teach, or why kids can't learn from fat](#)

[teachers: the discursive politics of school reform and teacher health](#)*Carolyn Vander Schee & Michael Gard*

The idea of using schools for public health ends has a long and complex history. If anything, interest in the public health role of schools may actually be intensifying, perhaps driven by the attention given to a range of health matters affecting young people, notably mental illness, drugs and alcohol, and obesity. This paper deals predominantly with obesity but emerges out of our ongoing research into both the nature and consequences of policies and interventions that seek to use American public schools to prosecute public health goals. In particular, our focus is on the kinds of school-based interventions that widespread panic about childhood obesity has generated and their consequences for teachers. We take up this matter by examining how American teachers' health – and the associated responsibilities and obligations to inspire health among young people – are discursively constructed in legislation, policy documents, and academic articles. Our review and analysis of these texts reveal the presence of three distinct discursive formations: teachers as health role models, teachers as fiscal liabilities, and teachers as instruments of policy compliance. These formations, we argue, suggest a novel and, in some cases, alarming trajectory in school-based obesity policies and interventions.

In this month's [Health, Risk and Society](#) you'll find:

[‘I can choose’: the reflected prominence of personal control in representations of health risk in Canada](#)*Jennifer E.C. Lee, Christine Dallaire, Marie-Pierre L. Markon, Louise Lemyre, Daniel Krewski & Michelle C. Turner*

Multidisciplinary research has contributed to a better understanding of the personal and societal correlates of risk perception. However, representations of ‘health risk’ remain to be characterised more fully. Drawing on a Canadian study conducted in 2004, an analysis was conducted to develop better characterisations of individual representations of health risk. The study involved a national telephone survey (N = 1503) and face-to-face semi-structured interviews with individuals across Canada (N = 73) in which participants' representations of health, risk and health risk were elicited using a word association technique. In the telephone survey, it was found that

representations of health risk were most frequently negative, with many participants referring to disease and illness. The concept of health risk was also associated with lifestyle, individual control and personal agency, suggesting that individual health behaviour and personal responsibility for health were prominent features of public discourse on health risk in Canada. However, subtle variations in representations of health risk were observed in analyses of semi-structured interviews, pointing to important differences according to age and gender in this specific discourse. There was agreement among participants that health risks were associated with individual vulnerability and menace to life or health, and that such vulnerability increased with age. However, women were less likely to focus on the idea of actively making choices to control health risks and less frequently made references to the positive aspects of health risks.

[Counselling uncertainty: genetics professionals' accounts of \(non\)directiveness and trust/distrust](#)

Michael Arribas-Ayllon & Srikant Sarangi

In genetic counselling, uncertainty is central to the client–professional relationship where decisions are made on the basis of risk information/assessment. For various historical reasons, genetic counsellors adopt an ethos of ‘nondirectiveness’ to communicate risk and offer support without advising their clients on what decisions to reach. However, nondirectiveness remains an ambiguous and contested concept that has acquired a negative meaning of ‘not influencing clients’ or ‘adopting an indifferent stance’. We argue that nondirectiveness also implies a positive sense of acknowledging genetic counselling as a process of influence. Drawing on interview data (n = 25) involving professionals from England and South Wales (UK), accounts of genetic testing indicate a dynamic relationship between managing uncertainty on the one hand and negotiating trust and distrust on the other. In the counselling process, trusting and distrusting are coexisting techniques of assessing clients’ motivations, expectations and reasons for genetic testing. Using rhetorical discourse analysis as our analytical approach, we identify a pattern of accounting whereby professionals justify a directive stance when they are not confident whether clients have considered the uncertainty of the situation. More than a veneer of neutrality and indifference, we argue that nondirectiveness is a technique by which genetics professionals explore whether clients can be trusted to make autonomous decisions within a climate of uncertainty. Eliciting confidence and establishing trust within the

context of genetic counselling are enabling, pastoral strategies for configuring risk and emotion.

[Australian mothers' notions of risk and uncertainty in relation to their pre-teen children](#)

Jan Wright, Christine Halse, Gary Levy & Catherine Hartung

In this article we examine the ways discourses of risk manifested and played out within and across two groups of Australian mothers living in two large urban centres in Australia: the first comprised of mothers who had a pre-teen child diagnosed with an eating disorder (n = 13); the second of mothers who had a pre-teen child without the symptoms or diagnosis of an eating disorder (n = 13). In 2011 and 2012, we conducted in-depth interviews with the mothers in their homes on their ideas about health and their relationships with their children. An analysis of the data collected from these interviews indicated that having a pre-teen child diagnosed with an eating disorder had a decisive impact on how the mothers constituted and responded to risk. For mothers, who had a pre-teen child with an eating disorder, risk was intensified by bio-medical discourses. The particular intensifications of risk limited the ways in which mothers could act and often threatened to undermine their abilities as competent carers. By contrast, the mothers who did not have a pre-teen child with an eating disorder spoke about risk less directly, and with less sense of immediacy. Where these mothers acknowledged risk discourses particularly in regard to health, they were in a stronger position to negotiate them. Our analysis indicates that the ways in which mothers responded to risk is contingent on circumstances and contexts. Mothers' responses to risk were related to the calculability of the risk and their perceived capacity to manage it.

In addition to the as always numerous book reviews, the [Journal of the History of Medicine and Allied Sciences](#) published the following original articles this month:

[The Unwanted Heroes: War Invalids in Poland after World War I](#)

Anita Magowska

This article focuses on the unique and hitherto unknown history of disabled ex-servicemen and civilians in interwar Poland. In 1914, thousands of Poles were conscripted into the Austrian, Prussian, and Russian armies and forced to fight against each other. When the war ended and Poland regained independence after more than

one hundred years of partition, the fledgling government was unable to provide support for the more than three hundred thousand disabled war victims, not to mention the many civilians left injured or orphaned by the war. The vast majority of these victims were ex-servicemen of foreign armies, and were deprived of any war compensation. Neither the Polish government nor the impoverished society could meet the disabled ex-servicemen's medical and material needs; therefore, these men had to take responsibility for themselves and started cooperatives and war-invalids-owned enterprises. A social collaboration between Poland and America, rare in Europe at that time, was initiated by the Polish community in the United States to help blind ex-servicemen in Poland.

[Efficacy and Enlightenment: LSD Psychotherapy and the Drug Amendments of 1962](#)

Matthew Oram

The decline in therapeutic research with lysergic acid diethylamide (LSD) in the United States over the course of the 1960s has commonly been attributed to the growing controversy surrounding its recreational use. However, research difficulties played an equal role in LSD psychotherapy's demise, as they frustrated researchers' efforts to clearly establish the efficacy of treatment. Once the Kefauver Harris Drug Amendments of 1962 introduced the requirement that proof of efficacy be established through controlled clinical trials before a drug could be approved to market, the value of clinical research became increasingly dependent on the scientific rigor of the trial's design. LSD psychotherapy's complex method of utilizing drug effects to catalyze a psychological treatment clashed with the controlled trial methodology on both theoretical and practical levels, making proof of efficacy difficult to obtain. Through a close examination of clinical trials performed after 1962, this article explores how the new emphasis on controlled clinical trials frustrated the progress of LSD psychotherapy research by focusing researchers' attention on trial design to the detriment of their therapeutic method. This analysis provides a new perspective on the death of LSD psychotherapy and explores the implications of the Drug Amendments of 1962.

[The Rise of Emergency Medicine in the Sixties: Paving a New Entrance to the House of Medicine](#)

Anne K. Merritt

Emergency medicine evolved into a medical specialty in the 1960s under the leadership of physicians in small communities across the country. This paper uses three case studies to investigate the political, societal, and local factors that propelled emergency medicine along this path. The case studies—Alexandria Hospital, Hartford Hospital, and Yale-New Haven Hospital—demonstrate that the changes in emergency medicine began at small community hospitals and later spread to urban teaching hospitals. These changes were primarily a response to public demand. The government, the American public, and the medical community brought emergency medical care to the forefront of national attention in the sixties. Simultaneously, patients' relationships with their general practitioners dissolved. As patients started to use the emergency room for non-urgent health problems, emergency visits increased astronomically. In response to rising patient loads and mounting criticism, hospital administrators devised strategies to improve emergency care. Drawing on hospital archives, oral histories, and statistical data, I will argue that small community hospitals' hiring of full-time emergency physicians sparked the development of a new specialty. Urban teaching hospitals, which established triage systems and ambulatory care facilities, resisted the idea of emergency medicine and ultimately delayed its development.

[Neuro Psychiatry 1943: The Role of Documentary Film in the Dissemination of Medical Knowledge and Promotion of the U.K. Psychiatric Profession](#)

Edgar Jones

In 1943, Basil Wright produced a documentary film about the treatment of servicemen and civilians with psychological disorders at Mill Hill Emergency Medical Service Hospital. Funded by the Ministry of Information, *Neuro Psychiatry* was shot to convince influential clinicians and policy makers in North America that the British had developed expertise in the management of psychiatric casualties. By emphasizing novel and apparently effective interventions and excluding severe or intractable cases from the film, Wright encouraged an optimistic sense of achievement. Filmed at a time when victory was considered an eventual outcome, the picture presented a health service to which all had access without charge. Children and unemployed women, two groups excluded under the 1911 National Insurance Act, had been required to pay for healthcare in the prewar period and were shown receiving free treatment from the Emergency Medical Service. However, the therapeutic optimism presented in the film

proved premature. Most U.K. battle casualties arose in the latter half of the conflict and follow-up studies failed to confirm the positive outcome statistics reported in the film. Aubrey Lewis, clinical director of the hospital, criticized research projects conducted at Mill Hill for a lack of rigor. The cinematographic skills of Wright and director Michael Hankinson, together with their reformist agenda, created a clinical presentation that emphasized achievements without acknowledging the limitations not only of the therapies offered by doctors but also the resources available to a nation at war.

Two new articles in [Philosophy, Ethics, and Humanities in Medicine](#):

[Ethical pharmaceutical promotion and communications worldwide: codes and regulations](#)

Jeffrey Francker, Jose Zamarrigo Izquierdo, Tamara Music, Kirti Narsai, Chrisoula Nikidis, Heather Simmonds & Paul Woods

The international pharmaceutical industry has made significant efforts towards ensuring compliant and ethical communication and interaction with physicians and patients. This article presents the current status of the worldwide governance of communication practices by pharmaceutical companies, concentrating on prescription-only medicines. It analyzes legislative, regulatory, and code-based compliance control mechanisms and highlights significant developments, including the 2006 and 2012 revisions of the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) Code of Practice.

Developments in international controls, largely built upon long-established rules relating to the quality of advertising material, have contributed to clarifying the scope of acceptable company interactions with healthcare professionals. This article aims to provide policy makers, particularly in developing countries, with an overview of the evolution of mechanisms governing the communication practices, such as the distribution of promotional or scientific material and interactions with healthcare stakeholders, relating to prescription-only medicines.

[The epistemological role of empathy in psychopathological diagnosis: a contemporary reassessment of Karl Jaspers' account](#)

Panagiotis Oulis

Introduction

In his classic essay “The phenomenological approach to psychopathology”, Karl Jaspers defended the irreducible reality of the “subjective” mental symptoms and stressed the pivotal role of empathy in their diagnostic assessment. However, Jaspers’ account of the epistemological role of empathy in psychopathological diagnosis was far from clear: whereas at several places Jaspers claimed that empathy provides a direct access to patients’ abnormal mental experiences, at other places he stressed that it did so only indirectly, through a whole battery of their observable clinical indicators. The aim of this paper is to reassess Jaspers’ account of the epistemological role of empathy in psychopathological diagnosis.

Methods

I examine thoroughly Jaspers’ assertions on in the role of empathy in the diagnosis of “subjective” symptoms. Moreover, I explicate briefly the epistemological status of psychopathological diagnostic examination with the aid of the distinction between direct and indirect observation.

Results

Diagnostic assessment of “subjective” mental symptoms involves necessarily indirect psychopathological observation. Jaspers’ ambiguity is traced to his failure to distinguish clearly between direct and indirect psychopathological observation along with his excessive reliance on empathy. Relatedly, Jaspers’ ambiguity is also traced to his conflation of the semantics with the epistemology of psychopathological concepts representing patients’ “subjective” mental symptoms. These results apply also to contemporary phenomenological approaches to psychopathological diagnostic examination which maintain that patients’ abnormal mental experiences are invariably expressed in their overt behavior.

Conclusions

Jaspers was right in stressing that psychopathological concepts of subjective mental symptoms represent patients’ genuine abnormal experiences irreducible to concepts representing their associated behavioral manifestations. Moreover, he was right in stressing the importance of the empathic ‘second person’ approach to patients’ mental experiences. However, he failed to recognize unambiguously that the epistemological access to patients’ mental symptoms, though enormously aided by empathy, remains mainly indirect and thus requires also a ‘third person’ approach to them. Overall then, clinical psychopathological examination requires both a ‘second’ and a ‘third’ person approach, as well as their judicious alternation during the diagnostic interview. Although focused on Jaspers’ essay, my critical analysis is also highly

relevant to contemporary psychopathological approaches aiming to overcome the serious limitations of currently prevailing systems of diagnostic criteria of mental disorders.

As usual, [Social Science & Medicine](#) is very fast and churning out a large volume of articles. Volumes 106 and 107 cover April 2014. I was especially interested in the following:

[Historical trauma as public narrative: A conceptual review of how history impacts present-day health](#)

Nathaniel Vincent Mohatt, Azure B. Thompson, Nghi D. Thai, Jacob Kraemer Tebes

Theories of historical trauma increasingly appear in the literature on individual and community health, especially in relation to racial and ethnic minority populations and groups that experience significant health disparities. As a consequence of this rapid growth, the literature on historical trauma comprises disparate terminology and research approaches. This critical review integrates this literature in order to specify theoretical mechanisms that explain how historical trauma influences the health of individuals and communities. We argue that historical trauma functions as a public narrative for particular groups or communities that connects present-day experiences and circumstances to the trauma so as to influence health. Treating historical trauma as a public narrative shifts the research discourse away from an exclusive search for past causal variables that influence health to identifying how present-day experiences, their corresponding narratives, and their health impacts are connected to public narratives of historical trauma for a particular group or community. We discuss how the connection between historical trauma and present-day experiences, related narratives, and health impacts may function as a source of present-day distress as well as resilience.

[Poverty and mental health in Indonesia](#)

Gindo Tampubolon & Wulung Hanandita

Community and facility studies in developing countries have generally demonstrated an inverse relationship between poverty and mental health. However, recent population-based studies contradict this. In India and Indonesia the poor and non-poor show

no difference in mental health. We revisit the relationship between poverty and mental health using a validated measure of depressive symptoms (CES-D) and a new national sample from Indonesia – a country where widespread poverty and deep inequality meet with a neglected mental health service sector. Results from three-level overdispersed Poisson models show that a 1% decrease in per capita household expenditure was associated with a 0.05% increase in CES-D score (depressive symptoms), while using a different indicator (living on less than \$2 a day) it was estimated that the poor had a 5% higher CES-D score than the better off. Individual social capital and religiosity were found to be positively associated with mental health while adverse events were negatively associated. These findings provide support for the established view regarding the deleterious association between poverty and mental health in developed and developing countries.

['Safer environment interventions': A qualitative synthesis of the experiences and perceptions of people who inject drugs](#)

Ryan McNeil & Will Small

There is growing acknowledgment that social, structural, and environmental forces produce vulnerability to health harms among people who inject drugs (PWID), and safer environment interventions (SEI) have been identified as critical to mitigating the impacts of these contextual forces on drug-related harm. To date, however, SEIs have been under-theorized in the literature, and how they minimize drug-related risks across intervention types and settings has not been adequately examined. This article presents findings from a systematic review and meta-synthesis of qualitative studies reporting PWID's experiences with three types of SEIs (syringe exchange programmes, supervised injection facilities and peer-based harm reduction interventions) published between 1997 and 2012. This meta-synthesis sought to develop a comprehensive understanding of SEIs informed by the experiences of PWID. Twenty-nine papers representing twenty-one unique studies that included an aggregate of more than 800 PWID were included in this meta-synthesis. This meta-synthesis found that SEIs fostered social and physical environments that mitigated drug-related harms and increased access to social and material resources. Specifically, SEIs: (1) provided refuge from street-based drug scenes; (2) enabled safer injecting by reshaping the social and environmental contexts of injection drug use; (3) mediated access to resources and health care services; and, (4) were constrained by drug prohibition and law enforcement activities. These findings indicate that it is critical to situate SEIs in relation to the lived

experiences of PWID, and in particular provide broader environmental support to PWID. Given that existing drug laws limit the effectiveness of interventions, drug policy reforms are needed to enable public health, and specifically SEIs, to occupy a more prominent role in the response to injection drug use.

[Tracking human activity and well-being in natural environments using wearable sensors and experience sampling](#)

Sean T. Doherty, Christopher J. Lemieux & Culum Canally

A growing range of studies have begun to document the health and well-being benefits associated with contact with nature. Most studies rely on generalized self-reports following engagement in the natural environment. The actual in-situ experience during contact with nature, and the environmental features and factors that evoke health benefits have remained relatively unexplored. Smartphones offer a new opportunity to monitor and interact with human subjects during everyday life using techniques such as Experience Sampling Methods (ESM) that involve repeated self-reports of experiences as they occur in-situ. Additionally, embedded sensors in smartphones such as Global Positioning Systems (GPS) and accelerometers can accurately trace human activities. This paper explores how these techniques can be combined to comprehensively explore the perceived health and well-being impacts of contact with nature. Custom software was developed to passively track GPS and accelerometer data, and actively prompt subjects to complete an ESM survey at regular intervals throughout their visit to a provincial park in Ontario, Canada. The ESM survey includes nine scale questions concerning moods and emotions, followed by a series of open-ended experiential questions that subjects provide recorded audio responses to. Pilot test results are used to illustrate the nature, quantity and quality of data obtained. Participant activities were clearly evident from GPS maps, including especially walking, cycling and sedate activities. From the ESM surveys, participants reported an average of 25 words per question, taking an average of 15 s to record them. Further qualitative analysis revealed that participants were willing to provide considerable insights into their experiences and perceived health impacts. The combination of passive and interactive techniques is sure to make larger studies of this type more affordable and less burdensome in the future, further enhancing the ability to understand how contact with nature enhances health and well-being.

[Motivation, justification, normalization: Talk strategies used by Canadian medical tourists regarding their choices to go abroad for hip and knee surgeries](#)

Keri Cameron, Valorie A. Crooks, Vera Chouinard, Jeremy Snyder, Rory Johnston & Victoria Casey

Contributing to health geography scholarship on the topic, the objective of this paper is to reveal Canadian medical tourists' perspectives regarding their choices to seek knee replacement or hip replacement or resurfacing (KRHRR) at medical tourism facilities abroad rather than domestically. We address this objective by examining the 'talk strategies' used by these patients in discussing their choices and the ways in which such talk is co-constructed by others. Fourteen interviews were conducted with Canadians aged 42–77 who had gone abroad for KRHRR. Three types of talk strategies emerged through thematic analysis of their narratives: motivation, justification, and normalization talk. Motivation talk referenced participants' desires to maintain or resume physical activity, employment, and participation in daily life. Justification talk emerged when participants described how limitations in the domestic system drove them abroad. Finally, being a medical tourist was talked about as being normal on several bases. Among other findings, the use of these three talk strategies in patients' narratives surrounding medical tourism for KRHRR offers new insight into the language-health-place interconnection. Specifically, they reveal the complex ways in which medical tourists use talk strategies to assert the soundness of their choice to shift the site of their own medical care on a global scale while also anticipating, if not even guarding against, criticism of what ultimately is their own patient mobility. These talk strategies provide valuable insight into why international patients are opting to engage in the spatially explicit practice of medical tourism and who and what are informing their choices.

[The potential consequences of informal interpreting practices for assessment of patients in a South African psychiatric hospital](#)

Sanja Kilian, Leslie Swartz, Tessa Dowling, Mawande Dlali & Bonginkosi Chiliza

In South Africa health care practitioners are commonly professionals who speak only one, or at most two, of the languages spoken by their patients. This provides for language provision challenges, since many patients are not proficient in English or Afrikaans and ad hoc and haphazard arrangements are made for interpreting by untrained personnel. As part of a larger

study (conducted in 2010) in a public psychiatric hospital, we report here on the potential consequences for diagnostic assessments of 13 psychiatric evaluations mediated by ad hoc interpreters who were employed as health care workers and household aides. The psychiatric evaluations were recorded and transcribed verbatim. The first author checked for accuracy of transcription and translations, and the two members of the author team who are both senior African language academics rechecked transcription and translation. We used the typology developed by Vasquez and Javier (1991) to study interpreter errors (i.e. omissions, additions and substitutions). All errors were independently rated by a senior psychiatrist and a senior clinical psychologist to determine whether the errors were likely to have a bearing on clinical decisions concerning the patient and to rate whether errors deemed clinically significant contributed to making the patient appear more ill psychiatrically, or less ill. Of the 57 errors recorded, 46% were rated as likely to have an impact on the goal of the clinical session. Raters concurred that the clinically significant errors contributed towards potentially making the patient look more psychiatrically ill. Detailed analyses of evaluations demonstrate the complexity of informal interpreter positioning regarding issues of diagnosis and cultural factors in illness. Evaluations conducted where clinicians and interpreters are not trained in language and interpreting issues may create a distorted picture of the patients' mental health conditions.

[Gender, acculturation, and smoking behavior among U.S. Asian and Latino immigrants](#)

Bridget K. Gorman, Joseph T. Lariscy & Charisma Kaushik

In this paper we examine smoking prevalence and frequency among Asian and Latino U.S. immigrants, focusing on how gender differences in smoking behavior are shaped by aspects of acculturation and the original decision to migrate. We draw on data from 3249 immigrant adults included in the 2002–2003 National Latino and Asian American Study. Findings confirm the gender gap in smoking, which is larger among Asian than Latino immigrants. While regression models reveal that gender differences in smoking prevalence, among both immigrant groups, are not explained with adjustment for measures of acculturation and migration decisions, adjustment for these factors does reduce gender differences in smoking frequency to non-significance. Following, we examine gender-stratified models and test whether aspects of migration decisions and acculturation relate more strongly to smoking behavior among women; we find that patterns are complex and

depend upon pan-ethnic group and smoking measure.

[Sites of institutional racism in public health policy making in New Zealand](#)

Heather Came

Although New Zealanders have historically prided ourselves on being a country where everyone has a 'fair go', the systemic and longstanding existence of health inequities between Māori and non-Māori suggests something isn't working. This paper informed by critical race theory, asks the reader to consider the counter narrative viewpoints of Māori health leaders; that suggest institutional racism has permeated public health policy making in New Zealand and is a contributor to health inequities alongside colonisation and uneven access to the determinants of health. Using a mixed methods approach and critical anti-racism scholarship this paper identifies five specific sites of institutional racism. These sites are: majoritarian decision making, the misuse of evidence, deficiencies in both cultural competencies and consultation processes and the impact of Crown filters. These findings suggest the failure of quality assurance systems, existing anti-racism initiatives and health sector leadership to detect and eliminate racism. The author calls for institutional racism to be urgently addressed within New Zealand and this paper serves as a reminder to policy makers operating within other colonial contexts to be vigilant for such racism.

[Who donates their bodies to science? The combined role of gender and migration status among California whole-body donors](#)

Asad L. Asad, Michel Anteby & Filiz Garip

The number of human cadavers available for medical research and training, as well as organ transplantation, is limited. Researchers disagree about how to increase the number of whole-body bequeathals, citing a shortage of donations from the one group perceived as most likely to donate from attitudinal survey data – educated white males over 65. This focus on survey data, however, suffers from two main limitations: First, it reveals little about individuals' actual registration or donation behavior. Second, past studies' reliance on average survey measures may have concealed variation within the donor population. To address these shortcomings, we employ cluster analysis on all whole-body donors' data from the Universities of California at Davis, Irvine, Los Angeles, and San Francisco. Two donor groups emerge from the analyses: One is made of slightly younger, educated, married

individuals, an overwhelming portion of whom are U.S.-born and have U.S.-born parents, while the second includes mostly older, separated women with some college education, a relatively higher share of whom are foreign-born and have foreign-born parents. Our results demonstrate the presence of additional donor groups within and beyond the group of educated and elderly white males previously assumed to be most likely to donate. More broadly, our results suggest how the intersectional nature of donors' demographics – in particular, gender and migration status – shapes the configuration of the donor pool, signaling new ways to possibly increase donations.

[Transnational nurse migration: Future directions for medical anthropological research](#)

Megan Prescott & Mark Nichter

Transnational nurse migration is a serious global health issue in which inequitably distributed shortages hinder health and development goals. This article selectively reviews the literature on nurse migration that has emerged from nursing, health planning, and the social sciences and offers productive directions for future anthropological research. The literature on global nurse migration has largely focused on push/pull economic logic and the concept of brain drain to understand the causes and effects of nurse migration. These concepts obscure political-economic, historical, and cultural factors that pattern nurse migration and influence the complex effects of nurse migration. Global nurse care chain analysis helps illuminate the numerous nodes in the production and migration of nurses, and management of this transnational process. Examples are provided from the Philippines and India to illustrate ways in which this analysis may be deepened, refined and rendered more critical by anthropological research.

[Is shared misery double misery?](#)

Merehau Cindy Mervin & Paul Frijters

The literature has shown strong associations between health, financial and social life events and mental health. However, no studies as yet have looked at the temporal nature of the effects of life events on stated mental health nor have they included the effects of the events befalling partners within a household. This paper looks at the spillover in mental health, measured with the SF-36 scale, from one partner to the other, using life events to identify this relationship. We propose a new model that allows for

both a temporal spacing of effects (anticipation and adaptation) as well as a spillover factor, which we define as the degree to which the events that are experienced by the partner affect us in the same way as if these events were to happen to us. We use data from 51,380 person-year observations of the Household, Income and Labour Dynamics in Australia survey (2002–10) which consistently measures nine distinct events, including illnesses, social shocks and financial shocks. We find that the events befalling a partner on average have an effect about 15% as large as the effect of own events. We use the estimates to compute the compensation required to offset own and partner's life events. The methodology in this paper is potentially useful for estimating other spillover parameters such as the effects of others in the family or in the neighbourhood.

[Gender difference in the health risk perception of radiation from Fukushima in Japan: The role of hegemonic masculinity](#)

Rika Morioka

This paper presents the preliminary findings of gender difference in the perception of radiation risk in the aftermath of the Fukushima nuclear disaster in Japan. In-depth interviews were conducted with the residents of Fukushima and other parts of Japan in November 2011 and July 2012. Compared to mothers, fathers in general expressed less concern for radiation. Fathers prioritized their responsibilities as the breadwinner for their families and saw radiation risk as a threat to economic stability and masculine identity. As a result, mothers' health concerns were dismissed, and they were prevented from taking preventive actions. The social norms in the dominant institutions such as corporations and the government influenced men's perception of radiation risk. The findings illustrate the importance of sociocultural context in which meanings of health risk are constructed.

[Adapting to social and political transitions – The influence of history on health policy formation in the Republic of the Union of Myanmar \(Burma\)](#)

Shakil Ahmed & Beverley-Ann Biggs

The Republic of the Union of Myanmar (Burma) has a long and complex history characterized by internal conflict and tense international relations. Post-independence, the health sector has gradually evolved, but with health service development and indicators lagging well behind regional expectations. In recent years, the country has initiated political reforms and a reorientation

of development policy towards social sector investment. In this study, from a systems and historical perspective, we used publicly available data sources and grey literature to describe and analyze links between health policy and history from the post-independence period up until 2012. Three major periods are discernable in post war health system development and political history in Myanmar. The first post-independence period was associated with the development of the primary health care system extending up to the 1988 political events. The second period is from 1988 to 2005, when the country launched a free market economic model and was arguably experiencing its highest levels of international isolation as well as very low levels of national health investment. The third period (2005–2012) represents the first attempts at health reform and recovery, linked to emerging trends in national political reform and international politics. Based on the most recent period of macro-political reform, the central state is set to transition from a direct implementer of a command and control management system, towards stewardship of a significantly more complex and decentralized administrative order. Historical analysis demonstrates the extent to which these periodic shifts in the macro-political and economic order acts to reset the parameters for health policy making. This case demonstrates important lessons for other countries in transition by highlighting the extent to which analysis of political history can be instructive for determination of more feasible boundaries for future health policy action.

And finally, [Social Studies of Science](#) brings you this:

[Physician–industry collaboration: Conflicts of interest and the imputation of motive](#)

Sarah Wadman

Policies about physicians' involvement with pharmaceutical companies spawn contradictory ideas. One set of policies aims to stimulate collaboration between private companies and publicly employed researchers to spur innovation and economic growth, another addresses what is seen as the problem of physicians' conflicts of interest stemming from industry collaboration. This article explores how these contradictory policies interact with everyday practice in clinical hypertension research in Denmark. I argue that 'corporate' and 'academic' research is entangled as physicians participate in industry trials to pursue their own

research. Building on document analysis, observations of contract research, and interviews with clinician researchers and industry executives, I show how the establishment of industry 'ties' can serve as a way for physicians to navigate the constraints of research infrastructures and live up to intergenerational norms that knit the medical collective together. I discuss how this entanglement shapes medical research in ways that may run counter to the aims of medical innovation policies and that conflicts of interest policies do little to address. I conclude that appreciation of the ways in which economic and moral valuations come together is necessary to understand the conditions for medical research in an intertwined public–private research environment.

[Epidemiology and 'developing countries': Writing pesticides, poverty and political engagement in Latin America](#)

Ben W. Brisbois

The growth of the field of global health has prompted renewed interest in discursive aspects of North–South biomedical encounters, but analysis of the role of disciplinary identities and writing conventions remains scarce. In this article, I examine ways of framing pesticide problems in 88 peer-reviewed epidemiology papers produced by Northerners and their collaborators studying pesticide-related health impacts in Latin America. I identify prominent geographic frames in which truncated and selective histories of Latin America are used to justify research projects in specific research sites, which nevertheless function rhetorically as generic 'developing country' settings. These frames legitimize health sector interventions as solutions to pesticide-related health problems, largely avoiding more politically charged possibilities. In contrast, some epidemiologists appear to be actively pushing the bounds of epidemiology's traditional journal article genre by engaging with considerations of political power, especially that of the international pesticide industry. I therefore employ a finer-grained analysis to a subsample of 20 papers to explore how the writing conventions of epidemiology interact with portrayals of poverty and pesticides in Latin America. Through analysis of a minor scientific controversy, authorial presence in epidemiology articles, and variance of framing strategies across genres, I show how the tension between 'objectivity' and 'advocacy' observed in Northern epidemiology and public health is expressed in North–South interaction. I end by discussing implications for postcolonial and socially engaged approaches to science and technology studies, as well as their relevance to the actual practice of global health research. In particular, the complicated interaction

of the conflicted traditions of Northern epidemiology with Latin American settings on paper hints at a far more complex interaction in the form of public health programming involving researchers and research participants who differ by nationality, ethnicity, gender, profession, and class.

AMA citation

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