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## In the Journals: November 2014, Part I

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By Thurka Sangaramoorthy

Happy November! Please find below the first half of this month's roundup including selections from *American Ethnologist*; *Health*; *Philosophy, Ethics, and Humanities in Medicine*; and *Social Theory and Health*. In addition, [Medical Anthropology Theory \(MAT\)](#) went live this month. There is a previous write-up on MAT on Somatosphere—you can find it [here](#). Enjoy.

### [American Ethnologist](#)

[The paradoxical victim: Intimate violence narratives on trial in Italy](#)

*Alessandra Gribaldo*

Victims' testimony plays a pivotal role in domestic violence hearings in Italy. In examining this role, Gribaldo approaches the Italian legal field as a heterogeneous system of knowledge and power that engages in complex relations with techniques of subjection and discourses of truth and, thus, as eminently suited to investigating the production of the victim-subject. Paradoxically, the testimony of female victims of abuse is trapped between the normativity of justice system requirements and the confessional device, rendering it legally insignificant and thus essentially inadequate. In this context, the women's credibility and agency are central. Gribaldo outlines one legal case in which race and class intersect and the required modes of testimony are disrupted through the use of communication styles drawn from popular culture.

### [Health](#)

[The context of empowerment and self-care within the field of diabetes](#)

*Sasha Scambler, Paul Newton, and Koula Asimakopoulou*

There is a growing emphasis within the diabetes literature on the importance of empowerment as a way of encouraging people to

take control of and responsibility for the successful management of their disease. Patients are actively encouraged to become active participants in their care, and there is an expectation that health-care professionals will facilitate this process. This article uses Bourdieu's concept of field, as a bounded social space in which actors conduct their lives day-to-day, to explore the context within which issues of empowerment are addressed and negotiated. The practice of empowerment within the biologically defined and biomedically 'policed' field of diabetes is explored using empirical data from a study of diabetes health-care professionals' understanding and practices around empowerment. It is concluded that rather than promoting active self-management and empowerment, the nature of the field of diabetes, and in particular its privileging of the biomedical, can mitigate against people with diabetes negotiating the field effectively and taking control of the disease and its management.

#### [Local status and power in area-based health improvement partnerships](#)

*Katie Powell, Miranda Thurston, and Daniel Bloyce*

Area-based initiatives have formed an important part of public policy towards more socio-economically deprived areas in many countries. Coordinating service provision within and across sectors has been a common feature of these initiatives. Despite sustained policy interest in area-based initiatives, little empirical work has explored relations between area-based initiative providers, and partnership development within this context remains under-theorized. This article addresses both of these gaps by exploring partnerships as a social and developmental process, drawing on concepts from figurational sociology to explain how provider relations develop within an area-based initiative. Qualitative methods were used to explore, prospectively, the development of an area-based initiative targeted at a town in the north west of England. A central finding was that although effective delivery of area-based initiatives is premised on a high level of co-ordination between service providers, the pattern of interdependencies between providers limits the frequency and effectiveness of co-operation. In particular, the interdependency of area-based initiative providers with others in their organization (what is termed here as 'organizational pull') constrained the ways in which they worked with providers outside of their own organizations. 'Local' status, which could be earned over time, enabled some providers to exert greater control over the way in which provider relations developed during the course of the initiative. These findings demonstrate how historically constituted

social networks, within which all providers are embedded, shape partnership development. The theoretical insight developed here suggests a need for more realistic expectations among policymakers about how and to what extent provider partnerships can be managed.

[International medical migration: A critical conceptual review of the global movements of doctors and nurses](#)

*Hannah Bradby*

This paper critically appraises the discourse around international medical migration at the turn of the 21st century. A critical narrative review of a range of English-language sources, including grey literature, books and research reports, traces the development and spread of specific causative models. The attribution of causative relations between the movement of skilled medical workers, the provision of health care and population health outcomes illustrates how the global reach of biomedicine has to be understood in the context of local conditions. The need to understand migration as an aspect of uneven global development, rather than a delimited issue of manpower services management, is illustrated with reference to debates about 'brain drain' of Africa's health-care professionals, task-shifting and the crisis in health-care human resources. The widespread presumed cause of shortages of skilled health-care staff in sub-Saharan Africa was overdetermined by a compelling narrative of rich countries stealing poor countries' trained health-care professionals. This narrative promotes medical professional interests and ignores historical patterns of underinvestment in health-care systems and structures. Sociological theories of medicalization suggest that the international marketization of medical recruitment is a key site where the uneven global development of capital is at work. A radical reconfiguration of medical staffing along the lines of 'task-shifting' in rich and poor countries' health-care systems alike offers one means of thinking about global equity in access to quality care.

[Medical professionalism on television: Student perceptions and pedagogical implications](#)

*Roslyn Weaver, Ian Wilson, and Vicki Langendyk*

Previous research has pointed to the role television can play in informing health practices and beliefs. Within the academic setting

in particular, some educators have raised concerns about the influence of medical dramas on students. Less research, however, draws on the perspectives of students, and this study therefore explores medical students' perceptions of medical practice and professionalism in popular medical television programs. Qualitative data from surveys of Australian undergraduate medical students showed that students perceived professionalism in dichotomous ways, with three main themes: cure–care, where a doctor's skill is either technical or interpersonal; work–leisure, where a doctor is either dedicated to work or personal life; and clinical–administration, where work is either direct patient care or administration. There continue to be imagined divisions between curing and caring for students, who express concerns about balancing work and leisure, and expectations that doctors should have little administrative work. Given students were able to identify these important contemporary issues around professionalism on television, there is pedagogical value in using popular images of the medical world in medical education.

[The experiences of close persons caring for people with chronic kidney disease stage 5 on conservative kidney management: Contested discourses of ageing](#)

*Joe Low, Jason Myers, Glenn Smith, Paul Higgs, Aine Burns, Katherine Hopkins, and Louise Jones*

Chronic kidney disease stage 5 is a global health challenge in the context of population ageing across the world. The range of treatment options available to patients at all ages has increased and includes transplantation and dialysis. However, these options are often seen as inappropriate for older frailer patients who are now offered the option of conservative kidney management, which is presented as a non-invasive alternative to dialysis, involving symptom management and addressing psychosocial needs. In this study, we conducted qualitative interviews with 26 close persons caring for someone with chronic kidney disease stage 5 in the United Kingdom to investigate how conservative kidney management interacted with implicit ideas of ageing, in both the experience of conservative kidney management and the understanding of the prognosis and future care of the kidney disease. Our findings highlighted participant confusion about the nature of conservative kidney management, which stems from an initial lack of clarity about how conservative kidney management differed from conventional treatments for chronic kidney disease stage 5. In particular, some respondents were not aware of the implicit palliative nature of the intervention or indeed the inevitable

end-of-life issues. Although these findings can be situated within the context of communication failure, we would further argue that they also bring to the surface tensions in the discourses surrounding ageing and old age, drawing on the use of a 'natural' and a 'normal' paradigm of ageing. In the context of chronic kidney disease stage 5, more patients are being dialyzed at older ages, but conservative kidney management is being advanced as a better option than dialysis in terms of quality of life and experience. However, in doing so, conservative kidney management implicitly draws on a notion of older age that echoes natural ageing rather than advocate a more interventionist approach. The role of discourses of ageing in the provision of treatments for conservative kidney management has not previously been acknowledged, and this article addresses this gap.

#### [Parent-led conferences as sites of medical work](#)

*Rebecca Dimond*

Conferences are novel sites for understanding medical work. Through describing styles of presentation that take place at conferences attended by patients and parents, this article highlights how clinicians on stage present ordinary and extraordinary aspects of medicine. Attention is drawn to the reaction of the parents in the audience. The power of the presenter to direct proceedings highlights the potential vulnerability of the audience. The relationship between clinician on stage and parents in the audience reflects the clinical relationship between doctor and patient. But through identifying insiders and outsiders, the conference setting also enables new relationships and collective identities to be formed. Drawing on an ethnographic study of rare disease conferences, this article extends understanding of medical work by identifying how conferences offer new ways of witnessing the clinical gaze, the doctor–patient relationship and the formation and enactment of a conference community.

#### [Timescapes of obesity: Coming to terms with a complex socio-medical phenomenon](#)

*Ulrike Felt, Kay Felder, Theresa Öhler, and Michael Penkler*

Obesity is generally considered to be a growing global health problem that results from changes in the way we live in late modern societies. In this article, we argue that investigating the complexities of contemporary timescapes (i.e. the entanglement of physical, culturally framed and personally experienced times) is of

key importance for understanding how ‘the obesity phenomenon’ is conceptualized, performed and acted upon. Analyzing both focus groups and print-media articles, we identified three major groups of temporal narratives that shape our perception of obesity: trajectories, temporalities and timing. Each group of narratives follows a different logic and performs a specific kind of ordering work: ontological work that defines what obesity ‘really is’, diagnostic work that assesses the state of contemporary society and moral work that assigns responsibility to act. We show how the narratives are assembled into distinct timescapes that distribute agency in specific ways. Combining data from both focus groups and media articles allows us to analyze how these two discursive arenas are intertwined, as it makes visible how stories travel and converge, but also diverge in quite important ways. This highlights the importance of a multi-arena approach to fully understand the tensions between different framings of health-related issues. The article argues that the difficulties of controlling body weight are closely entangled with a perceived lack of control over time on both collective and individual levels. In conclusion, we suggest time-sensitive approaches for the analysis of health phenomena and the development of corresponding policy measures.

## **[Philosophy, Ethics, and Humanities in Medicine](#)**

### [Discourse on medicine: meditative and calculative approaches to ethics from an international perspective](#)

*David Cruise Malloy, Ronald Martin, Thomas Hadjistavropoulos, Peilai Liu, Elizabeth Fahey McCarthy, Ilhyeok Park, N Shalani, Masaaki Murakami and Suchat Paholpak*

Heidegger’s two modes of thinking, calculative and meditative, were used as the thematic basis for this qualitative study of physicians from seven countries (Canada, China, India, Ireland, Japan, Korea, & Thailand). Focus groups were conducted in each country with 69 physicians who cared for the elderly. Results suggest that physicians perceived ethical issues primarily through the lens of calculative thinking (76%) with emphasis on economic concerns. Meditative responses represented 24% of the statements and were mostly generated by Canadian physicians whose patients typically were not faced with economic barriers to treatment due to Canada’s universal health care system.

[Nonconsensual withdrawal of nutrition and hydration in prolonged disorders of consciousness: Authoritarianism and trustworthiness in medicine](#)

*Mohamed Y Rady and Joseph L Verheijde*

The Royal College of Physicians of London published the 2013 national clinical guidelines on prolonged disorders of consciousness (PDOC) in vegetative and minimally conscious states. The guidelines acknowledge the rapidly advancing neuroscientific research and evolving therapeutic modalities in PDOC. However, the guidelines state that end-of-life decisions should be made for patients who do not improve with neurorehabilitation within a finite period, and they recommend withdrawal of clinically assisted nutrition and hydration (CANH). This withdrawal is deemed necessary because patients in PDOC can survive for years with continuation of CANH, even when a ceiling on medical care has been imposed, ie, withholding new treatment such as cardiopulmonary resuscitation for acute life-threatening illness. The end-of-life care pathway is centered on a staged escalation of medications, including sedatives, opioids, barbiturates, and general anesthesia, concurrent with withdrawal of CANH. Agitation and distress may last from several days to weeks because of the slow dying process from starvation and dehydration. The potential problems of this end-of-life care pathway are similar to those of the Liverpool Care Pathway. After an independent review in 2013, the Department of Health discontinued the Liverpool Care pathway in England. The guidelines assert that clinicians, supported by court decisions, have become the final authority in nonconsensual withdrawal of CANH on the basis of “best interests” rationale. The authors posit that these guidelines lack high-quality evidence supporting: 1) treatment futility of CANH, 2) reliability of distress assessment from starvation and dehydration, 3) efficacy of pharmacologic control of this distress, and 4) proximate causation of death. Finally, the authors express concerns about the utilitarian-based assessment of what constitutes a person’s best interests. The authors express their dismay at the level and the role of medical authoritarianism institutionalized by these national guidelines when deciding on the worthiness of life in PDOC. The authors conclude that these guidelines are not only harmful to patients and families, but they represent the means of nonconsensual euthanasia. The latter would constitute a gross violation of the public’s trust in the integrity of the medical profession.

[Spanning our differences: moral psychology, physician beliefs, and the](#)

[practice of medicine](#)

*Ryan M Antiel, Katherine M Humeniuk and Jon C Tilburt*

Moral pluralism is the norm in contemporary society. Even the best philosophical arguments rarely persuade moral opponents who differ at a foundational level. This has been vividly illustrated in contemporary debates in bioethics surrounding contentious issues such as abortion and euthanasia. It is readily apparent that bioethics discourse lacks an empirical explanation for the broad differences about various topics in bioethics and health policy. In recent years, social and cognitive psychology has generated novel approaches for defining basic differences in moral intuitions generally. The authors propose that if empirical research using social intuitionist theory explains why people disagree with one another over moral issues, then the results of such research might help people debate their moral differences in a more constructive and civil manner. The authors illustrate the utility of social intuitionism with data from a national physician survey.

[Ebola, epidemics, and ethics – what we have learned](#)

*G Kevin Donovan*

The current Ebola epidemic has presented challenges both medical and ethical. Although we have known epidemics of untreatable diseases in the past, this particular one may be unique in the intensity and rapidity of its spread, as well as ethical challenges that it has created, exacerbated by its geographic location. The authors look at the infectious agent and the epidemic it is causing, in order to understand the ethical problems that have arisen.

[Social Theory and Health](#)[Challenging the field: Bourdieu and men's health](#)

*Mark Robinson and Steve Robertson*

This article considers how understandings of health promotion with men may be assisted by engagement with Bourdieu's theoretical work. The article outlines leading concepts within Bourdieu's work on 'field', 'habitus' and 'capital'; considers subsequent critical debates among gender, feminist and sociological theorists around structure and agency; and links these to discussions within men's



health. A particular focus concerns structural disruption of, and movement of social actors between, 'fields' such as family, work and leisure settings. The article examines, through Bourdieu's critical legacy, whether such disruption establishes conditions for transformative reflexivity among men in relation to previously held dispositions (*habitus*), including those inflected by masculinities, that affect men's health practices. Recent work within Bourdieu's heritage potentially facilitates a re-framing of understandings of men's health practices. The article specifically explores masculine ambivalence within accounts of reflexivity, identities and practice, and considers how social and symbolic (masculine) capital are in play. Implications of Bourdieu's leading concepts for theorizing settings-focused approaches to men's health promotion are exemplified with reference to a men's health project in a football stadium leisure setting. The article considers the benefits and challenges of applying gendered critical insights drawing on Bourdieu's work to men's health promotion, and discusses emerging theoretical dilemmas.

#### [Classification in psychiatry: Inevitable but not insurmountable](#)

*Huw Green*

The debate about psychiatric nosology was reignited last year when the fifth edition of the Diagnostic and Statistical Manual (DSM) was published to widespread criticism. Critics cite a number of problems with 'psychiatric diagnosis', though it is sometimes unclear which classificatory practices are included under this broad heading. Although it may be possible to avoid the problems inherent in the DSM system, other difficulties associated with classification (labelling, stigma) may prove harder to escape. The first part of this article argues that some form of psychiatric classification is made inevitable by the communicative, epistemic and ethical pressures on psychiatry. In the second half it is suggested that there are ways to think differently about our relationship to psychiatric classification, and that these could play a role in mitigating the harms outlined by diagnosis' critics.

#### [Governing through choice: Food labels and the confluence of food industry and public health discourse to create 'healthy consumers'](#)

*Christopher Mayes*

Food industry and public health representatives are often in conflict, particularly over food labelling policies and regulation. Food corporations are suspicious of regulated labels and perceive

them as a threat to free market enterprise, opting instead for voluntary labels. Public health and consumer groups, in contrast, argue that regulated and easy-to-read labels are essential for consumers to exercise autonomy and make healthy choices in the face of food industry marketing. Although public health and food industry have distinct interests and objectives, I argue that both contribute to the creation of the food label as a governmental strategy that depends on free-market logics to secure individual and population health. While criticism of 'Big Food' has become a growth industry in academic publishing and research, wider critique is needed that also includes the activities of public health. Such a critique needs to address the normalizing effect of neoliberal governmentality within which both the food industry and public health operate to reinforce individuals as 'healthy consumers'. Drawing on Michel Foucault's lectures at the Collège de France, I examine the food label through the lens of governmentality. I argue that the rationale operating through the food label combines nutrition science and free-market logics to normalize subjects as responsible for their own health and reinforces the idea of consumption as a means to secure population health from diet-related chronic diseases.

[Relocation, realignment and standardisation: Circuits of translation in Huntington's disease](#)

*Jamie Lewis, Jacki Hughes and Paul Atkinson*

Based on complementary ethnographies of a biomedical laboratory and a clinic – both working on Huntington Disease (HD) – we discuss the circuits of translation evident in biomedical and clinical research. By examining a recent epistemological shift from understanding the disease as genetic to understanding the disease as a problem for neuroscience, as well as documenting the multiple framings of the disease that migrate between the laboratory and the clinic, we emphasize the complexity involved in the movement of biomedical science into clinical work. We stress that this is not a one-way flow from the colloquially known bench to bedside, but is dependent on a cluster of contextual activities and local actors. We also stress the extent to which global collaborations, standardization and regulatory frameworks can facilitate such framing and migration by aligning local practices and different disciplinary outlooks. We take a sociological perspective on translational processes – or rather to an expanded understanding of translation – to capture the material flows and conceptual transformations that are involved in the complex relationships between fundamental and clinical research.

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