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## In the Journals -- February 2016, Part II

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By Aaron Seaman

And now for a very belated February post (not even the extra day could help this year...). However, there is much to dig in to here, including two special issues, "The Sociology of Health Care Safety and Quality" in *Sociology of Health & Illness* and "Anthropology and Medical Photography: Ethnographic, Critical and Comparative Perspectives" in *Visual Anthropology*. Enjoy!

### [Social Science & Medicine](#)

[Invisible walls within multidisciplinary teams: Disciplinary boundaries and their effects on integrated care](#)

*Elisa Giulia Liberati, Mara Gorli, Giuseppe Scaratti*

Delivery of interdisciplinary integrated care is central to contemporary health policy. Hospitals worldwide are therefore attempting to move away from a functional organisation of care, built around discipline-based specialisation, towards an approach of delivering care through multidisciplinary teams. However, the mere existence of such teams may not guarantee integrated and collaborative work across medical disciplines, which can be hindered by boundaries between and within professions. This paper analyses the boundaries that affect collaboration and care integration in newly created multidisciplinary teams. Empirical data are drawn from an ethnographic research conducted in the sub-intensive stroke unit of an Italian public hospital. Data collection involved 180 h of observations and conversations with 42 healthcare providers. Findings show that disciplinary boundaries hinder both intra-professional and inter-professional collaboration. Doctors from different disciplines adopt different, and sometimes conflicting, clinical approaches, doctors and nurses construct discipline-specific professional identities, and conflicts emerge between doctors and nurses from different disciplines over the regulation of the medical–nursing boundary. Achieving collaboration and integration between professionals from different disciplines may be particularly challenging when the group with less institutional power (nurses, in this case) has developed a high

level of expertise on the needs of the patients targeted by the team. Effective interdisciplinary work thus requires not only bridging boundaries within the medical professional group, but also addressing the dynamics of resistance in merging doctors and nurses with different disciplinary backgrounds. In the paper, we summarise these results in a framework that contributes knowledge to the field of professional boundaries in healthcare while offering practical insights to forge new interdisciplinary relationships, which are more embedded in the daily experience of care providers.

[Migrant encounters in the clinic: Bureaucratic, biomedical, and community influences on patient interactions with front-line workers](#)

*Sarah A. Smith*

Ethnographic research on the clinical encounter has focused almost exclusively on what happens in exam rooms—particularly patient-provider interactions—leaving much to be understood about other actors within the clinic. As part of a larger ethnographic study examining the impact of colonialism, transnational migration, discrimination, and gender relations on Chuukese migrant women’s reproductive and sexual health outcomes in Guam, I conducted eight months of participant observation in three publicly funded health clinics, 24 interviews with health care workers, and 15 life-history interviews with Chuukese women between September 2012 and February 2014. Findings demonstrated differential treatment of Chuukese patients by front-line workers (FLWs), who engaged in “boundary work” with these patients. Further, care varied by clinic space and the actors in that space. This differential treatment and variation in care impacted Chuukese women’s access to and experiences with health care in Guam. Utilizing the concept of “deservingness,” this analysis unpacks how FLWs, like Lipsky’s “street-level bureaucrats,” are influenced by bureaucratic, biomedical, and community hierarchies, all contributing to differential patient treatment. This study concludes by calling for more integrated analyses of clinical environments which utilize Lipsky’s concept to include community narratives of “deservingness” and incorporate the influence of clinic and community stratification.

[Neoliberalism and indigenous knowledge: M?ori health research and the cultural politics of New Zealand’s “National Science Challenges”](#)

*Erica Prussing and Elizabeth Newbury*

In 2012–13 the Ministry of Business, Innovation and Employment (MBIE) in New Zealand rapidly implemented a major restructuring of national scientific research funding. The “National Science Challenges” (NSC) initiative aims to promote greater commercial applications of scientific knowledge, reflecting ongoing neoliberal reforms in New Zealand. Using the example of health research, we examine the NSC as a key moment in ongoing indigenous Māori advocacy against neoliberalization. NSC rhetoric and practice through 2013 moved to marginalize participation by Māori researchers, in part through constructing “Māori” and “science” as essentially separate arenas—yet at the same time appeared to recognize and value culturally distinctive forms of Māori knowledge. To contest this “neoliberal multiculturalism,” Māori health researchers reasserted the validity of culturally distinctive knowledge, strategically appropriated NSC rhetoric, and marshalled political resources to protect Māori research infrastructure. By foregrounding scientific knowledge production as an arena of contestation over neoliberal values and priorities, and attending closely to how neoliberalizing tactics can include moves to acknowledge cultural diversity, this analysis poses new questions for social scientific study of global trends toward reconfiguring the production of knowledge about health. Study findings are drawn from textual analysis of MBIE documents about the NSC from 2012 to 2014, materials circulated by Māori researchers in the blogosphere in 2014, and ethnographic interviews conducted in 2013 with 17 Māori health researchers working at 7 sites that included university-based research centers, government agencies, and independent consultancies.

### [The assisted presentations of self in nursing home life](#)

*Anders Næss, Eivind Grip Fjær, and Mia Vabø*

In this paper, based on ethnographic data from five nursing homes, we introduce the concept of assisted self-presentation as an analytical tool for exploring how different care practices affect nursing home residents’ dignity and sense of self. Practices of assisted self-presentation are geared at recognizing and preserving the individuality and autonomy of residents in situations where it may otherwise come under threat or be misrecognized. Sufficient or appropriate forms of attentiveness to residents’ selves and sense of dignity is thus a matter of finding the right balance between intervening too much or too little in residents’

production of their physical or social appearance. Here, staff-members' knowledge and recognition of the individuality of residents is essential. Whereas intervening too much in residents' appearance or performance of self might be perceived and experienced as pacifying, infantilizing, or as paternalistic overbearingness, intervening too little might be seen as neglectfulness or inhumane. Since practices of assisted self-presentation refer to a kind of social action, which will always be contingent upon the specific capacities and conditions of performing actors, it allows for the simultaneous recognition of failed or perverted work practices as well as promising practices through which residents' selves are successfully recognized.

[Bananas, pesticides and health in southwestern Ecuador: A scalar narrative approach to targeting public health responses](#)

*Benjamin Brisbois*

Public health responses to agricultural pesticide exposure are often informed by ethnographic or other qualitative studies of pesticide risk perception. In addition to highlighting the importance of structural determinants of exposure, such studies can identify the specific scales at which pesticide-exposed individuals locate responsibility for their health issues, with implications for study and intervention design. In this study, an ethnographic approach was employed to map scalar features within explanatory narratives of pesticides and health in Ecuador's banana-producing El Oro province. Unstructured observation, 14 key informant interviews and 15 in-depth semi-structured interviews were carried out during 8 months of fieldwork in 2011–2013. Analysis of interview data was informed by human geographic literature on the social construction of scale. Individual-focused narratives of some participants highlighted characteristics such as carelessness and ignorance, leading to suggestions for educational interventions. More structural explanations invoked farm-scale processes, such as uncontrolled aerial fumigations on plantations owned by elites. Organization into cooperatives helped to protect small-scale farmers from 'deadly' banana markets, which in turn were linked to the Ecuadorian nation-state and actors in the banana-consuming world. These scalar elements interacted in complex ways that appear linked to social class, as more well-off individuals frequently attributed the health problems of other (poorer) people to individual behaviours, while providing more structural explanations of their own difficulties. Such individualizing narratives may help to stabilize inequitable social structures.

Research implications of this study include the possibility of using scale-focused qualitative research to generate theory and candidate levels for multi-level models. Equity implications include a need for public health researchers planning interventions to engage with scale-linked inequities, such as disparities within nation-states. Finally, the prominence of the global North in explanatory narratives is a useful reminder that 'structural factors' prominently include inequities related to the legacies of colonialism.

[Our flesh is here but our soul stayed there: A qualitative study on resource loss due to war and displacement among internally-displaced women in the Republic of Georgia](#)

*Maureen Seguin, Ruth Lewis, Tinatin Amirejibi, Mariam Razmadze, Nino Makhashvili, and Bayard Roberts*

Losses experienced by conflict-affected civilians in low and middle income countries is a relatively unexplored area. The aim of our paper is to explore the concept of resource loss in the accounts of internally displaced women in Georgia. We use Hobfoll's Conservation of Resources (COR) theory to guide our approach by examining the loss of objects, personal characteristics, conditions, and energies. Semi-structured interviews were conducted on 42 purposively-selected Georgian women residing in internally displaced persons settlements during fieldwork in Georgia from December 2012 to February 2013. Line-by-line open-coding was conducted on translated and transcribed interviews using Nvivo. The conservation of resources theory was utilised to guide the 'mapping' of the relationships between losses which occurred in the post-conflict period. War-related trauma led to the loss of property, which caused the loss of livelihood and subsequent loss of social networks and mental and physical health. The mental and physical health losses, along with the loss of livelihood, constituted a loss spiral in which losses in one area perpetuated on-going losses in the other areas. Interventions at supporting livelihoods are needed in order to address the cascade of losses resulting from war.

[Social Studies of Science](#)

[Constructing failure in big biology: The socio-technical anatomy of Japan's Protein 3000 Project](#)

*Masato Fukushima*

This study focuses on the 5-year Protein 3000 Project launched in 2002, the largest biological project in Japan. The project aimed to overcome Japan's alleged failure to contribute fully to the Human Genome Project, by determining 3000 protein structures, 30 percent of the global target. Despite its achievement of this goal, the project was fiercely criticized in various sectors of society and was often branded an awkward failure. This article tries to solve the mystery of why such failure discourse was prevalent. Three explanatory factors are offered: first, because some goals were excluded during project development, there was a dynamic of failed expectations; second, structural genomics, while promoting collaboration with the international community, became an 'anti-boundary object', only the absence of which bound heterogeneous domestic actors; third, there developed an urgent sense of international competition in order to obtain patents on such structural information.

[The anxious production of beauty: Unruly bodies, surgical anxiety and invisible care](#)

*So Yeon Leem*

This study is based on ethnographic fieldwork at a plastic surgery clinic in Seoul, South Korea. Examining the three phases of plastic – consultation, operation and recovery – I show how surgeons work to shape not only patients' bodies but also expectations and satisfaction. Surgeons do so in part to assuage their own anxieties, which arise from the possibility of misaligned beauty standards and unforeseen anatomies, as well as the possible dissatisfaction of the patient. I offer the concept of 'surgical anxiety', which occurs in relation to inherently unruly patient bodies in which worries, fear, frustration, self-pity, cynicism, anger and even loneliness are symptomatic. The unpredictability and uncontrollability of patients' bodies, which generates anxiety for both patients and surgeons, work to constrain the power of plastic surgery and making it inherently vulnerable. This study also pays attention to the invisible work of taking care of surgical anxiety, as practised by female staff members, and surgeons' dependence on these workers. My focus on anxiety is a kind of remedy for the predominant concern with 'ambivalence' in constructivist science and technology studies; rather than continue to highlight the power differentials between experts/practitioners and lay people/patients, this study illuminates surgical anxiety as their shared vulnerability. Thus, this study

proposes a new politics of care in technoscience and medicine, which begins with anxiety.

[Controlled human malaria infection trials: How tandems of trust and control construct scientific knowledge](#)

*Else M. Bijker, Robert W. Sauerwein, and Wiebe E. Bijker*

Controlled human malaria infections are clinical trials in which healthy volunteers are deliberately infected with malaria under controlled conditions. Controlled human malaria infections are complex clinical trials: many different groups and institutions are involved, and several complex technologies are required to function together. This functioning together of technologies, people, and institutions is under special pressure because of potential risks to the volunteers. In this article, the authors use controlled human malaria infections as a strategic research site to study the use of control, the role of trust, and the interactions between trust and control in the construction of scientific knowledge. The authors argue that tandems of trust and control play a central role in the successful execution of clinical trials and the construction of scientific knowledge. More specifically, two aspects of tandems of trust and control will be highlighted: tandems are sites where trust and control coproduce each other, and tandems link the personal, the technical, and the institutional domains. Understanding tandems of trust and control results in setting some agendas for both clinical trial research and science and technology studies.

[Trust, regulatory processes and NICE decision-making: Appraising cost-effectiveness models through appraising people and systems](#)

*Patrick Brown, Ferhana Hashem, and Michael Calnan*

This article presents an ethnographic study of regulatory decision-making regarding the cost-effectiveness of expensive medicines at the National Institute for Health and Care Excellence (NICE) in England. We explored trust as one important mechanism by which problems of complexity and uncertainty were resolved. Existing studies note the salience of trust for regulatory decisions, by which the appraisal of people becomes a proxy for appraising technologies themselves. Although such (dis)trust in manufacturers was one important influence, we describe a more intricate web of (dis)trust relations also involving various expert advisors, fellow

committee members and committee Chairs. Within these complex chains of relations, we found examples of both more blind-acquiescent and more critical-investigative forms of trust as well as, at times, pronounced distrust. Difficulties in overcoming uncertainty through other means obliged trust in some contexts, although not in others. (Dis)trust was constructed through inferences involving abstract systems alongside actors' oral and written presentations-of-self. Systemic features and 'forced options' to trust indicate potential insidious processes of regulatory capture.

[The pluralization of the international: Resistance and alter-standardization in regenerative stem cell medicine](#) (*open access*)

*Achim Rosemann and Nattaka Chaisinthop*

The article explores the formation of an international politics of resistance and 'alter-standardization' in regenerative stem cell medicine. The absence of internationally harmonized regulatory frameworks in the clinical stem cell field and the presence of lucrative business opportunities have resulted in the formation of transnational networks adopting alternative research standards and practices. These oppose, as a universal global standard, strict evidence-based medicine clinical research protocols as defined by scientists and regulatory agencies in highly developed countries. The emergence of transnational spaces of alter-standardization is closely linked to scientific advances in rapidly developing countries such as China and India, but calls for more flexible regulatory frameworks, and the legitimization of experimental for-profit applications outside of evidence-based medical care, are emerging increasingly also within more stringently regulated countries, such as the United States and countries in the European Union. We can observe, then, a trend toward the pluralization of the standards, practices, and concepts in the stem cell field.

[Social Theory & Health](#)

[SARS, pandemic influenza and Ebola: The disease control styles of Britain and the United States](#)

*Charles Allan McCoy*

Some researchers claim that nation states have begun to conform to an internationally uniform response to infectious disease. A potential barrier to this development are the distinct systems of disease control that industrialized nation states have developed over long periods of time. I explain the divergent public policy responses of the United Kingdom and the United States to SARS, pandemic influenza and Ebola by taking a historical approach. I examine the different medical theories of disease that existed in Britain and America in the nineteenth century as each country began to develop its public health system. I also examine where in the state apparatus disease control was located in each country. In Britain disease control was historically part of the welfare sector of the state, while in the United States it was originally operated by the military. These different starting conditions helped push Britain and the United States along different paths of disease control and this helps explain why they respond to contemporary diseases in such different ways. The 'historical durability' national styles of disease may make it more difficult for the international community to enact a truly uniform response to pandemics.

[Preparedness as a technology of \(in\)security: Pandemic influenza planning and the global biopolitics of emerging infectious disease](#)

*Sarah Sanford, Jessica Polzer, and Peggy McDonough*

This article takes as its starting point the idea that re-emerging infectious disease has become a paradigmatic way of thinking about disease. The framing of infectious disease as a threat to global public health and economic security coincides with preemptive forms of control. A particular type of preemptive regulation is global pandemic influenza planning that entails the governing of an imminent, albeit uncertain, global health event. We examine the discourse of 'preparedness' within pandemic planning documents produced by the World Health Organization from 1999 to 2009. We present key findings on: the construction of the influenza virus in terms of its potential to transform and expand across corporeal and territorial boundaries; and the integration of pandemic preparedness into everyday practices. Our analysis illustrates how the discourse of preparedness links the justification for population-level preemptive approaches to discursive constructions of the virus. By articulating this relationship, this article contributes to understandings of the implications of 'molecular' constructions for the biopolitical regulation of the

global population.

[Hepatitis C health promotion and the anomalous sexual subject](#)

*Emily Lenton and Suzanne Fraser*

Research shows that diagnosis with the blood-borne liver disease hepatitis C can lead to significant changes in intimate relationships, including a reduction in sexual contact and avoidance of new relationships. This article examines hepatitis C health promotion materials and their treatment of sexuality and sexual transmission. The article analyses 21 Australian hepatitis C health promotion resources collected as part of research degree project exploring the interrelationships between hepatitis C, injecting drug use, HIV and the body. It uses the work of theorist Margrit Shildrick on the 'anomalous' body, and a discourse analysis method, to understand these interrelationships and their metaphorical and symbolic implications. Our analysis shows that health promotion materials regularly present information about sexual transmission in ways likely to add to confusion and uncertainty about risk. Despite regular acknowledgements that hepatitis C is not a sexually transmissible infection, some resources place an inappropriately heavy focus on the possibility of hepatitis C transmission via heterosexual activity. Others contain mixed messages about the possibility for disease transmission through sex, at the same time enjoining hepatitis C positive readers to practise safe sex. We argue that these injunctions are linked to the ways that the resources figure people living with hepatitis C as intrinsically anomalous. In doing so, the resources run the risk of inadvertently naturalising stigma, anxiety and fear surrounding intimate contact. The article concludes by noting that agencies responsible for the delivery of health promotion need to carefully examine the messages they produce if they are to avoid creating uncertainty and anxiety about the implications of hepatitis C for sexuality and intimacy.

[Institutions of care, moral proximity and demoralisation: The case of the emergency department \(open access\)](#)

*Alexandra Hillman*

This article draws on concepts of morality and demoralisation to

understand the problematic nature of relationships between staff and patients in public health services. The article uses data from a case study of a UK hospital Emergency Department to show how staff are tasked with the responsibility of treating and caring for patients, while at the same time their actions are shaped by the institutional concerns of accountability and resource management. The data extracts illustrate how such competing agendas create a tension for staff to manage and suggests that, as a consequence of this tension, staff participate in processes of 'effacement' that limit the presence of patients and families as a moral demand. The analysis from the Emergency Department case study suggests that demoralisation is an increasingly important lens through which to understand health-care institutions, where contemporary organisational cultures challenge the ethical quality of human interaction.

[Acquiring a diagnosis of fibromyalgia syndrome: The sociology of diagnosis](#)

*Sue Madden and Julius Sim*

Despite past attempts to develop theoretical frameworks to explain diagnostic behaviour, recent work suggests that the sociology of diagnosis needs further development. Accordingly, this article explores the diagnostic search in fibromyalgia syndrome (FMS), a biomedically unexplained disorder. Semi-structured interviews were conducted with 17 people diagnosed with FMS. Analysis was driven by interactionist notions of negotiated order and the self. The diagnosis of FMS is not ascribed, but is achieved through a process of negotiation between patient and doctor, in which power is both wielded and ceded by each party. In the process, individuals with FMS differentiate between the self and the body, where illness is conceptualized as an external force that invades the body and cannot be controlled by the self. It is this meaning of the illness experience, and the emergence of an 'expert' self, that guides the individual's negotiation of an acceptable outcome in the diagnostic search. However, it is also guided by a social discourse that reflects lay understandings of acceptable help-seeking, such as proving one has attempted to cope with the illness, knowing when seeking help is acceptable, as well as cultural expectations regarding access to medical care.

[Limitations in the bioethical analysis of medicalisation: The case of love drugs](#)

*Nathan Emmerich*

A number of articles concerning the idea of 'love drugs' have recently appeared in the bioethical literature. While, as yet, the idea is little more than science fiction, such drugs have been positioned as 'neurotechnologies' that will offer us the opportunity to enhance our marriages. Following a classically liberal approach, the strategy has been, first, to argue that there is no reason individuals should be prevented from using such drugs if they wish to use them, and, second, to adduce reasons why individuals might be morally motivated to do so. This work has been followed by a paper that considered whether such drugs will 'medicalise' love and, if so, whether any (bio)ethical implications follow from their potential to do so. In response, this article argues that traditional forms of bioethical analysis are ill placed to fully grasp the moral dimension of medicalisation. Using the concepts of biomedicalisation, therapeutisation and moralisation I attempt to show that bioethical scholarship can be considered part of these social processes, and, properly understood, they imply that our social, cultural and political norms, such as those that inform our conception of love and intimacy, are subject to change. As a result a more biopolitical approach is to be recommended.

[Neither a sinner nor a saint: Health as a present-day religion in the age of healthism](#)

*Britta Pelters and Barbro Wijma*

In Western societies, religious imagery is often used in conjunction with the topic 'health' in this biomedicalized, healthistic time, but is that enough to qualify the structural characteristics of the presentations and practices of health as a present-day health religion? And what may be gained by adopting such a perspective? This article explores these questions by a hermeneutical rereading, using a comprehensive list of 10 religious features derived from the sociology of religion on texts describing (a) religiously charged health phenomena, (b) the interconnection between health and society and (c) health theories. The results show that health can rightfully be called a religion, with characteristics resembling Weber's protestant work ethic, which may accelerate the formation of a new economic and health-related underclass. Viewing health from a religious angle has the potential of

introducing new concepts and ideas of religious origin into the sphere of health. We believe that this introduction will facilitate and inspire new ways of thinking about health which add a 'religious edge' to the seeming rationality of health, that is, an emotionalized commitment to health as a dignified authority, which an understanding of health as a moral obligation hardly captures

### [Sociology of Health & Illness](#)

*Special Issue: The Sociology of Healthcare Safety and Quality*

### [Towards a sociology of healthcare safety and quality](#)

*Davina Allen, Jeffrey Braithwaite, Jane Sandall, and Justin Waring*

The contributions to this collection address technologies, practices, experiences and the organisation of quality and safety across a wide range of healthcare contexts. Spanning three continents, from hospital to community, maternity to mental health, they shine a light into the boardrooms, back offices and front-lines of healthcare, offering sociological insights from the perspectives of managers, clinicians and patients. We review these articles and consider how they contribute to some of the dilemmas that confront mainstream approaches to quality and safety and then look ahead to outline future lines of sociological inquiry to progress the theory and practice of quality and safety.

### [Healthcare quality and safety: a review of policy, practice and research](#)

*Justin Waring, Davina Allen, Jeffrey Braithwaite, and Jane Sandall*

Over the last two decades healthcare quality and safety have risen to the fore of health policy and research. This has largely been informed by theoretical and empirical ideas found in the fields of ergonomics and human factors. These have enabled significant advances in our understanding and management of quality and

safety. However, a parallel and at times neglected sociological literature on clinical quality and safety is presented as offering additional, complementary, and at times critical insights on the problems of quality and safety. This review explores the development and contributions of both the mainstream and more sociological approaches to safety. It shows that where mainstream approaches often focus on the influence of human and local environment factors in shaping quality, a sociological perspective can deepen knowledge of the wider social, cultural and political factors that contextualise the clinical micro-system. It suggests these different perspectives can easily complement one another, offering a more developed and layered understanding of quality and safety. It also suggests that the sociological literature can bring to light important questions about the limits of the more mainstream approaches and ask critical questions about the role of social inequality, power and control in the framing of quality and safety.

[What is the role of individual accountability in patient safety? A multi-site ethnographic study](#) (*open access*)

*Emma-Louise Aveling, Michael Parker, and Mary Dixon-Woods*

An enduring debate concerns how responsibility for patient safety should be distributed between organisational systems and individual professionals. Though rule-based, calculus-like approaches intended to support a 'just culture' have become popular, they perpetuate an asocial and atomised account. In this article, we use insights from practice theory – which sees organisational phenomena as accomplished in everyday actions, with individual agency and structural conditions as a mutually constitutive, dynamic duality – along with contributions from the political science and ethics literature as a starting point for analysis. Presenting ethnographic data from five hospitals, three in one high-income country and two in low-income countries, we offer an empirically informed, normative rethinking of the role of personal accountability, identifying the collective nature of the healthcare enterprise and the extent to which patient safety depends on contributions from many hands. We show that moral responsibility for actions and behaviours is an irreducible element of professional practice, but that individuals are not somehow 'outside' and separate from 'systems': they create, modify and are subject to the social forces that are an inescapable feature of any organisational system; each element acts on the other. Our work illustrates starkly the structuring effects of the broader

institutional and socioeconomic context on opportunities to 'be good'. These findings imply that one of the key responsibilities of organisations and wider institutions in relation to patient safety is the fostering of the conditions of moral community.

[Enacting corporate governance of healthcare safety and quality: a dramaturgy of hospital boards in England](#) (*open access*)

*Tim Freeman, Ross Millar, Russell Mannion, and Huw Davies*

The governance of patient safety is a challenging concern for all health systems. Yet, while the role of executive boards receives increased scrutiny, the area remains theoretically and methodologically underdeveloped. Specifically, we lack a detailed understanding of the performative aspects at play: what board members say and do to discharge their accountabilities for patient safety. This article draws on qualitative data from overt non-participant observation of four NHS hospital Foundation Trust boards in England. Applying a dramaturgical framework to explore scripting, setting, staging and performance, we found important differences between case study sites in the performative dimensions of processing and interpretation of infection control data. We detail the practices associated with these differences – the legitimisation of current performance, the querying of data classification, and the naming and shaming of executives – to consider their implications.

[The social practice of rescue: the safety implications of acute illness trajectories and patient categorisation in medical and maternity settings](#) (*open access*)

*Nicola Mackintosh and Jane Sandall*

The normative position in acute hospital care when a patient is seriously ill is to resuscitate and rescue. However, a number of UK and international reports have highlighted problems with the lack of timely recognition, treatment and referral of patients whose condition is deteriorating while being cared for on hospital wards. This article explores the social practice of rescue, and the structural and cultural influences that guide the categorisation and ordering of acutely ill patients in different hospital settings. We draw on Strauss et al.'s notion of the patient trajectory and link this with the impact of categorisation practices, thus extending insights beyond those gained from emergency department triage to

care management processes further downstream on the hospital ward. Using ethnographic data collected from medical wards and maternity care settings in two UK inner city hospitals, we explore how differences in population, cultural norms, categorisation work and trajectories of clinical deterioration interlink and influence patient safety. An analysis of the variation in findings between care settings and patient groups enables us to consider socio-political influences and the specifics of how staff manage trade-offs linked to the enactment of core values such as safety and equity in practice.

[Sensemaking and the co-production of safety: a qualitative study of primary medical care patients](#) (*open access*)

*Penny Rhodes, Ruth McDonald, Stephen Campbell, Gavin Daker-White, and Caroline Sanders*

This study explores the ways in which patients make sense of 'safety' in the context of primary medical care. Drawing on qualitative interviews with primary care patients, we reveal patients' conceptualisation of safety as fluid, contingent, multi-dimensional, and negotiated. Participant accounts drew attention to a largely invisible and inaccessible (but taken for granted) architecture of safety, the importance of psycho-social as well as physical dimensions and the interactions between them, informal strategies for negotiating safety, and the moral dimension of safety. Participants reported being proactive in taking action to protect themselves from potential harm. The somewhat routinised and predictable nature of the primary medical care consultation, which is very different from 'one off' inpatient spells, meant that patients were not passive recipients of care. Instead they had a stock of accumulated knowledge and experience to inform their actions. In addition to highlighting the differences and similarities between hospital and primary care settings, the study suggests that a broad conceptualisation of patient safety is required, which encompasses the safety concerns of patients in primary care settings.

[Chains of \(dis\)trust: exploring the underpinnings of knowledge-sharing and quality care across mental health services](#)

*Patrick R. Brown and Michael W. Calnan*

Quality and safety in healthcare settings are underpinned by

organisational cultures, which facilitate or impede the refinement, sharing and application of knowledge. Avoiding the use of the term culture as a residual category, we focus specifically on describing chains of (dis)trust, analysing their development across relatively low-trust service contexts and their impact upon knowledge-sharing and caregiving. Drawing upon data from in-depth interviews with service users, healthcare professionals, service managers and other stakeholders across three mental healthcare (psychosis) teams in southern England, we identify micro-mechanisms that explain how (dis)trust within one intra-organisational relationship impacts upon other relationships. Experiences and inferences of vulnerability, knowledge, uncertainty, interests and time, among actors who are both trustees and trusters across different relationships, are pertinent to such analyses. This more micro-level understanding facilitates detailed conceptualisations of trust chains as meso-level tendencies that contribute to wider vicious or virtuous cycles of organisational (dis)trust. We explore how knowledge-sharing and caregiving are vitally interwoven within these chains of trust or distrust, enhancing and/or inhibiting the instrumental and communicative aspects of quality healthcare as a result.

[Spatio-temporal elements of articulation work in the achievement of repeat prescribing safety in UK general practice](#)

*Suzanne Grant, Jessica Mesman, and Bruce Guthrie*

Prescribing is the most common healthcare intervention, and is both beneficial and risky. An important source of risk in UK general practice is the management of 'repeat prescriptions', which are typically requested from and issued by non-clinically trained reception staff with only intermittent reauthorisation by a clinical prescriber. This paper ethnographically examines the formal and informal work employed by GPs and receptionists to safely conduct repeat prescribing work in primary care using Strauss's (1985, 1988, 1993) concept of 'articulation work' across eight UK general practices. The analytical lens of articulation work provided an investigative framing to contextually map the informal, invisible resources of resilience and strength employed by practice team members in the achievement of repeat prescribing safety, where risk and vulnerability were continually relocated across space and time. In particular, the paper makes visible the micro-level competencies and collaborative practices that were routinely employed by both GPs and receptionists across different socio-cultural contexts, with informal, cross-hierarchical

communication usually considered more effective than the formal structures of communication that existed (e.g. protocols). While GPs held formal prescribing authority, this paper also examines the key role of receptionists in both the initiation and safe coordination of the repeat prescribing routine.

[Infections and interaction rituals in the organisation: clinician accounts of speaking up or remaining silent in the face of threats to patient safety](#)

*Julia E. Szymczak*

Clinician silence in the face of known threats to patient safety is a source of growing concern. Current explanations for the difficulties clinicians have of speaking up are conceptualised at the individual or organisational level, with little attention paid to the space between – the interaction context. Drawing on 103 interviews with clinicians at one hospital in the United States this article examines how clinicians talk about speaking up or not in the face of breaches in infection prevention technique. Accounts are analysed using a microsociological lens as stories of interaction, through which respondents appeal to situational and organisational realities of medical work that serve to justify speaking up or remaining silent. Analysis of these accounts reveals three influences on the decision to speak up, shaped by background conditions in the organisation; mutual focus of attention, interactional path dependence and the presence of an audience. These findings suggest that the decision to speak up in a clinical setting is dynamic, highly context-dependent, embedded in the interaction rituals that suffuse everyday work and constrained by organisational dynamics. This article develops a more sophisticated and distinctly sociological understanding of the reasons why speaking up in healthcare is so difficult.

[Transcultural Psychiatry](#)

[The role of sensorial processes in Q'eqchi' Maya healing: A case study of depression and bereavement](#)

*Andrew R. Hatala and James B. Waldram*

Theory and research on the healing practices of Indigenous communities around the globe have often been influenced by models of “symbolic healing” that privilege the way patients consciously interpret or derive meaning from a healing encounter. In our work with a group of Q’eqchi’ Maya healers in southern Belize, these aspects of “symbolic healing” are not always present. Such empirical observations force us to reach beyond models of symbolic healing to understand how healing might prove effective. Through the extended analysis of a single case study of rahil ch’ool or “depression,” we propose to advance understanding of forms of healing which are not dependent on a shared “mythic” or “assumptive world” between patient and healer or where therapeutic efficacy does not rely on the patient’s ability to “believe” in or consciously “know” what is occurring during treatment. In this we demonstrate how the body, as a site of experience, transformation, and communication, becomes the therapeutic locus in healing encounters of this kind and argue that embodied mediums of sensorial experience be considered central in attempts to understand healing efficacy.

### [Visual Anthropology](#)

*Special Issue: Medicine, Photography and Anthropology*

### [Anthropology and Medical Photography: Ethnographic, Critical and Comparative Perspectives](#)

*Christos Lynteris and Ruth J. Prince*

The study of medical photography, inclusive of epidemiological and humanitarian applications of the genre, is a promising new field for visual anthropology. Focusing on the interlinked questions of visual witnessing and evidential ethics of medical photography, as well as on the entangled temporalities and dialectics of visibility and invisibility underlying this visual practice, the introduction to this special issue on medicine, anthropology and photography explores key issues arising out of recent work in the area. While reviewing the contributions of history, STS and photographic theory to the study of medical visual cultures, regimes and economies, we

explore what a distinctively anthropological approach—through its ethnographic and comparative scope—offers to the topic.

[The Prophetic Faculty of Epidemic Photography: Chinese Wet Markets and the Imagination of the Next Pandemic](#)

*Christos Lynteris*

Dominant trends in epidemiological research and medical journalism today share a belief in the “next pandemic,” a microbiological catastrophe of Old Testament proportions that threatens to annihilate humanity. Expected to arise out of a zoonotic spillover, in most cases a newly emergent or mutant form of animal-to-human influenza, the ground zero of the “next pandemic” is located in so-called wet markets, live animal markets in East Asia and China in particular. Focusing on photographic representations of wet markets during the SARS outbreak of 2003, this article examines critically the visual regime constructed around and supporting this outbreak narrative. Examining the temporality of spillover events and the dialectic between their visibility and invisibility, the article argues that the photographic visualization of points of pandemic eruption sets in place a prophetic faculty. Imaging spillover as an inevitable destiny and, at the same time, as having always or already occurred, wet market photography constitutes a new biomedical temporality that institutes human extinction as a never-completed but always in process end-event.

[Seeing Cellular Debris, Remembering a Soviet Method](#)

*Ann H. Kelly*

A 1962 photomicrograph of a mosquito taken in what was then a Tanganyikan mountain laboratory offers a prompt to consider the social salience and affective power of scientific images. Drawing inspiration from anthropological work on photographic practices, this article excavates the diverse geopolitical and domestic contexts of the image’s production, consumption and circulation, so as to grasp the relationship between scientific labors and lives. As much souvenir as “epistemic thing,” the photomicrograph provides new directions in thinking about the materiality of memory in tropical medicine.

[The Diseased Body and the Global Subject: The Circulation and Consumption of an Iconic AIDS Photograph in East Africa](#)

*Ruth J. Prince*

This article focuses on a photographic image that has become iconic of the journey of AIDS patients in Kenya: the representation of a young man's emaciated body "before treatment" with antiretroviral therapy (ART), and another of the same man "after treatment" and the restoration of his health and life. Showing one of his patients in Haiti and taken by the medical anthropologist and activist Paul Farmer, the photograph traveled to Kenya where it was made into an AIDS-education poster and used as a key tool in ART programs. With its strong "conversion" narrative, the poster seeks to convert viewers to a biomedical way of seeing, and experiencing, disease and infection. I explore the production, circulation and reception of this image, its social history and its agency, as it entered into local moral economies concerning HIV, visibility and value, and drew globalized connections, discourses and practices into novel forms of self-fashioning. In being stretched across different scales, and in being displayed in public as well as domestic spaces, this photographic object creates new relationships between these spaces and the actors who inhabit them.

[Risky Business: Race, Nonequivalence and the Humanitarian Politics of Life](#)

*Adia Benton*

Analyses of humanitarian imagery generally highlight how images are used to mobilize empathy and collective action. Recent critical ethnographic accounts of humanitarianism have either disregarded or underplayed the role of race in the practice of humanitarianism, focusing on risk as crucial to a "humanitarian politics of life." In this article I suggest that combining textual and visual analysis deepens the evidentiary base for claims linking race, risk and humanitarianism. I argue that heroism and humanitarianism are often conflated, and that this conflation relies on racialized perceptions of risk, in which blackness is a central mediator.

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