10:45am – 12:15pm
PANEL 1A: Promises and Pitfalls: Medical Technologies in Practice   506 E

Dana Greenfield (University of California, San Francisco)
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"*Homo experimentus*: Quantified selves and digital techniques of the body"

This paper will explore the implications of quantified self technologies for subjectivity and care. It is based on fieldwork done in the Quantified Self movement and with people and communities who utilize self-tracking and digital health technologies to measure, understand, improve, and care for themselves. I argue that through these techniques of self-care and self-reflection a kind of relation to self, that I call *Homo experimentus*, emerges. I explore the nuances of these practices for the people who use them, as well as for clinical practice, where "patient-generated data" is just beginning to challenge the epistemic boundaries of clinical encounters.

Leslie S. Leighton, MD (Emory University)
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"The history of the 'cardiac chair' and resistance to its use in patients with myocardial infarction, 1950-1961"

Cardiologist Bernard Lown asserts that "the cardiac chair" did more than any other intervention in the 1950s to reduce mortality from myocardial infarction (MI). Evidence shows that although used extensively at the Peter Bent Brigham its acceptance nationally was limited. Additionally, claims Lown, historically it has been under recognized in terms of its impact and contribution to the care of patients with MI. In 1912, James Herrick declared to the world that MI was not universally fatal and recommended that patients who survived be placed at bed rest to promote recovery. It was Samuel Levine who, in 1944, first questioned the wisdom and appropriateness of this recommendation, publishing in 1951 his first paper on the "cardiac chair," advocating that it would be better for patients post-MI to be seated rather than fully recumbent. He reasoned that the diseased heart would do better if not overwhelmed by fluid returning to the heart; favoring pooling of blood in the legs. He also believed the chair reduced other complications. He enlisted Lown to join him in his effort to advocate for the chair. Lown believed the chair promoted recovery better than strict bed rest for a different reason. He felt that sitting a patient up in a chair led to an improved sense of well-being that resulted in earlier recovery and reduced mortality. Levine and Lown did a study which showed an improvement of 5% in mortality of patients in the chair over those at bed rest. They advocated for the chair and a number of centers followed suit, although many continued to believe, for unsubstantiated and unproven reasons, that bed rest was the

only way to treat MI. This presentation will discuss the chair, its importance in the history of coronary disease, and how it influenced future directions in treatment. It will also address reasons for its lack of greater acceptance and the continued insistence of many on prolonged bed rest. Specifically it will ask whether we can attribute any contributions in terms of improvements in morbidity and mortality to the chair and why it was not embraced by more individuals at the time.

Margaret Wardlaw, MD, PhD (Dell Childrens Medical Center)
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"'Do Absolutely Everything': The Technological Imperative and Perinatal Hospice Care in the United Kingdom"

Patients in the neonatal and perinatal period are a dramatically underserved population in terms of palliative care. Despite comprising 96% of all pediatric deaths, palliative care and hospice resources for this population remain very limited. Palliative medicine providers in Great Britain have recently prioritized improving the provision of high-level palliative care to the neonatal population. The British Association for Perinatal Medicine (BAPM), the General Medical Council (GMC), and the Association for Children's Palliative Care have identified palliative and hospice services as a critical part of neonatal care, recognizing that dying newborns deserve the same high standard of care as those infants who are expected to survive. Despite these initiatives, newborn hospice and palliative medicine remains controversial for many families and providers.

This project uses narrative interviews and site visits to inpatient pediatric hospices and NICUs in the United Kingdom during the spring of 2014 to investigate barriers to hospice care for the neonatal population. Semi-structured, narrative-based interviews were conducted with neonatologists, palliative medicine physicians, nurses and psychologists who work with neonates and their families at the end of life. Despite the availability of freestanding pediatric hospice facilities, the great majority of British neonates die in NICUs. Interviews suggested a technological imperative where aggressive medical intervention is often the norm even for babies with very poor prognosis. Providers identified uncertainty over patient outcomes as a major barrier to initiating palliative care, emphasizing the expectation of perfection in clinical practice and a tendency to view death as failure. Informants also pointed to an inappropriately dichotimized view of intensive care and palliative medicine ("do everything" vs. "do nothing.") Finally, interview data suggested a tension between autonomy and beneficence and many providers suggested a role for paternalism in end of life care for neonates.

Anita Chary (Washington University, St. Louis)
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"Debating the Standard of Care for the Poor: The Politics of Alternative Cervical Cancer Screening in Guatemala"

Visual inspection with acetic acid (VIA), a low-resource cervical cancer screening technique, has become one of global health's greatest success stories of how innovative technologies can transform health outcomes. In comparison to the Pap smear, the conventional infrastructure-intensive screening test used in Western countries, VIA is cheap and "low-tech": a simple spray of vinegar on a woman's cervix can reveal pre-cancerous lesions. Authoritative health agencies and agenda setters, such as WHO and the Gates Foundation, endorse VIA as ideal for low- and middle-income countries, which lack robust Pap smear infrastructures. This presentation explores the politics of alternative standards of care for the poor. It draws from ethnographic research about cervical cancer in Guatemala, where VIA-based cervical cancer prevention programs have proliferated in the last decade. Particularly, I examine how health care providers' and policymakers' opinions about VIA in Guatemala vary based on spatial imaginaries tied to notions of development, rurality, and "global" health. Proponents of VIA see the technique as adequately suited to the needs of the under-resourced nation, and in particular, rural populations with otherwise limited access to care. Opponents deem VIA a "technology for the poor," see the technique as "a big excuse" to avoid creating Pap smear infrastructure, and espouse that the "standard of care" ought to be the same across the globe. This paper raises questions about how standards of care are established, accepted, and contested along political and geospatial lines.

10:45am – 12:15pm
PANEL 1B: Critical Readings of Medicine in Literature   505 E

Spencer Barrington Stubbs (University of Pennsylvania)
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"Controllin' The Planet Revisited With a Tale of Two Diagnoses: Schizophrenia and Depression"

Background: Ever since the term schizophrenia was coined by Paul Euden Bleuler in 1911, it has seen dramatic shifts in pragmatic and clinical representations in patient populations. The shifting frame surrounding schizophrenia had consequences in real-world clinical settings: starting in the late 1960s, schizophrenia became a diagnosis disproportionately applied to African American men. For instance, in the 1960s and 1970s, researchers "discovered" that African American men were "significantly more likely" than white men to receive schizophrenia diagnoses. And throughout the 1980s and 1990s, a host of articles from leading psychiatric and medical journals showed that doctors diagnosed the paranoid subtype of schizophrenia in African American men five to seven times more often than in white men (Delahanty 2001).

Objective: The primary aim of this project was to examine and compare how psychiatric terms like schizophrenia and depression developed valence in musical circles with contrasting demographic populations and target audiences.

Study Design: This was a content analysis-driven study that used popular music indexed by lyric databases to compare the ways in which diagnostic language in popular music often mirrors the racialization of diagnoses in the real world.

Findings: Depression appears a privileged position for those who have time (i.e. white populations). But schizophrenia is a threat, a crime in progress, and an impulse for survival (i.e. black populations).

Implications for medicine and policy: Historical trajectories need to be further acknowledged and decontextualized by healthcare leaders who have backgrounds in the social sciences. There were two 1960-era trajectories that set up the grounding for these two diagnostic terms – depression and schizophrenia. One, there was a transformation in psychiatry. Two, there was a split mind in black philosophical thought which was used to pathologize political protest and which was used to articulate the need for protest in the first place. Limitations: Lyrics are adjectives and abstractions, even when they are nouns. Lyrics depict bravado or mimesis or fantasy as often as they do actual events; as such, and like all poems, lyrics play to the multiplicities, rather than the essences of meaning.

Richard Sanders (University of Illinois, Urbana-Champaign)
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"The Perpetual Present of Medicine's Colonial Past: A comparative literature approach to uncovering medicine's enduring colonial dimensions"

In an ostensibly postcolonial world where colonies in the formal sense no longer exist many of the same political narratives and structures going into and emerging from the colonial project still operate. Commentary surrounding the Ebola epidemic, for instance, signaled a new cycle of the enduring colonial association between disease and ethnicity. Regrettably, this disease-ethnicity association of which Ebola is the just the most recent example belongs to a constellation of colonial mechanisms that endure and continue to shape medical practice. Deploying a comparative literary approach, I examine three pairs of texts for the purpose of uncovering other mechanisms that persist to this day. The first pair is comprised of texts from the postcolonial genre of literary theory: Frantz Fanon's Sociology of a Revolution (1959) and Edward Said's Orientalism (1978). Both illuminate the mechanisms by which medical activity furthered the colonial project, highlighting the political yoke to which even the most benevolent of colonial physicians were subjected and the biomedical frameworks that helped justify Western occupation, respectively. Despite being articulated within overtly colonial contexts, the mechanisms the authors discuss are understood in my reading to not require a colonial setting in order to function. The second pair, comprised of Michael Hardt and Antonio Negri's Empire (2000) as well as the work of Shula Marks in the social history of medicine, argues more explicitly for the survival of these mechanisms outside formal colonial settings. The final pair, the 2004 childhood memoir of Nobel Prize Winner J.M. le Clézio and the first major novel of celebrated Guadeloupian author Maryse Condé, published in 1976, imagines how the critical texts' theories manifest in lived experience. The former penetrates a doctor-patient relationship forged within a colonial context whereas the latter expresses ambivalence toward the disquieting revelation that medical activity can actually crystallize social stratification and thereby serve the aims of any oppressive governance, not just colonialism. Together, the texts assert the usefulness of postcolonial thought as a tool in the assessment of and even fight against the political and social disenfranchisement in which modern medicine participates or itself engenders.

Jennifer Tsai (Warren Alpert School of Medicine)
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"Race, Medicine, and Reproduction: Examining the Biologicalization of Black and White Racial Disparities in In Vitro Fertilization"

Research Question: Given the history of violence and regulation in Black female reproduction, especially in relation to the Eugenics movement, biomedical research that suggests biological bases for disparate reproductive outcomes should proceed with caution. This submission examines the

insufficiency of the biomedical framework for investigating racial disparities in In Vitro Fertilization (IVF) outcome.

Methodology: Using PubMed, the author identified twelve published articles discussing and documenting the causes of disparate IVF success between Black and white women. Using Grounded Theory methodology, the author identified themes and issues pervasive in these studies to critique the scientific literature surrounding racialized IVF disparities.

Discussion: Among other methodological flaws, including poor racial identification protocol and limited study size, 83% of studies did not include socioeconomic status (SES) in their analysis of IVF outcome. This is especially important given that while these publications found higher rates of IVF success in white women, the one publication controlling for SES found no significant racial disparities in outcome. This suggests failure to consider social variables skews data interpretation. Furthermore, several authors extrapolated conclusions to clinical practice. One author identified higher rates of aggressive hormone treatment regimens for Black women undergoing IVF in discussion of these disparities. Such information, when presented alongside biological factors such as genotypic markers, may be perverted to construct the stereotype that Black women require more aggressive hormone protocols to achieve successful IVF outcomes due to innate racial difference. This is especially dangerous considering higher rates of side effects like Ovarian Hyperstimulation Syndrome (OHSS) among Black women.

Conclusion: Biomedical literature which focuses too narrowly on biological explanations for racialized IVF disparities may be misinterpreted and contribute to actual discrepancies in clinical approach. Methodological flaws and contradictions in studies on IVF efficacy demonstrate that utilizing race as an independent variable in connection with genomic interpretation should be careful not to infer that racial differences are necessarily biologically inherent. This issue raises concerns about the unexamined and inconsistent use of race in medical education and medical care at large.

PANEL 1C: Clinical Education: Current Status and Future Directions 516 E

D. Daphne Owen (University of Pennsylvania)
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"Social Justice and Advocacy in Graduate Emergency Medicine Training"

As Medicine in general, and Emergency Medicine in particular, evolves to serve the needs of diverse patients in a changing social and political landscape, increased community engagement, addressing social determinants of health, and creating new avenues to access preventative care will become essential. These issues must be embraced by the medical system as a whole, and not seen as solely the domain of Primary Care and Family Medicine. As such, including training in social justice and advocacy will become crucial components of best-practice graduate medical education programs, especially Emergency Medicine. Currently, few models for such programs exist outside of Family Medicine. It is important to identify if there is an interest in social justice and advocacy training among future residents, and explore potential models for such training.

Gulnar Ali (University of Huddersfield, UK)
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"Integrating spirituality in Nursing Education"

Nursing standards of competence specify that nurses must "carry out comprehensive, systematic nursing assessments that take account of relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors…" Despite this, the assessment of spiritual needs is not often considered. Difficulties persist in conceptualising spiritual needs and understanding their relevance to wellbeing. The wider study of which this review forms part has investigated how these issues are addressed in nursing education. The purpose of this literature review and some initial data collection is to contribute to a better understanding of how nursing competencies in understanding and addressing spiritual needs are currently approached in undergraduate nurse education. On the basis of this improved understanding it may be possible to propose ways of further developing education in this area to address patient need in a more holistic way. Literature review from 1993-2014 revealed some challenges and gaps between theory and knowledge implementation with reference to integrating spiritual care in nursing education. Further investigation has been carried out through data collection using multiple case study approach across different parts of England. In -depth interviews from nursing educators, document reviews from nursing curriculum and few focus group studies from nursing students alludes some key challenges. Acknowledging the breadth and relevance of the concept of spirituality, and its relationship to compassionate and mindful care opens a new

horizon of competency for teaching and integrating spirituality into nursing education. There is a dearth of research identifying the required competencies for nursing educators in preparing nurses confident to identify and respond to spiritual care needs.

Jonathan Fuller (University of Toronto)
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"Social Science and Humanities Research in MD/PhD Training"

Only a handful of MD/PhD trainees in Canada are presently pursuing social science or humanities (SSH) research. The University of Toronto contains Canada's largest MD/PhD program, but of its 66 graduates none to date have completed a PhD in SSH. In this talk, I will analyze opportunities and challenges for trainees wishing to pursue SSH research in an MD/PhD program without any precedent for this kind of research (such as the University of Toronto). In order to further this agenda, I will then ask: how can we argue - in a way that aligns with dominant discourses at health science research-intensive universities - that knowledge generated by SSH research helps us achieve the goals of medicine?

As the first MD/PhD student at the University of Toronto to pursue SSH research, I will draw heavily on first-person experience and personal insights with respect to overt and covert opportunities and barriers. As a philosopher, I will adopt a normative approach; I will argue the value of SSH for academic medicine. A recent article by O'Mara and colleagues [1] highlighted the ways in which clinician-researchers trained in disciplines such as social sciences can promote health and health equity through addressing their social determinants. I will extend their analysis by suggesting ways in which SSH research can illuminate physician knowledge and expertise [2,3].

My conclusions are that curricular and funding structures that bias against SSH are perhaps the greatest barriers, and that advocates of SSH in MD/PhD training might position SSH scholarship as translational medical research with implications for education and public policy, analogous to the implications for technology and practice often touted for translational biomedical research.

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Ryan O'Mara (Princeton University)

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"The current state of affairs for MD-PhD training programs in the social sciences and humanities"

Traditional biomedical and clinical sciences cannot effectively address the behavioral, environmental, social, economic, political, cultural, familial and other non-medical causes of health inequities. A 2011 task force of the National Institutes of Health (NIH) recognized that in order to affect patient and population health beyond medical determinants, academic medical centers must lever on diverse disciplines, skill sets and competencies both within and outside traditional biomedical and clinical sciences to prepare future practitioners and researchers. If the anticipated biomedical research workforce requires diverse training outside traditional medical sciences, then current progress to diversify training among future physician-scientists must be assessed. Despite the breadth of graduate training possibilities allowed by the Medical Scientist Training Program (MSTP) of the National Institute of General Medical Sciences (NIGMS), a recent survey of 24 MD-PhD programs (representing 43% of current trainees in the U.S. and nearly half of all programs receiving MSTP grants) revealed only 5% of trainees were studying a discipline outside biomedical sciences (86%) or engineering (9%). Although the Association of American Medical Colleges (AAMC) estimates nearly one-third of MD-PhD programs offer graduate training options in disciplines other than biological or physical sciences, the American Physician Scientists Association (APSA) is able to identify only 13 out of 127 MD-PhD programs (about 10%) that have current trainees pursuing PhDs in a social science or humanities discipline. Upon closer inspection, most programs that allow non-traditional PhDs limit options to a few specific disciplines such as public health and medical anthropology. Within many of these programs, inequities in MD-PhD scholar funding based solely on graduate discipline overtly demonstrate the diminished value attributed to non-traditional disciplines in physician-scientist training. If the call to diversify the future biomedical research workforce is to be taken seriously, then non-traditional MD-PhD scholars should be valued and supported in the same manner as traditional biomedical scholars. This presentation identifies potential barriers and solutions to increasing diversity of MD-PhD training in order to meet the anticipated needs of the future biomedical research workforce.

2:30 – 4:00pm
PANEL 2A: Healthcare Markets, Utilization, and Outcomes   506 E

Nora V. Becker (University of Pennsylvania)
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"The Affordable Care Act's Impact on Out-of-Pocket Contraceptive Costs for Privately-Insured Women"

Motivation: The Affordable Care Act (ACA) mandates that preventive services, including FDA-approved prescription contraceptives, be covered by private health insurance plans with no consumer cost-sharing. This mandate went into effect on August 1st, 2012. Prior research suggests that a decrease in OOP price of a medical service may result in increased utilization of that service. However, the actual impact of the ACA mandate on OOP costs and use of prescription contraceptives has not yet been studied.

Methods: Examine changes in out-of-pocket (OOP) prices and utilization of prescription contraceptives before and after implementation of the ACA mandate, using an administrative claims dataset from a large national insurer. I estimate individual OOP costs and utilization at the monthly level from January 2008 to June 2013 for eight types of prescription contraceptive methods: oral contraceptive pills (OCPs), the vaginal ring, the cutaneous patch, emergency contraception (EC), diaphragms/cervical caps, the injection, the intrauterine device (IUD), and the subcutaneous implant.

Population: 790,895 women between the ages of 13 and 45 who were enrolled in private health insurance for any period of time between January 2008 and June 2013.

Results: I find evidence that OOP costs of contraceptive have decreased sharply since the implementation of the ACA mandate. Median costs for most methods dropped to zero between August 2012 and June 2013, and mean costs decreased 30-80% during this same period. The exceptions are for patch and the ring contraceptive methods, which do not show the same OOP price decreases as other methods. I see no immediate changes in claim rates or estimates of utilization for any contraceptive method following mandate implementation.

Conclusion: The ACA mandate appears to have produced large drops in OOP expenditures on prescription contraceptives, but there appear to be no immediate corresponding changes in utilization. There are several possible explanations for these findings. Demand for contraceptives among women in private health insurance may not be sensitive to price, or may require a longer follow-up period to detect effects on utilization. Future work is needed to disentangle these possibilities.

Elise A. Carpenter, MD, PhD (Kraft Center, Greater Lawrence Family Health Center)
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"Primary Care and Super-Utilizer Research - Political and Social Movements in Health Care Delivery"

Super-utilizer research has gained increasing attention from the public, politicians, insurance companies and national foundations since Atul Gawande's 2011 New Yorker article on David Benner's technique of hot spotting heavy hospital utilizers and his innovative care solutions. At my clinical site, Greater Lawrence Family Health Center, a FQHC in a medium-sized urban industrial city in MA, we are currently wrapping up a super-utilizer project funded by the Blue Cross, Blue Shield Foundation. I will briefly highlight some of our findings, but explore more broadly the limitations and difficulties involved in this type of research in a primary care setting. Using my experiences I will explore an existing debate as laid out in Annals of Family Medicine by Polk Newton and Lefebvre versus Emeche in 2015 about whether this type of research is a goad to system reorganization or instead distorts clinical care by categorizing patients by their cost to the system rather by how much the system could benefit the patient. Examining the Robert Wood Johnson Super-utilizer Summit report from 2013 my talk will further ask questions about how this field is part of larger social and political changes in health care delivery and explore its relationship to primary care reorganization and Accountable Care Act Implementation.

Jennifer Ghandhi (University of Chicago)
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"Pro-cyclical mortality, nursing supply, and informal caregiving"

The significant, inverse relationship between mortality and unemployment rates has been documented in the United States and many other developed countries. Previous work has found that the effect is strongest in elderly women and especially counter-cyclical for deaths in nursing homes. This paper further explores the notion that the cyclical rise and fall in mortality may be driven by changes in health care quality. I present a simple labor/leisure model to show the relationship between labor force participation and non-market versus market provision of elder care. I use county-level variation in unemployment from 1972-2012 to empirically show that rises in unemployment are correlated with falls in mortality. Finally, I use the Bartik method to suggest a causal relationship between nursing supply and mortality that varies with the business cycle.

Ari B. Friedman (University of Pennsylvania)
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"Why Wait? An Econometric Analysis Of The Supply Of Emergency Department Care"

Background: Despite substantial policy attention focused on reducing demand for ED services, ED wait times continue to increase. An extensive literature documents interventions to improve ED flow, but they remain

under-adopted. The reason that economic forces have not increased the supply side of emergency care in order to decrease wait times remains unexamined.

Objectives: We hypothesized that the uninsured affect the supply of ED services, but that EDs do not discriminate against individual uninsured patients.

Methods: We used a 2.5% sample of the 2005-11 State Emergency Department Databases for MA and NJ, and a novel, validated dataset of estimated wait times for each visit. Linear regression assessed the effect of hospital uninsurance status on wait times and total ED length-of-stay, controlling for detailed diagnosis (ICD9-CM), demographic indicators, contemporaneous volume of visits to the same ED, and individual insurance status. The ED's uninsurance rate was instrumented with the county's uninsurance rate. Standard errors were block bootstrapped by hospital.

Results: Over 340,000 visits to 157 hospitals, ED uninsurance rates ranged from 3% to 53%, a 50 percentage point (pp) range. Instrumental variable analysis demonstrated that a 50pp increase in the ED uninsurance rate caused a 37.2 minute increase in wait times (p<0.01) and a 59.9 minute increase in total length-of-stay (p=0.06). Controlling for hospital uninsurance rate, individual uninsurance rate was uncorrelated with wait times (0.24 minute greater wait, p=0.99). The instrument was necessary (Hausman p<0.01) and strong (correlation of 0.78).

Conclusion: Hospitals that see many uninsured patients have higher wait times as a direct result, but uninsured patients do not wait longer at a given hospital. Providing insurance to the uninsured therefore may have a large, positive spillover effect on insured patients in EDs. States that expand Medicaid should see reduced ED wait times, even if expansion initially causes more visits to the ED.

2:30 – 4:00pm
PANEL 2B: Contesting Legitimate Forms of Care   505 E

Amrapali Maitra (Stanford University)
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 "'When Will I Go Home?': Care and Violence in an Indian Women's Shelter"

This talk explores Bengali women's experiences of domestic violence embedded in local understandings of intimacy and care. Care denotes practices oriented toward survival. How do poor women who face violence at home interpret such acts as practices of endurance? How do employees of clinic spaces and NGOs serving abused women constitute their own moral definitions of care?

I draw from four months of ethnographic fieldwork at a women's psychiatric shelter in Kolkata, India, where many residents carry histories of domestic abuse. My methods include participant observation, clinical ethnography, semi-structured interviews with 10 shelter residents and 5 staff members, and life histories of 2 informants. This fieldwork is part of a doctoral dissertation studying care, intimacy, and domestic violence in Kolkata.

Engaging with the work of Angela Garcia, Clara Han, Emily Yates-Doerr and other medical anthropologists of care, as well as South Asian scholarship on class and obligation (Sarah Lamb, Lawrence Cohen, Srimatu Basu, and others), I situate care within locally-embedded hierarchy. By doing so, a limitation of the concept of care becomes visible: some gestures of care across lines of class and power are simply irrefutable, even if oriented towards survival. Forms of caring cement hierarchy because of the irrefutable nature of what is given. Instead, Indian ideas of obligation or dependence help to think through intimate relations forged by necessity.

This talk concludes that women's experiences in the shelter complicate care and violence on multiple registers. First, residents labor to maintain the shelter through cooking, cleaning, laundry, and sewing. They care for each other and for the shelter employees (directors, field workers, therapists, nurses, psychiatrists, etc.) At the same time, shelter employees care for the residents, providing a safe space away from women's abusive families, delivering bodily wellbeing and psychiatric intervention. Furthermore, care unfolds on the register of narrative, as women reimagine through speech the caring relations towards families they have left behind. The tensions among these registers of care ring through the refrain of many women in the shelter: "When will I go home?" Abused women yearn for reconstructed intimacies with husbands and families, even while caring and being cared for in the shelter's space. Relations and gestures of both care and violence are supple and shifting.

Elise Ann Geist Duwe (University of Illinois, Urbana-Champaign)
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"Self Care Practices of Urban American Indians with Chronic Pain"

In this conference presentation, I will discuss the self-care that urban American Indians seek for the chronic pain they continue to suffer due to centuries of colonial policies and politics. I hypothesize that participants who engage in pluralistic healing practices that integrate biomedical, complementary and alternative, and indigenous approaches will have a lower pain score and report better coping than those who engage exclusively in healing practices from one approach (either biomedical, complementary and alternative, or indigenous). The data for this talk come from a mixed methods study of 40 off-reservation dwelling, self-identified American Indians. All participants completed an extensive survey that included a demographics questionnaire, the McGill Pain Questionnaire, the Stressful Life Events Screening Questionnaire, the Historical Loss Scale, the Texas Revised Inventory of Grief, the Resilience Scale, and a list of 13 healing practices. In an open-ended, in-depth interview, all participants shared their stories of life with chronic pain. From the interviews arose dichotomies of good and bad days with pain, things that help pain and things that make pain worse, and pain with a physical etiology and with an emotional etiology. Despite the fragmentation of pain conceptualization, participants manage their pain with very integrated care. On average, participants utilize almost 7 different healing practices, demonstrating the active role they take in caring for their chronic pain. When asked, all participants wish healing would result in the elimination of their pain, but upon reality check, they seek to function without further debility and to maintain their economic, spiritual, social, and physical wellness. Within a healthcare system attempting evolution from fragmentation toward integration, this research provides evidence for continued progress toward rewarding integrated self-care that promotes wellness. This research found that in the context of chronic pain for urban American Indians integrated healing practices, when including cultural practices, result in increased wellness.

Sara Rendell (University of Pennsylvania)
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"Proximity to and Perception of Pain in the Context of Burkina Faso's Maternal Care Subsidy Policy"

Since 2008, the government of Burkina Faso has subsidized the cost obstetric and neonatal care. In this policy, the government assumes 80% of the direct costs of vaginal deliveries including the cost of local anesthetics for episiotomy repair. This study asked how, in the context of this policy, providers, patients and policymakers understand the continued practice of withholding lidocaine injections from women.

This ethnography consists of observation, participation and interviews over 10 months in homes, places of worship, marketplaces, pharmacies, and obstetric wards in Burkina Faso. I conversed with health professionals in and

out of obstetric clinics, participated in provision of care, accompanied pregnant women to prenatal visits and deliveries, and interviewed 78 Burkinabe women, six maternal health professionals from four health centers, four male partners of pregnant women, and three health administrators. To date, a rich base of ethnographic scholarship explores how triage of therapy, including therapy for pain control, exposes and normalizes social inequity. 1, 2, 3, 4

In the current study, care providers often made authoritative claims about the legitimacy and severity of the pain women experienced during the episiotomy procedures, assigning a higher pain threshold onto women of lower socioeconomic status. Providers deployed biomedical authority to make claims about the severity of a given woman's pain and her need for pain relief. Women who had undergone episiotomies without local anesthetic offered many explanations for what they understood to be the provider's choice to withhold lidocaine. Moreover, some women explained that only good behavior earned the "pain injection." Others hoped that if they endured the pain of an episiotomy repair, their scars would heal more quickly or they would bleed less. Some women said the choice not to numb them before sutures was cruel. Others said that the "pain injection" was only offered to women who had resources to bribe providers. Rationales that emerge to explain the practice of withholding local anesthetic in this context reveal how neo-colonial logics mesh with a techno-medical understanding of care to delineate the care-provider's proximity to a patient's suffering.

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Erica Dwyer, PhD (University of Pennsylvania)
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"An ode to donkeywork: nursing care and bureaucracy in the shadow of a global health research project in South Africa"

In March 2006, the CDC reported the discovery of extensively drug-resistant tuberculosis (XDR-TB), a form of tuberculosis resistant to most

anti-TB drugs. Later that year, XDR-TB came to be understood as a threat emerging from Tugela Ferry, a small town in South Africa: 51 of 52 XDR-TB cases identified in a Yale University study had died. The New York Times reported that "Virulent TB in South Africa May Imperil Millions" across the continent.

What followed was an intense effort by public health agencies and American and South African researchers to study, publicize, and address drug-resistant tuberculosis in Tugela Ferry. Policy makers and biomedical researchers, most of them physicians, took the stage in expert consultations, conferences, and research papers to discuss the meaning of this new entity.

Tuberculosis care in South Africa, however, is primarily nurse-driven, and any effective response to drug-resistant TB required the active participation of government-employed nurses. Community-based treatment programs were put in place that required dozens of nurses to travel many miles across rural mountains to visit patients at home and provide them with daily injections. Yet the CEO of the hospital in Tugela Ferry easily dismissed the caring and administrative work of nurses as "donkeywork," while attributing successes in TB control to one engaged physician and his American physician-scientist colleagues.

What does it mean to be a government TB nurse in the context of a global health research intervention? How do we credit the role of nurses in creating the spaces of possibility in which global health actors make their professional mark? Drawing on two years of participant field work in clinical settings in South Africa I portray the donkeywork of TB care and argue that conventional readings of the XDR-TB response as a US-driven global health intervention undervalues the crucial roles nurses played in developing strategies of care that worked. Just as research assistants in Malawi learn to "see like a research project" (Biruk, 2012), and providers in Botswana "improvise" cancer medicine to the best of their abilities (Livingston, 2012), it is the nurses in Tugela Ferry who allow both the TB global health project and the patient to thrive.

2:30 – 4:00pm
PANEL 2C: Spaces of Care, Environments of Health   516 E

Stephanie Rieder (University of Illinois, Urbana-Champaign)
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"Clinical Frontiers and Cowboy Medicine: American medical missionaries' constructions of spaces, subjects, and standards in rural Ethiopia"

The arrival of American surgical teams on short-term volunteer mission trips catalyzes the transformation of a rural Ethiopian hospital, repartitioning spaces, redefining patients, and reconstructing ethical medical practices. Representing a unique type of "global health" project, short-term volunteer teams understand themselves and their work as exceptional within this transnational medical space Their words, actions, and their very presence construct the hospital and community as a frontier, defined by Tsing (2005) as an imagined space characterized by its emptiness and lack. Frontier constructions allow for particular types of lawlessness and informality in which American practitioners' discourses of urgency and morality displace Ethiopian bodies and expertise and allow establishment of exclusive American spaces within the Ethiopian hospital, whose borders are tightly controlled by the mobile teams. Within these spaces, informal, often unsanctioned, practices that disrupt ideals of universal medical ethics and standardization are made necessary and new types of medical objects in the form of "project patients" are produced, reinforcing inequalities of access, resources, and mobility.

Relying on eight months of participant observation and qualitative interviews with American and Ethiopian physicians, this paper examines a specific transnational clinical space in a former mission hospital in Ethiopia that is visited by American surgical teams several times each year. Building on Brada's (2011) work, I ask what spaces, subjectivities, and practices are produced when this Ethiopian clinic is imagined as a frontier and how these imaginations and their products are contested and destabilized by hospital staff and administration. This paper interrogates the tensions between ideals of borderless mobility and border-making projects that result in exclusive clinical spaces. Rather than constituting failed global health missions, as some critics have argued (e.g. Berry 2014; Wall 2006), I argue that short-term medical trips are productive of economies, subjects, and practices that are integral to sustaining locally-contextualized clinical knowledge and work within this space. While acknowledging potentially harmful medical outcomes of short-term volunteerism, this paper encourages examination of these trips, not as aberrations, but as vital components of this local medical system, providing informal connections to a globalized biomedical economy, even while reinforcing inequalities and abjection.

Kalen Flynn (University of Pennsylvania)
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"Neighborhood levels of social trust and adolescents' perceived safety"

Increased exposure to adverse neighborhood conditions including social instability and physical signs of disorder are shown to negatively impact emotional wellbeing and perceived safety of adolescents. Research on how neighborhood conditions affect adolescents suggests that social trust could mediate perceptions of safety that are based on observable conditions in one's immediate surroundings. 139 males (10-18 years) were enrolled with random digit dial in Philadelphia from 2009-2012. Using GIS-assisted interviews, subjects mapped the path of their activities and reported their perceived safety. Activity paths were overlaid on mapped layers of the built and social environment. Our key predictor was social trust, built as a composite Census tract-level variable from several indicators of social trust measured with a city-wide telephone survey. Mixed effects regression estimated adolescents' perceived safety based social trust level in areas they traversed, controlling for age, companions, and other confounders. Perceived safety levels ranged from 1 (low) to 5 (high) and most (78.4%) subjects felt less than entirely safe (<5) at some point. Compared to spending time in areas in the lowest tertile of social trust, participants were 73 percent more likely to feel unsafe (p < 0.01) when in areas with medium social trust and 89 percent more likely to feel unsafe (p < 0.01) when in areas of high social trust.

Chuan Hao (Alex) Chen (Harvard University)
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"Scopes of Practice: Tracing the Emergency Medical Technician's Critical Habitus"

The Boston Marathon Bombings on April 15th, 2013, demonstrated the importance of emergency systems infrastructure in limiting injuries and casualties during unanticipated catastrophic events. Whereas existing literature have elaborated on how governments, medical experts, and NGOs form fields of resilience infrastructure – policies, materials, and practices – few have looked at Emergency Medical Technicians in the landscape of emergency biopolitics. Drawing from a year of ethnographic fieldwork in a Massachusetts EMS training program, this presentation traces EMS "Scope of Practice" from federal to personal scales to show how pre-hospital care is defined and systematized in the classroom. Every year, around 3,000 individuals complete certification in Massachusetts. The process by which these individuals learn EMS practices remains unclear.

Following the recent spatial turn in the social sciences and humanities, as well as the nascent field of design research (using iterative drawing, information graphics, and mapping to analyze complex phenomena), the presentation will use maps and complex diagrams to explore the uneven projection of emergency services infrastructure on geographic and social space. Such representations facilitate an understanding of the duality of social space – described by Pierre Bourdieu (1989) as in between the objectivist constructions

and subjective interpretations of social fact – and critical space, described by Latour (2004) as the polarized application of structural vs. individual critiques. In the field of EMS pedagogy, "how to care" emerges out of these dualities: the text, or the curriculum and policies, and its reading and interpretation. Contrasting dogma with stories from the field and physical bodily engagements, instructors teach by critically pointing out inherent contradictions and priorities. These contradictions, noted through sarcastic remarks, jokes, and polemics, are practices that form the habitus of care that is constitutive of emergency resilience infrastructure. This elaborates on Elaine Scarry's (2012) "Thinking in an Emergency," to show precisely how emergency care depends on a critical reading of existing "scopes of practice" or policy.

Jeremy Levenson (Ichan School of Medicine at Mount Sinai)
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"The Rikers 'Risk Environment': Health Care on a Solitary Confinement Unit"

Units dedicated to punitive segregation, also known as solitary confinement, at New York City's Rikers Island Jail have disproportionately high rates of self-harm incidents by inmates and use of force actions by corrections officers. Healthcare, administered by privately contracted providers and supervised by public agencies, occupies a central presence in this space of maximum control and institutional brutality. Why are rates of self-harm and use of force incidents so high and how does healthcare contribute to this unique 'risk environment'? Based on several months of ongoing participant observation in the daily provision of care to inmates held in solitary confinement on Rikers Island, this talk explores how and why correctional healthcare providers have become alternatively complicit with and resistant to institutional brutality and describes efforts by inmates to defend and promote their health.

10:45am – 12:15pm
PANEL 3A: Give and Take: Access, Community, and Wellbeing   506 E

Andrea Knittel, MD, PhD (University of California, San Francisco)
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"Sex Exchange in the City: Access to free or affordable healthcare services among young people exchanging sex in Detroit"

Access to healthcare is shaped by individual histories and geographies as well as the structure and capacity of the local healthcare system. This study uses a unique dataset collected in the City of Detroit using novel sampling approaches to reach young people exchanging sex on the street, in strip clubs, and at after-hours parties and other social clubs. The population is described and challenges of survey sampling and analysis briefly explored. Using multivariable logistic regression, factors predicting perceived access to free or affordable outpatient healthcare services in this population are examined, including how patterns of sexual exchange influence access not only to family planning and STD/HIV-related services, but also to primary care and mental health services. Across all venues, perceived access to HIV/STD testing services was endorsed by 91-96% of the sample, while fewer had perceived access to drug treatment and mental health, particularly in the street and strip club venues (62-86%); perceived access to family planning services was intermediate (72-88%). Approximately 1/3 of the sample at each venue had not accessed healthcare services in the past year due to cost. Individuals participating in street-based transactional sex were significantly less likely than other study participants to report access to services other than STD/HIV testing, and, when adjusting for the venue in which exchanges took place, White respondents were significantly less likely than African-American respondents to identify free or affordable STD/HIV testing and community-based primary care clinics. The effects of other factors including employment separate from sexual exchange, drug use, and access to reliable transportation are also explored. The specifics of Detroit public health policy, geography, and healthcare infrastructure are discussed, as are implications of these results and possible community-based interventions in collaboration with our community partners aimed at improving access to care within this population are considered.

Allison Thompson (University of Pennsylvania)
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"Stakeholder Reactions toward Child Welfare-Based Natural Mentoring"

Last year, nearly 25,000 youth nationwide emancipated from foster care without legal permanency, representing 10% of all children/youth who exited care. Poor outcomes often follow, including increased rates of behavioral health symptomology, unemployment and economic hardship, homelessness, low

educational attainment, criminal justice involvement, and unplanned pregnancy. An emerging evidence base suggests that natural mentoring relationships (i.e., an enduring relationship with a caring, nonparental adult from within a youth's existing social network) may function protectively for older youth in care, ameliorating some of these negative outcomes into adulthood. However, evidence-based natural mentoring services do not presently exist, and no known studies have explored how stakeholders feel toward such services. Thus, this qualitative study is the first to investigate the attitudes and beliefs among a sample of child welfare professionals and youth in foster care regarding the implementation of a child welfare-based natural mentoring intervention. Eleven focus groups were conducted with 37 child welfare professionals and older youth in foster care from a Department of Human Services (DHS) located in a large urban city in the Northeast United States. Youth were eligible to participate if they were presently placed in foster care, age 15 years or older, and at risk of emancipating from foster care; child welfare professionals were eligible if they had served a youth in the past three years meeting these criteria. All focus group data were digitally recorded, transcribed and entered into Dedoose for coding, which was guided by the conventional content analysis approach. The following themes emerged: 1) the nature of the limited, impermanent role of child welfare professionals in conjunction with a lack of legally permanent relationships creates a service concern for older youth aging out of care; 2) a natural mentoring program must be youth-driven and sensitive to the unique needs of youth in foster care; 3) the use of natural mentors, as opposed to unfamiliar adults from a formal mentoring program may be a more appropriate fit for youth in foster care; 4) natural mentoring relationships may provide a more natural setting to develop the youth's life skills as compared to a traditional instructional-based model.

Katherine Magerko (University of Illinois, Urbana-Champaign)
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"Access to Health Care, Family Child Care Providers, and the Wellbeing of Young Children"

Health care access is a critical component for health and well-being. Family child care providers (FCCPs), who provide care to young children in their homes, struggle with accessing health care. In a 2013 survey, 19.6% of FCCPs were uninsured compared to16% of residents in the same state. Twelve and half million U.S. children under five are in out of the home child care each week. Traditionally, child care in the U.S. has been considered a personal issue; however, there is growing attention to how child care policies are essential for family wellbeing. That said, child care providers continue to lack living wages, especially FCCPs who are the lowest earners. This proposal explores how FCCPs' access to care may affect their health and the health of the children in their care.

In 2014, 105 Illinois FCCPs completed an anonymous survey. Independent t-tests (SPSS v.22) compared these data to a Behavioral Risk Factor Surveillance System (BRFSS, 2013) sample of Illinois employed females (matched income/education). While 88.6% of FCCPs have insurance, similar to the BRFSS sample, FCCPs were more likely to not see a doctor due to cost (although not significantly so: 19.4% vs. 13.2%; $p = 0.14$). They were significantly less likely to have had a routine check-up in the past year (61.6% vs. 68.6%; $p<0.05$) and were significantly more likely to be overweight (69.6% vs. 58.0%; $p<0.05$).

FCCPs were less likely to have had a seasonal influenza vaccine (29.3% vs. 39.9%; $p<0.05$). They were comparable to the low levels of tetanus, diphtheria, and acellular pertussis (22.0% vs. 23.5%; $p = 0.68$). While these vaccines are critical for protecting young children and should be higher for those in close contact with young children compared to other populations, cost and time barriers may suppress vaccination participation. Many FCCPs reported not seeing a doctor because they lack help at their child care business. While FCCPs are critical to many children's healthy development, FCCPs are typically low-income and potentially at higher health risk than the general population. These data indicate that further research and policies must focus on and support these family child care providers.

Kimberly Sue, PhD (Harvard University)
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"On the Erosion of Community-Based Addiction Treatment: Addiction Medicine and the Politics of Disavowal"

This paper explores the increasingly problematic relationship between community addiction/substance use treatment programs and the prison. Part of my fieldwork on prison-based drug treatment entailed observing the increasingly common phenomenon of the closure of addiction units and treatment programs in the state of Massachusetts. I first interrogate on what epistemological grounds bureaucrats base their decisions (largely in the name of "modern" addiction science and treatment methods but also in the language of efficiency), as well as assess the community response. Medicine and the biological sciences more generally, with their increasingly effective treatment armamentaria, have become means to identify and map groups of people, to treat some and deny others. So how exactly is addiction medicine wielded in a politics of disavowal in some cases, and as a politics of profit in others, within a larger biopolitical scheme of governance of the sick and poor?

10:45am – 12:15pm
PANEL 3B: Troubling Boundaries in the History of Healthcare Policy   505 E

Linda C. Magaña (University of Oxford)
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"An Eruption of Buboes: Plague Politics in Puerto Rico, 1912-1914"

At the turn of the twentieth century, Puerto Rico remained relatively free of major epidemic outbreaks of yellow fever and malaria, two mosquito-borne diseases that afflicted much of the Caribbean throughout the eighteenth and nineteenth centuries. Not until 1912 did the island encounter bubonic plague as the third pandemic circulated among large swaths of the globe's population via commercial and immigration routes. Considering the turmoil and uncertainty over the reorganization of sanitary services on the island following the Spanish-American War, the 1912 outbreak of bubonic plague in Puerto Rico could have been devastating if left to the whims of island party politics and a neglectful Congress. This paper seeks to explore how a shifting culture of Western biomedicine, an invigorated collaboration between insular and federal personalities, and a melding of political and economic interests facilitated an effective and efficient anti-plague campaign. Successful interventions in public health and sanitation in these first years of the twentieth century required a burgeoning biomedical knowledge circulating among the world's scientists and health professionals, working to translate their research for implementation in partnership with local leaders from divergent sectors of society.

The historiographical frameworks, source base, and approach that I use are essential given the limitations of existing scholarship on U.S. medical interventions in Puerto Rico. I draw on secondary literature as well as published primary sources to better situate the San Juan outbreak in the larger course of the Third Pandemic, in particular, using the American experience in San Francisco and Hawaii to understand contemporary advances in public health policy. Additionally, by considering letters and newspaper articles written to the Governor by members of the public, business leaders, and other interest groups, a fuller picture of the reactions and responses to the anti-plague campaign is ascertained.

Above all, the officials directing the anti-plague work in Puerto Rico intuitively and almost instantaneously understood the lessons learned from other port cities' experiences with plague: limit fear, protect commerce, and maintain communication (and cooperation) with the public. In the local landscape of an abundance of competing interest groups, Puerto Rican health officials recognized that the goals of the Sanitation Service could only be achieved if policy directives were carried out with "absolute impartiality.

Kristen Ann Ehrenberger, PhD (University of Illinois, Urbana-Champaign)
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"'The completely scandalous way in which the distribution of food for the sick has occurred': A historical vignette about rationing and the policies and politics of care"

When on the heels of the declaration of World War I in August 1914, the Allied Powers initiated an increasingly strict trade embargo on Central Europe, international politics filtered down the food chain to the caring practices of local German housewives, healers, and physicians. Then as now, laypeople were accustomed to diagnosing and treating minor illnesses themselves, often with "sick foods" like milk, beef broth, and pureed fruit. However, the Allies' so-called "hunger blockade" and the socialized food economy cobbled together in response made it difficult if not impossible for individuals to acquire needed foodstuffs without compromising the family's general rations, turning to the black market, or paying for a doctor's visit. A certificate of ill health entitled one to purchase "sick rations" through a separate, increasingly complicated system that attempted to replicate the variety of dietetic prescriptions to which clinicians and patients were accustomed and that cutting-edge nutritional science deemed necessary. Supply failed to meet demand, so workers in "war-important" industries and non-terminal patients received preference. By war's end, food rations for the sick and the well effectively calculated the worth of bodies based on their ability to labor for the war effort. Drawing from personal and governmental archival materials, this paper is constructed around a case study set in Dresden, Saxony, an advanced, industrialized state in the German Empire heavily dependent on imports to feed its largely urban population. From the relative safety of the past, I will elaborate the tensions between humanitarianism and utilitarianism that suffused Germany's centralized food economy during and after World War I. Finally, this paper is intended to open a discussion about the possibilities and pitfalls of managed care, the stewardship of shared resources, and the exclusionary politics of belonging that develop alongside the rhetoric and reality of scarcity.

Rimma Osipov (University of Texas, Medical Branch)
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"Strangers at the Bedside: The Evolving role of IMGs in the US context"

Foreign, or International, medical graduates make up about 25% of current American medical trainees and 20% of physicians actively practicing medicine in the United States. In some specialties, particularly in primary care, the percentage of residents who received their medical education abroad nears 50%. Furthermore, International medical graduates or IMGs, known as Foreign Medical Graduates or FMGs before the mid- 1990s, are far from a novel presence within the American medical center, often credited with disproportionately caring for indigent, urban, institutionalized, and rural Americans. The cultural role of these physicians, however, has long been contradictory. On the one hand strangely absent from public and professional awareness (at least in proportion to their numbers), on the other pointedly

controversial, engendering suspicion from organized medicine, and concerns from policy analysts about physician surpluses in the US and a "brain drain" of needed medical talent from poorer nations. This presentation focuses on the history of IMGs in the US and how they have been constructed by the medical profession and the general public, tracing how the US went from a "source" to a "destination" country between 1900 and 1965. Along the way I will discuss the special case of the WW2 Boston committee, and its attempt to employ Jewish-immigrant physicians—explaining how this debate within medicine would prefigure later ones. I will then look at the role of exchange visitor programs and the 1965 immigration reform on the very visible influx of IMG into the US healthcare system (redefining Rothman's idea of "Strangers at the Bedside.") Popular, Professional, and policy responses to this perceived influx will be analyzed, particularly the backlash against this group of healthcare workers in the 1970s. Through a narratively attuned, historical exploration, this project will re-evaluate the material and symbolic roles of medical migrants in the academic medical center and American medical practice since WWII, arguing that the presence of these physicians materially impacted the nature and development of the US healthcare system, masking many of its safety-net shortfalls.

Vanessa Burrows and Barbara Berney, PhD, MPH (Graduate Center, CUNY)
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"Medicare and the Desegregation of US Hospitals"

In March of 1966 less than half of US hospitals—and only 25% of southern hospitals—were in compliance with Title VI of the 1964 Civil Rights Act's prohibition of racial discrimination in facilities receiving federal funds. The impending roll-out of Medicare on July 1, 1966 offered a "golden opportunity" to incentivize voluntary hospital desegregation. Spurred on by the Civil Rights Movement, the federal government organized a massive hospital inspection effort to ensure that no hospital practicing racial discrimination would receive Medicare funding. By July, more than 90% of the nation's approximately 6,000 hospitals were certified in compliance with the Civil Rights Act, offering life-saving medical care to thousands and signaling a revolutionary advancement towards greater health equity.

The desegregation of US hospitals is a testament to the transformative power of federal health policy. Without federal commitment, it would have been virtually impossible to achieve such quick and enduring change at the national level. Yet, it is also emblematic of the limitations of federal power, as the government relied heavily on the support of dedicated medical civil rights activists to collect information, raise awareness and perform hospital inspections. It is fair to say that the federal commitment to hospital desegregation was made possible by a vigorous social movement, decades in the making. Drawing on filmed oral histories profiled in the forthcoming documentary The Power to Heal, this presentation will reflect on the

collaborative effort that accomplished this unsung achievement in medical civil rights.

10:45am – 12:15pm
PANEL 3C: Minding the Mind: Exploring Brain, Behavior, and Self   516 E

Ashish Premkumar, MD (University of California, San Francisco)
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"'The opposite of a history': what substance use in pregancy can lend to an ethics of accompaniment"

       Theoretical work in critical medical anthropology and biomedicine surrounding substance use in pregnancy has yet to develop a cohesive framework of the maternal-fetal unit as a dynamic process. Anthropologists within the field of reproductive health have situated concepts of history, risk, and agency primarily in line with research on biomedical practices, such as amniocentesis or provision of abortion. Biomedicine, tied intimately with other forms of governmentality, is critiqued due to its' reliance on a neo-Enlightenment, monolithic conception of an individual woman's will. The maternal-fetal unit, as evinced by clinical practice, is not a static assemblage, but rather a dynamic unit moving through biosocial space. Substance use during pregnancy offers interesting problems, particularly around the construction of history, risk, and agency within the maternal-fetal unit. By evaluating the case of Carla – a young woman actively using heroin in her pregnancy – through critiques of subjective utilitiarianism, discussed by Byron Good, and the concept of becoming, elucidated by Gilles Deleuze and Félix Guattari, an ethics of accompaniment, focused on both individual patient care and wider sociopolitical advocacy, can be constructed. These ethics help to redefine the maternal-fetal unit, and support a critical clinical anthropology of addiction, wherein social scientific research and biomedical care can unite to provide new and unique ways of providing services to this often marginalized and vulnerable population.

Jennifer Baldwin (University of Illinois, Urbana-Champaign)
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"From Soldier's Heart to Veterans' Brains: Theorizing War-acquired Traumas in a Neuroscientific Era"

       Historically, trauma theory has maintained a distinction between psychological and physical modes of trauma, attending to what Cathy Caruth identifies as "a wound inflicted not upon the body but upon the mind". However, recent attentions paid to both embodiment and the neuroscientific turn within the interdisciplinary field of trauma studies problematize this divide between the mind and body with regards to traumatic conditions and events. These novel approaches advance the horizons of trauma scholarship by permitting transdisciplinary analyses of the role the body plays in the lived experience and effects of trauma. Yet, such approaches also present new problematics that arise from this turn towards meanings and methodologies

that are themselves enmeshed in broader biopolitical projects. One illustrative example is the tendency amongst trauma theorists to equate and collapse humanist definitions of individual trauma with biomedical constructs of PTSD and other neurological conditions. This paper will analyze the promises and pitfalls of such new approaches to trauma by analyzing both the role of the body in understanding traumatic experiences, as well as what neuroscientific renderings of trauma allow and disavow in understanding the experiences of Post-traumatic Stress Disorder and traumatic brain injury in US veterans returning form Iraq and Afghanistan. As such, this paper hopes to invite discussion on what exactly is the subject of both these veterans' traumatic conditions, as well as the humanistically-oriented field of trauma studies in light of shifting and emergent disciplinary approaches to each. Moreover, it will invite reflection on the critical stances and interventions that the field of trauma studies has traditionally offered to biomedicine and understandings of the experience of violence and war of which we should not lose sight in an increasingly neuroscientific era.

Elizabeth Bromley, MD, PhD (University of California, Los Angeles)
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"Understanding Physician Suicide: An Interpretive Phenomenological Approach"

Several studies have identified an increased risk of suicide among physicians, with the relative risk of suicide estimated to be 1.5 to 3.8 among male physicians and 3.7 to 4.5 among female physicians, as compared with other professionals. My current research uses narrative-based approaches to examine work-related factors that may underlie physicians' increased risk of suicide.

In this paper, I use interpretive phenomenological analysis (IPA) to examine physicians' responses to a colleague's suicide. From a phenomenological perspective, the interpretation of an event is a key aspect of the construction of the event itself. That is, the phenomenon of physician suicide is comprised of both its lived reality and the meaning made of it. In this paper, IPA is used to highlight otherwise inaccessible attitudes and assumptions about suicide.

Methods: I use interview data from 8 physicians responding to the suicide of a colleague. Six subjects respond to the suicide of a plastic surgeon who died by suicide in 2009. Two subjects respond to the suicide of a male physician who died by suicide in 2014.

Results: A colleague's suicide leads interviewees to reinterpret past events in light of what they could have or should have perceived at the time. Interviewees reimagine the relationship with the deceased physician as one defined by what shameful feelings were being hidden. Some interviewees describe feeling threatened by a colleagues' vulnerability, as if experiences like suicide had contagious, insidious, or protean aspects. Others naturalize suicide by attributing it to biological illnesses that are beyond an individual's control or

the community's reach. Still others exoticize suicide as defying explanation or comprehension, an attitude that seems to limit interviewees' access to the emotional experience of the death (e.g., sadness, anger). On the whole, physicians describe suicide as a covert threat that may lurk imperceptibly, both anywhere and nowhere.

Conclusions: Exploring physicians' interpretations of a colleague's suicide may help to map the cultural and psychological terrain in which physician suicide takes place. Physicians' assumptions about suicide are not firmly grounded in fact. The tendency to interpret suicide as unknowable may constitute a significant barrier to prevention efforts.

Arielle Lasky (University of California, Los Angeles)
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"ADHD in context: the role of occupational environment in the manifestation of adult ADHD"

What happens when children diagnosed with ADHD grow up and make choices regarding their occupations? Are there particular contexts in the "real world" these individuals report functioning better in than others? Experimental studies demonstrate that certain environmental contexts can significantly reduce ADHD symptom severity. Does the lived experience of young adults with ADHD in different occupational settings parallel the experimental data? Though much is known about the difficulties faced by children with ADHD in standard school settings, very little research has explored the functioning of adults with ADHD in their day-to-day work environments.

We analyze the results of semi-structured interviews with 125 adults, originally diagnosed with ADHD as children, regarding their work environments. By closely examining the content of these interviews, we are able to generate hypotheses about the role of environmental context on ADHD symptom expression, and to raise theoretical questions about the disease concepts used to study the experience of ADHD. Many young adults report that their symptoms are context-dependent; working in specific occupations, they feel less encumbered by their symptoms. In some of these environments, participants describe feeling more able to focus; in others, their symptoms—such as high energy levels—become assets rather than liabilities. Several subjects characterized these jobs more specifically. Jobs for which they felt best-suited often involved high levels of stress or mental challenge, novel or varied tasks, a fast pace, hands-on work, physical labor, interacting with others, and/or topics of intrinsic interest. In these contexts, they felt their symptoms lessen; in other types of occupational settings, they worsened. These exploratory findings validate the need to more seriously account for the role of environmental context in our understanding of ADHD as a psychiatric disorder, especially as it manifests in adulthood. Implications for clinical care, diagnostic conceptualization of the disorder, and further lines of research are discussed.

Amira Adawe (University of Minnesota)
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"Skin-Lightening Practices and Mercury Exposure in the Somali Community"

Somali women often use creams and soaps to lighten skin tone, fade freckles or get rid of age spots. Use of these products raises a health concern, as some have been found to contain mercury. This article describes an investigation that involved interviewing Somali women about skin-lightening practices and the products they use and then testing those products for mercury. Twenty-seven samples of products purchased at markets in Minneapolis and St. Paul were analyzed by the Minnesota Department of Health for specific mercury levels. Eleven of the 27 (47%) were found to contain mercury. Some exceeded the current FDA threshold of 1 part per million. This has prompted both state and federal health officials to issue warnings about the use of these products.

Cordelia Erickson-Davis (Stanford University)
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"Risk and responsibility in medical device regulation"

Medical devices play an increasingly central role in health care and the US economy. Despite this, little is known about how a device travels from bench to bedside and then away again. The ways in which policymakers evaluate medical devices, including the processes by which they mediate between conflicting technical interpretations, their views on the role of industry in device development, and the role of government in risk management and regulation, will be discussed using the case of the laproscopic power morcellator. With it I will explore how understanding and negotiation of risk and responsibility at the level of the Federal regulatory authority comes to manifest materially in device design and bodily injury.

Victoria Boggiano; Lesley Harris, PhD, MSW; Michele Barry, MD, FACP (Stanford School of Medicine)
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"Homeless Youth in Vietnam: A Qualitative Inquiry"

This qualitative exploratory study examined the impact that length of time living on the streets has on the street-based lifestyles of homeless youth ages 18-25 in Ho Chi Minh City (HCMC), Vietnam. Only by understanding the dynamics of street life are we then able to provide culturally appropriate care to young people who reside there. Two focus groups and twelve one-on-one interviews were conducted with a total of 28 homeless youth. We found that

there are six phases of street life for homeless youth in HCMC: experiencing a conflict in the home; arriving on the streets; initiation into the "work force"; gaining stability & meeting physical needs; becoming dissatisfied with the current situation; and finding a new source of income & re-gaining stability. The last three phases form a cycle that youth repeat several times, depending on how long they have been living on the streets. External factors that youth face when they first arrive on the streets include arrests, trafficking, violence, risk of sexually transmitted diseases, and pregnancy. Internal factors that youth deal with on a daily basis include trauma, the need to belong, and (for some) the obligation to send money back to their families and/or a past history of childhood abuse. There is also an "exit" path out of street life for those who are able to find stable, respectable jobs and obtain permanent housing, which we will describe. This community-based participatory research project was conducted in collaboration with Save the Children in Vietnam's HCMC office. Our findings will inform public health and social work interventions and policy advocacy programs targeted towards improving the lives of Vietnam's street youth population. We hope that this work will bring us one step closer to providing appropriate health interventions that improve the wellbeing of young people living in HCMC's parks and markets.

Y. Nina Gao (University of Chicago)
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"Specialist Interests and Medicare Reimbursements: Evidence from the RBRVS"

The Resource Based Relative Value Scale (RBRVS) is central to determining Medicare Part B medical provider reimbursement. The Centers for Medicare and Medicaid Services sends procedures for review annually to be evaluated and assigned new reimbursement values by a committee known as the RVS Update Committee (RUC). The RUC includes representatives from various medical specialties that are responsible for unbiased assessments of physician compensation levels by procedure subject to a federally mandated maximum.

I use committee rotating seats as a source of exogenous variation and show that RUC rotating seat membership is associated with a 1-3 percent increase in Medicare reimbursement on average for specialty-relevant procedures. Additionally, I demonstrate that this increase results from favorable changes in reimbursements for highly specialized procedures and occurs at the expense of more generalized procedures, which are commonly billed across many specialties. I show that this increase occurs in spite of the fact that Centers for Medicare and Medicaid Services selection of procedures for review appears to be negatively correlated with RUC composition.

Mara Gordon (University of Pennsylvania)
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"Participatory design of eHealth solutions for women from vulnerable populations with perinatal depression"

Objective: Cultural and health service obstacles affect the quality of pregnancy care that women from vulnerable populations receive. Using a participatory design approach, the SPIRIT group developed specifications for a suite of eHealth apps to improve quality of perinatal mental health care.

Materials and Methods: We established a longitudinal participatory design group consisting of low-income racial/ethnic minority with a history of antenatal depression. their prenatal providers, mental health specialists, and researchers. The group met 20 times over 24 months. Apps were designed using rapid prototyping. Meetings were documented using field notes.

Results and Discussion: The group achieved a high level of continuity and engagement. Three apps were developed: an app to support high-risk women after discharge from hospital, a screening tool for depression, and a mobile patient decision aid for supporting treatment choice.

Conclusion: Longitudinal participatory design groups are a promising, highly feasible approach to developing technology for underserved populations.

Laura Medford-Davis, MD (University of Pennsylvania)
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"Quantifying Patient Dumping: Orthopaedic Trauma Presenting to a Public Hospital ED"

Background: Trauma centers and public hospitals receive underinsured patients with acute orthopaedic trauma that were initially seen in community EDs. Many times patients are discharged and verbally told to follow up at the public hospital but no official transfer or referral is made, and patients present without records or imaging studies. As a result, patients experience uncoordinated care, duplicate testing, and potential for adverse outcomes. The prevalence of this practice has not been recently documented.

Objective: Quantify the extent of orthopedic patients in one public hospital ED that were initially seen at another ED for the same problem.

Methods: A standardized data abstraction form was used for a retrospective chart review of 1,166 consecutive adult patients receiving an orthopedic consult in an urban public hospital ED from January to June, 2011. Descriptive statistics quantify our primary outcome of inappropriate orthopaedic referrals without transfer documentation.

Results: Of the 1,166 orthopedic patients, 236 (20.2%) were initially treated at an outside ED; 209 (88.6%) were uninsured (compared to a county uninsured rate of 28.6%), 17 (7.2%) were publicly insured, and 10 (4.2%) were privately insured. 156 (66.1%) went on to require surgical intervention. The name of the initial ED was recorded for 167 (70.8%) patients; of these 107 (65.1%) were initially treated at a nonprofit hospital with advertised orthopedic

services. The median treatment delay from outside ED evaluation to presentation at the public ED was 4 days (SD 9.4; IQR 2-10). Median length of stay for the second ED visit was 13hrs, 23 min (SD 5:18; IQR 10:24-18:06). A total of $526,880.45 was billed for duplicate ED services at our hospital (median $2,099.12 per patient; SD $954.36; IQR $1234.00-$2860.21).

Conclusions: A significant portion of orthopaedic patients seen at a public hospital ED, including those requiring surgical intervention, were initially seen, imaged, and splinted by other hospitals that did not send records and had the resources to provide definitive orthopaedic care. Both the initial hospital and the public hospital seek government assistance for uncompensated care provided to the same patients. Work is needed to quantify excess costs and adverse outcomes related to treatment delay among vulnerable populations.

Jennifer Sun (University of Michigan Ann Arbor)
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"Self-Perceptions of Aging and Overnight Hospitalization in a Nationally Representative Sample of Older US Adults"

As the Baby Boomer generation is reaching older adulthood, there is an increasing need to identify methods for reducing health care costs without sacrificing quality of care. Targeting the high rates of inpatient hospitalization among older adults with psychosocial interventions may be one potential route to increasing health system efficiency. One construct that may be important in understanding the risk of hospitalization among older adults is self-perceptions of aging. Self-perception of aging, or attitudes towards one's own aging experience, has been associated with a variety of positive health outcomes including fewer functional difficulties, better recovery after myocardial infarction, and longer lifespan. The present study uses data from the Health and Retirement Study, a nationally representative panel study of community-dwelling adults over the age of 50 in the United States, to determine the association between self-perceptions of aging and the number overnight hospitalizations from 2008-2012. Over the four-year follow-up, 43.93% of the 4,735 respondents in our sample were hospitalized overnight at least once (Range = 0-76, M = 1.10). In the fully adjusted model (sociodemographics + baseline health + health behaviors), one standard deviation increase in aging satisfaction was associated with 11% fewer overnight hospitalizations over follow-up (RR = 0.89, 95% confidence interval [CI] = 0.83–0.95, p = .001). The association remained after adjusting for the number of previous hospitalizations over the previous four years. These findings suggest that clinical and societal efforts aimed at promoting better self-perceptions of aging could lead to innovative approaches to reducing health care costs and promoting well-being among the aging population.

2:30-4:00pm
PANEL 4A: Faculty Roundtable Discussion on Curricular Reform   506 E

       This session will engage MD-PhD faculty who are involved in efforts to apply the insights of their social science training to clinical education. They will discuss their individual efforts at their respective institutions and the associated gains they hope to make, stumbling blocks they have encountered, and lessons learned in the process. Helena Hansen will discuss working on the structural competency initiative she developed with Jonathan Metzl to train clinicians to detect and act on larger systems of inequality beyond the individual clinician-patient interaction. Seth Holmes and Joshua Neff will discuss their effort to implement and evaluate a structural competency program within the Santa Rosa Family Medicine Residency program. Jeremy Greene will introduce his social medicine curriculum co-developed with Carolyn Sufrin at Johns Hopkins University. Barry Saunders will present his plans to bring insights from the discipline of Science and Technology Studies to a curriculum within and across medical science preclinical courses at the University of North Carolina School of Medicine.

2:30-4:00pm
PANEL 4B: Claiming Medical Authority, Transforming Care   505E

Emily Jones (University of Pennsylvania)
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"Technologies of care out of context: Behavioral autism intervention therapy in Kathmandu, Nepal"

> In the United States, extensive research and years of clinical practice have converged to define autism and develop a set of best practices for the care and management of behavioral problems of affected children. These therapeutic interventions, largely based on behaviorist classical conditioning models, operate within and mutually reinforce an infrastructure of state services and trained paraprofessionals as well as specific ideological constructions of subjecthood and agency.
>
> What happens when practices of care for children with autism, developed in an American and Western European bio and sociopolitical context, are reproduced in a different cultural and sociopolitical context? More specifically, how do these practices intersect with and intervene in existing structures of care and social relationships for mothers of children with autism? I examine these questions through an ethnographic study of mothers of children with autism in Kathmandu, Nepal who are being taught the psychiatric and biogenetic definitions of autism and are being instructed in techniques of behavioral therapy to manage and treat their children during a 3-month intensive training program at a local NGO.
>
> Through this program, mothers are trained to implement a highly regimented behavioral intervention therapy as part of their everyday parenting practice. Many of the implicit demands embedded in American clinical understandings of autism and best practices of care, unseen and unconsidered in the context in which they were developed, emerge clearly in the context of Nepal. My research aims to explore how these mothers navigate the proliferation of social and economic roles they are being asked to inhabit, examining their location in gendered economies of care within the rapidly changing cultural and political economic context of urban Kathmandu. I argue that the dual role of parent-therapist potentially imposes an unmanageable burden of affective and caring labor while isolating mothers from their existing cultural context, threatening relationships with existing networks of solidarity, care and support.

Rachel Cane, MD, PhD (University of Chicago, Comer Children's Hospital)
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"'If It Works, It Works': Asthma and the Problem of Efficacy in the Age of Evidence"

> In our medical training, we are taught to think of efficacy as a straightforward and unproblematic concept: a treatment either works, or it

doesn't. But operating within an evidence-based paradigm, our definition of efficacy is often narrowly constricted to outcomes that are feasible to measure. We rarely reflect on the pragmatic and political considerations that shape what is identified as a measureable outcome, and we are not inclined to examine the assumptions inherent to our understanding of efficacy. This has implications for how we evaluate clinical interventions, from complementary and alternative treatments to new biomedical pharmaceuticals and surgical procedures.

In this study, I do a close reading of a routine pediatric case of an asthma exacerbation to unpack the ways in which concepts of efficacy are invoked and negotiated in clinical practice. I argue that while we may believe we use a single, shared definition of efficacy, in fact we simultaneously hold multiple, competing ideas of efficacy and bring them to bear at various times as they fit the situation.

Specifically, first I explore the temporal and spatial dimensions of efficacy. Asthma is modeled as a chronic disease with acute exacerbations, and the effects of intervention can be mapped onto multiple time frames. Similarly, asthma and its treatments are understood on many scales, from the molecular to the corporate body. What obviously works at one level may be irrelevant at another, and where we chose to focus shapes our assessment of efficacy.

Secondly, I examine the ways in which the trend toward diagnosis based on response to treatment in pediatric respiratory illnesses subtly re-orients our thinking about efficacy in relationship to disease process.

Finally, I turn to the question of authority in the determination of efficacy. Whose voices are privileged in the pronouncement of treatment success or failure may prove complicated and at times surprising.

Through this case study I aim to demonstrate ways in which our taken-for-granted everyday knowledge in medicine is a product of social, practical, and political concerns, and ways in which we manage the unspoken limitations of evidence-based medicine in clinical practice.

Matthew Adamson (University of Illinois, Urbana-Champaign)
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"The Medicalization of Physical Activity in Multiple Sclerosis: Problems and Possibilities"

Physical activity (PA) as a viable treatment intervention is an important component in the research agendas of various chronic diseases. Consequently, in these contexts PA has become increasingly medicalized (i.e. the intervention of medical authority into the activities of daily life), being used to justify medical surveillance and the moralization of behaviors intended to prevent/treat disease risk factors associated with PA levels. Wheatley (2005) argues that risk discourse establishing physical inactivity as a risk factor for these diseases is integral to this process of medicalizing PA. It follows to use PA as treatment or preventive measure once physical inactivity is accepted as a risk factor. Those who engage in PA are consequently interpreted as good/normal, those who do

not as bad/deviant. The moralization of PA hinges on this relationship to inactivity.

Recent years have seen a surge of research related to PA and multiple sclerosis (MS). However, physical inactivity has not been implicated in the onset or progression of MS. Consequently, the relationship between physical inactivity as a risk factor and PA as treatment does not exist. What are the dynamics of the moralization of physical activity in MS when physical inactivity is not an established risk factor? Through a review of physical activity literature using a critical cultural theoretical lens, this paper explores MS as a unique context with important possibilities for both avoiding and exacerbating the problems of medicalizing PA. MS is characterized by unpredictable disease onset and progression stemming from factors such as genetics and disease type, some of which are poorly understood. Rapid onset of disability, as well as the nature of disability (cognitive, motor, and/or psychological), can be difficult for patients to cope with. Because of this ambiguity, moralization effects that place blame on the individual would be very detrimental. However, MS also provides a unique context in which the utilization of PA can move from a policy of surveillance towards a policy of resource for those affected. Hence, it is necessary to avoid the medicalization of PA while still offering it as a potentially beneficial and empowering mediator of disease symptoms and progression.

Steven D. Resnick, MD (Bassett Medical Center)
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"Proposed Study of Medicalization in Dermatology"

Medicalization is a process where nonmedical problems become defined and treated as medical problems. Many analyses have been critical, but scholars have also emphasized the importance of viewing medicalization first and foremost as a definitional social process. Medicalization is often studied by sociologists with a focus on disparate, compelling examples. The prototypic examples are conditions that are common in the human experience (aging, death, obesity), but also connected to various medical disciplines such psychiatry (ADHD), obstetrics (childbirth), dermatology (baldness), and various other specialties (erectile dysfunction, short stature).

Herein, I propose a specialty-specific examination of medicalization in dermatology. Such a study is pertinent to the broad investigation of medicalization, and more specifically, the medicalization of aging. It also appears central to understanding an historical shift in the scope and practice of dermatology. Over the past 3 decades dermatologists have been increasingly engaged in the treatment of aging. Dermatology has morphed from a cognitive, internal medicine-like specialty to encompass procedural and aesthetic missions. Cosmetic dermatology has become a distinct subspecialty. A variety of bioengineered "fillers" and neurotoxins are available for wrinkles and volume loss in the aging face. A tech industry of medical devices has flourished to enable addressing wrinkles, cellulite, brown lesions, and red spots.

Non-cosmetic medical dermatologists also devote substantial time to addressing concerns about common, harmless skin lesions that become more prevalent with aging. The drivers of this dermato-medicalization include dermatologists, industry (pharmaceuticial, device), insurance/reimbursement trends, and patients who have become consumers who are concerned about their appearance.

Further study of this dermato-medicalization is warranted to quantify the magnitude of the changes, to provide a more nuanced understanding of the different drivers, and to understand the potential effects on access to care for traditional medical dermatology. Ultimately, clinicians on the front lines of dermato-medicalization, regardless of their clinical focus, would benefit from an awareness and understanding of this process. Such understanding, in turn, could enable more thoughtful and effective care.

PANEL 4C: The Power of Numbers, the Politics of Difference   516 E

Jeffrey P. Brosco, MD, PhD (University of Miami)
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"Politics and Prevalence: Distributive Justice in US Disability Policy, 1950-2010"

> Each decade over the last century has seen developmental disability (DD) policy driven by what seemed like a new or emergent problem. From polio in the 1950s and mental retardation in the 1960s through autism in the 2000s, the epidemiology of each specific condition seemed to reveal that it was a critical problem deserving special attention. It may seem appropriate that prevalence would guide policy: as specific problems affect more children and families, society should respond to address those needs. When one condition gets so much attention, however, more general policies that might improve the health of all people with DD are neglected. Indeed, over the last half-century, disability policy has been built in layers, with each generation adding laws and programs in response to perceived immediate problems. Furthermore, the construction of estimates of prevalence—or other health statistics—is inherently a political process. The definition of a condition and the methods of determining prevalence occur in a specific historical context: Governors declare epidemics, not statisticians. By historically reconstructing how prevalence was measured over the last half century, I hope to reveal the specific social and political forces that led to each condition being central to disability policy for a specific period of time. This history is critical to understanding current dilemmas in distributive justice for all Americans.

Molly Hales (University of California, San Francisco)
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"Native Sovereignty by the Numbers: The metrics of Yup'ik behavioral health"

> Evidence-based practices are reshaping behavioral health programs in rural Alaska. As state and private funders demand new forms of statistical accountability, native agencies must scramble to capture the efficacy of their health programs without compromising their own core values in the process.
> Such demands are not unique to rural Alaska; the imperative to develop 'evidence based' interventions is currently reshaping the field of global public health (Biruk 2012; Erikson 2012; Adams 2013). Evidence-based practices make metrics the accepted standard for evaluating medical interventions, putting pressure on global health programs to incorporate quantitative research methods in order to demonstrate the efficacy of their projects.
> What role do health metrics play in struggles for indigenous sovereignty? Much recent literature draws attention to the ways in which global formations—including global health institutions and structures—can supersede and cross-cut nation-states (Comaroff and Comaroff 2001; Hardt and Negri

2001; Ong 2006; Bartelson 2006; Howland and White 2009; Adams, forthcoming).Yet it is important to locate the emergence of this "new global sovereign" within existing struggles over the sovereign status of indigenous peoples living in ongoing conditions of colonialism. For many such peoples, sovereignty is critically important to protecting livelihood and preserving authenticity.

In this presentation, I will explore some of the ways in which the legitimacy conferred by health metrics enter into the efforts of Yup'ik residents of southwestern Alaska to secure sovereign rights and recognitions. By making funding for Yup'ik behavioral health programs contingent on the production of health metrics, the post/colonial settler-state perpetuates relationships of financial and intellectual dependency. This is one way in which global health "aspirations towards a contemporary global sovereign" dovetail with longstanding colonial histories to ensure the perpetuation of colonial dependencies in indigenous communities (Adams, forthcoming). Yet metrics can also be mobilized by indigenous communities themselves. Even as they dispute the purported universality of health metrics, the directors of Yup'ik behavioral health search for creative ways to demonstrate evidence of efficacy. They are cognizant of the ways in which health metrics confer legitimacy to an international audience, and may help instantiate their claims to sovereignty.

Rico Kleinstein Chenyek (University of Illinois, Urbana-Champaign)
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"From Unconventional and Alternative to Complementary and Integrative: The Regulation of Alterity in U.S. Medicine and Latina-Indigenousness"

On May 16, 2014, the National Institutes of Health (NIH) National Center for Complimentary and Alternative Medicine (NCCAM) proposed a name change to the "National Center for Research on Complementary and Integrative Health," effectively eliminating the alternative from its focus. Director Dr. Josephine P. Briggs justified such a name change arguing, "true alternative medicine no longer exists" ("NCCAM Proposed Name Change," http://youtu.be/YPz8K30CfpE). Complementarity and integration are already arguably the priority and the means of regulating alterity in medicine. Such a name change would seem to more accurately represent the inner workings of the NCCAM. However, eliminating the "alternative" cuts all accountability of conventional U.S. public health efforts to alterities in medicine that seek to maintain autonomy or some other distinction from the conventional. Furthermore, such a name change would not be new. Since 1991, the NIH has supported first an office dedicated to unconventional medicine, then an Office of Alternative Medicine (OAM), and finally in 1999 the NCCAM was developed. Such name and inherent agenda changes are thus familiar to the NIH and regulating alterities in U.S. medicine.

James Harvey Young's "The Development of the Office of Alternative Medicine in the National Institutes of Health, 1991-1996," Eric Boyle's "The

Politics of Alternative Medicine at the National Institutes of Health" and his recent monograph, "Quack Medicine: A History of Combating Health Fraud in Twentieth-Century America" have examined the historical regulation of alterity in medicine by U.S. conventional medicine through respective quackery, unorthodoxy, unconventionality, alterity, and now complementarity, and integration categorizations. However, such scholarly accounts have dismissed the role of gendered racializations, particularly latinidad and indigeneity, in U.S. and NIH regulations of alterity in medicine. The current paper concerns notions of Latina-indigeneity, legality, and citizenship that have been inherent to legislation on alternative medical institutions, and how these are tied to an agenda of defining, monitoring, and regulating alterity in medicine. Such historical analysis allows for an understanding of national alternative medicine initiatives as a historical technology of regulation that may mask health movements that align with food security, environmental justice, land-based sovereignties, and feminist, queer, and trans health needs.

Josh Franklin (University of Pennsylvania)
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"Claiming the Right to Transgender Health in Brazil"

In 2007, a Brazilian federal appellate court ruled that the constitutional right to health guaranteed access to gender-affirming care for transgender individuals. Understanding the needs of transgender people in terms of a right to health can enable access to health services, but it also raises questions about the universal categories of gender and sexuality that are deployed. Although transgender people are put at significant risk by their social marginalization and structural violence, the class dimensions of transgender identity have been inadequately studied and theorized. While many have noted disparities in healthcare access attributed to socioeconomic status, too little has been said about the way in which class position shapes identity.

As an analytically distinct object of clinical knowledge, self-knowledge, and transformation, gender identity as a way of knowing enables certain forms of speech but precludes others. In this project, I draw on fieldwork conducted in a publicly funded gender identity clinic in Porto Alegre, Brazil between 2009 and 2012 to show how this limited construction of gender variance interacts with class and affects poor transgender people. By following the ways in which the disarticulated concept of gender identity is taken up in a context of poverty, I explore how the clinical transgender subjectivities that are produced put these people at risk, material and psychological. This project explores how concepts of gender identity, psychopathology and human rights take shape in the context of precarious public access to care among poor Brazilians.