Research Centre for Policy Analysis and Studies of Technologies  
(Tomsk State University, Russian Federation)  
Department of Health, Ethics and Society  
(Maastricht University, The Netherlands)  
with the support from The Open Society Foundations

The International Conference

Social Sciences & Medical Innovations

15—17 May 2014, Tomsk State National Research University,  
(Tomsk, Russia)

PROGRAMME

Advisory Committee:

Klasien Horstman, Professor of the Philosophy of Public Health, Leader of the Research Programme  
Health, Ethics and Society, Maastricht University, the Netherlands;  
Jessica Mesman, Associate Professor at the Department of Technology and Society Studies; Maastricht University, The Netherlands;  
Agnes Meershoek, Assistant Professor in Health Sciences, Department of Health, Ethics and Society, Maastricht University, the Netherlands;  
Demkin Vladimir, Vice-Rector of National Research Tomsk State University, Russia;  
Evgeniya Popova, Director of Research Centre for Policy Analysis and Studies of Technologies (REC PAST-Centre), National Research Tomsk State University, Russia.

Organizing Committee:

Olga Melnikova, Research Fellow, Centre for Policy Analysis and Studies of Technologies, National Research Tomsk State University;  
Olga Zvonareva, Research Fellow, Department of Health, Ethics and Society, Maastricht University.

15th May – Conference hall, Main Building, National Research Tomsk State University, Lenina, 36.  
16th May – Room 209, Main Building, National Research Tomsk State University, Lenina, 36.  
17th May – Building № 4, National Research Tomsk State University, Moskovsky tract, 8.
May 15th, 2014 (Thursday)
(Conference hall, Main Building, National Research Tomsk State University, Lenina, 36.)

11.00 – 11.30 – participant registration.

Vladimir Demkin (Vice-Rector of Tomsk State National Research University, Russia).
Evgeniya Popova (Director of Research Centre for Policy Analysis and Studies of Technologies, National Research State National Research University, Russia).

11.45 – 13.15 Key-note speech
Klasien Horstman (Maastricht University, The Netherlands).
Social sciences and medical innovations: a fruitful and critical companionship?
Discussant: Victor Vakhshtayn (The Moscow School of Social and Economy Sciences, Russia).


Section 1. Co-production of Science and Society
Section leader: Jessica Mesman (Maastricht University, The Netherlands).

13.30 – 14.00 Bart Penders (Maastricht University, The Netherlands, Harvard University, USA), Melanie Leenen (Maastricht University, The Netherlands).
Dissident Credibility: The Food Hourglass.

14.00 – 14.30 Evgeny Kulikov (Academy of Evidence-Based Medicine, Siberian State Medical University, Russia).
The role of evidence-based medicine in modern society and medical innovating.

14.30 – 15.00 Denis Sivkov (The Russian Presidential Academy of National Economy and Public Administration, Volgograd, Russia).
Ontologies of immune systems: metaphors, images and things.

15.00 – 16.00 Lunch.

16.00 – 16.30 Victor Vakhshtayn (The Moscow School of Social and Economy Sciences, Russia).
Trauma as metaphor: ontological policy of “traumacentrism”

16.30 – 17.00 Maria Polikashina (National Research University Higher School of Economics, Russia).
Between nature and society: conceptual analysis of the body in medical and social contexts.

17.00 – 17.30 Andrey Kuznetsov. (REC PAST-Centre, National Research Tomsk State University, Russia).
Clinic as a “Truth-Spot”: Politics of Theory in After-ANT Studies of Medical Practices.

Wrap-up.

17.30 – 18.00 Coffee Break.
18.15 – 19.45 Master-class on “Doing social science research in medicine and health” by Agnes Meershoek (Maastricht University, The Netherlands).

(Conference hall, Main Building, National Research Tomsk State University, Lenina, 36.)

The session will start with an introduction in a few social sciences theoretical perspectives that are useful for investigating medical and health related practices. The focus of the workshop will be on the use of (social sciences) theory in different approaches of qualitative research. Depending on the approach, theory plays an important role in the different phases of the research process in qualitative research. We will discuss the importance of theory for framing the research question, the way theory can be used in data collection and data analysis and the role of theory in generalization of results and drawing conclusions.

In the second part of the workshop, participant will do a small assignment in data analysis. They will be provided with a theoretical framework from the social sciences to analyze a video of medical practice. The results of the assignments and experiences of working with a social sciences theoretical framework will be discussed. The workshop will end with a sum up of lessons learned.

May 16th, 2014 (Friday)

(Room: № 209, Main Building, National Research Tomsk State University, Lenina, 36.)

11.30 – 13.00 – Key-Note Speech.

Jessica Mesman (Maastricht University, The Netherlands).

Exnovation: Towards an alternative understanding of patient safety

Discussant: Ivan Tchalakov (REC PAST-Centre, National Research Tomsk State University, University of Plovdiv, Bulgaria).

13.00 – 13.20 Coffee-Break.

Section 2. Innovation Governance

Section Leader: Agnes Meershoek (Maastricht University, The Netherlands).

13.20 – 14.00 Agnes Meershoek (Maastricht University, The Netherlands).

Democratizing science and technology policies: advantages and limits of STS inspired approaches.

14.00 – 14.30 Valentina Poliakova (Moscow Higher School of Economics, Russia).

Key challenges to social legitimation of stem cells technologies in Russia.

14.30 – 15.00 Pavel Vasilyev (Max Planck Institute for Human Development, Germany).


15.00-16.00 Lunch.

16.00 – 16.30 Alexandra Kurenkova (Institute of Ethnology and Anthropology, Russia).

Ethical Issues in ART Use: Case of Moscow IVF Clinic.

16.30-17.00 Olga Zvonareva (Maastricht University, The Netherlands).

Localizing the global: research and treatment in international clinical trials in Russia.
During the round table meeting the role of biomedical innovations in addressing social problems in Russia and the world will be discussed. The representatives of the different fields and sectors will come together: medical practitioners and scientists, members of state organizations and high-tech companies, staff members of non-commercial organizations working in biomedicine, including foreign ones, as well as sociologists and anthropologies. Such inclusive approach is important for analyzing the innovations in modern biomedicine and for understanding of the processes, difficulties and risks in this field in Russia and the world.

Discussion questions:
- Role of biomedical innovations in addressing social problems in Russia and the world
- Relations between international standards and development of biomedical innovations in Russia
- Issues of import and export of medical devices and pharmaceuticals
- Russian biomedical innovations: import substitution or creation of completely new technologies?
- The role of Russian technological platforms in biomedical innovations development

Organizers:
Policy-Analysis and Technologies Studies Center, Tomsk State University
Department of Health, Ethics and Society, Maastricht University

Moderators:
Evgeniya Popova, National Research Tomsk State University
Irina Kyrzina, Technology Platform ‘Medicine of the Future’

Key speakers and guests:
Alexey Sazonov, Doctor of Medical Sciences, Senior Research Fellow of the Central Research Laboratory, Siberian State Medical University. ‘The mechanisms of state support for biomedical innovations in Russia’
During the presentation the ways to finance scientific and technical projects for biomedical innovations development in Russia will be described.

Evgeniya Popova, PhD, Associate Professor in the Department of Political Science, Director of the PAST-Centre, National Research Tomsk State University ‘Export/import of biotechnologies in Russia: some results of state initiatives’
Based on the interviews with the directors of high-tech companies in Tomsk and Novosibirsk, the presentation aims to depict the strategies of bringing medical products into the market. The relations between the strategies and state initiatives will be discussed.
Olga Zvonareva, Research Fellow, Department of Health, Ethics and Society, Senior Staff Member of the Taskforce Russia Group, Maastricht University.

‘Triple helix and biomedical innovations governance in Russia and the Netherlands’

The examples of fruitful collaboration between government, academia and business in biomedical innovating will be discussed.

Elena Simakova, PhD, Lecturer at the University of Exeter, Member of the Advisory Group for the Directorate General for Research and Innovation of the European Commission.

‘Potential of technovisionary approaches in political decision-making with regards to bioinnovations: case of EU’

Vadim Zhdanov, Doctor of Medical Sciences, Professor, Deputy Scientific Director, Research Institute of Pharmacology.

‘Possibilities of development of biopharmaceutical field development in Russia’

The presentation will discuss the issues in creation of generic and innovative biopharmaceuticals in Russia.

Olga Vaisova, Doctor of Medical Sciences, Professor, Siberian State Medical University.

‘Major areas of preclinical research in innovative drugs development in Russia’

The presentation will discuss issues and trends in research in innovative drugs development in Russia.

Veniamin Khazanov, Doctor of Medical Sciences, Professor, the Head of the IPHAR (CO., LTD).

‘Development of innovative drugs in Russia’

Presentation will analyze the role of Russian and international standards in work of a pharmaceutical R&D company in Russia.

Zhanna Spitsko, Deputy Director of the Technology Platform ‘Medicine of the Future’

‘The role of the technology platform ‘Medicine of the Future’ in biomedical innovations development’

The information about the technology platform’s structure, main areas of work and collaborations with regional clusters in the fields of pharmaceuticals, biomedicine, medical devices and medical materials will be presented. Examples of innovative biomedical projects, supported by the technological platform ‘Medicine of the Future’, will be discussed.

Irina Kyrzina, Doctor of Physics and Mathematics, the Head of the Laboratory of Catalytic Chemistry, Tomsk State National Research University; Coordinator of International Collaboration, Technology Platform ‘Medicine of the Future’.

‘The experiences of Technological Platform ‘Medicine of the Future’ in international cooperation for biomedical innovations development’

The presentation will discuss major areas of international cooperation, which contribute to biomedical innovations development.

Iliya Kaminskii, Candidate of Pharmacology, Senior Lecturer, Department of Pharmaceutical Chemistry, Siberian State Medical University; the Head of workgroup for Analysis and Foresee, Technology Platform ‘Medicine of the Future’.

‘Participation of the technology platform ‘Medicine of the Future’ in the development of the foresight for scientific and technological development of Russia till 2030’
The presentation will describe the system of long-term foresight developed within the technology platform ‘Medicine of the Future’ as well as the main results of the foresight of the scientific and technological development in life sciences till 2030.

**Discussion participants:**
- **Nataliya Goncharova**, the Head of Commercialization Department, Institute of Strength Physics and Materials Science of the Siberian Branch of the Russian Academy of Sciences, Academic Secretary of the Technology Platform ‘Medicine of the Future’,
- **Yury Kistenev**, Doctor of Physics and Mathematics, Professor, the Head of Physics Department, Siberian State Medical University,
- **Margarita Dobrysina**, Candidate of Economic Sciences, Associate Professor, Economic Faculty, the Head of the Center of Medical Management, National Research Tomsk State University, Representatives of the Tomsk Oblast Center for Cluster Development.

The round table will be in Russian with simultaneous translation to English.

**18.15 – 19.45 Master-class on “Studying medical technologies”**
by **Agnes Meershoek** (Maastricht University, the Netherlands).

*(Room: № 308, Building № 4, National Research Tomsk State University, Moskovsky trakt, 8)*

The session will start with an introduction in STS-theory on implementing innovations/technologies in health care. We will discuss how the STS approach differs from more standard approaches to implementing medical technology and the implications of STS theory for the framing of research questions and the study design.

In the second part of the workshop participants will work on an assignment. They will be invited to apply STS innovation theory to topics of their interest and elaborate on the consequences of using STS theory for designing their own studies. The results of the assignments will be discussed.

The session will end with a few take home messages related to the use of STS as theoretical frame work in health care research.

**May 17th, 2014 (Saturday)**

**Section 3. Innovations, Medicine and Gender**

*(Room: № 520, Building № 4, National Research Tomsk State University, Moskovsky trakt, 8)*

**Section Leader: Anna Temkina** (European University at St. Petersburg, Russia).

11.00 – 11.40 **Anna Temkina** (European University at St. Petersburg, Russia).

*Trust and access to the childbirth service in Russia: Ariadne’s thread.*

11.40 – 12.10 **Ekaterina Borozdina** (European University at St. Petersburg, Russia).

*Institutionalization of Independent Midwifery Services in Russia.*

12.10 – 12.40 **Olga Melnikova** (REC PAST-Centre, National Research Tomsk State University, Russia).

*Technologies in Russian maternity hospitals: social practices and negotiations on the application of epidural anaesthesia.*

12.40 – 13.00 Coffee-Break.
13.00 – 13.30 Valentina Shipovskaya (University of Zurich UZH, Switzerland)
Gender Differences in Healthy Ageing: the Possibilities of Measurement.

13.30 – 14.00 Daria Schechvatova (Volgograd State Medical University, Russia),
Olga Kurushina (Volgograd State Medical University, Russia).
Male or female doctor, any difference?

14.00 – 14.30 Polina Vlasenko (Center for Society Research, Ukraine).
Biopower and Precarity: The Discourses of Assisted Reproductive Technologies (ART) In Ukraine.

Wrap-up.

Section 4. Cultures in Medicine
(Room: № 308, Building № 4, National Research Tomsk State University, Moskovsky trakt, 8)

Section Leader: Ivan Tchalakov (REC PAST-Centre, National Research Tomsk State University, University of Plovdiv, Bulgaria).

11.00 – 11.30 Nina Bagdasarova (American University of Central Asia, Bishkek, Kyrgyzstan);
Karen Petrosyan (the University of Massachusetts, Boston).
Exploring a process of de-stigmatization of mental disorders among professionals: the case of depression in post-soviet Kyrgyzstan.

11.30 – 12.00 Anna Leontieva (Moscow Higher School of Economics Russia).
Stigma, trust and self-management in using medical services by drug users in Russia.

12.00 – 12.30. Svetlana Abrosimova (The Ural Federal University, Russia).
Interpretation of advances in medicine and biotechnology by Judaism.

Wrap-up.

12.30 – 13.00 Coffee-Break.

Section 5. Innovation Design and Implementation
(Room: № 308, Building № 4, National Research Tomsk State University, Moskovsky trakt, 8)

Section leader: Elena Simakova (REC PAST-Centre, National Research Tomsk State University, Russia; University of Exeter, UK).

13.00 – 13.40 Elena Simakova (REC PAST-Centre, National Research Tomsk State University, Russia; University of Exeter, UK).
Responsible Research and Innovation: lessons from researching large scale technoscientific initiatives

13.40 – 14.10 Angelos Balatsas-Lekkas (Technical University of Denmark, Denmark).
Patient safety and “the laboratory”: Designing scenarios for medical simulation.

14.10 – 14.50 Ivan Tchalakov (REC PAST-Centre, National Research Tomsk State University, University of Plovdiv, Bulgaria).
Planet Mars and Knowledge about Health: Lessons from Past Colonizations
14.50-15.30 Lunch.

15.30 – 16.00 **Tetiana Stepurko** (National University of ‘Kyiv-Mohyla Academy’, Ukraine; Maastricht University, The Netherlands), **Milena Pavlova** (Maastricht University, The Netherlands), **Irena Gryga** (National University of ‘Kyiv-Mohyla Academy’, Ukraine), **Wim Groot** (Maastricht University, The Netherlands).

*Informal patient payments in Lithuania, Poland and Ukraine.*

16.00 – 17.30 **Natalia Abdulkina** (Tomsk Research Institute of Balneology and Physiotherapy, Russia). **Aleksey Zaitsev** (Tomsk Research Institute of Balneology and Physiotherapy, Russia).

*The contribution of balneology into socially-centred and recreation-oriented economy in Siberian region*

17.30 – 18.00 **Olga Kolesova** (Perm National Research Polytechnic University, Russia); **Ekaterina Makarova** (Perm National Research Polytechnic University, Russia); **Andrey Shulyatev** (Perm National Research Polytechnic University, Russia); **Elena Seredkina** (Perm National Research Polytechnic University, Russia), **Alexandra Trefilova** (Perm National Research Polytechnic University, Russia).

*Transdisciplinary research in the field of metabolism and diabetes in Polytechnic University.*

18.00 – 18.30 Coffee Break.

**18.30 – 20.00 Round table: Collaboration in Medical Innovation**

*(Room: № 308, Building № 4, National Research Tomsk State University, Moskovsky trakt, 8)*

*Moderator Bart Penders* (Maastricht University, The Netherlands, Harvard University, USA).

Relevant and responsible health care innovation requires the input and direct involvement of many. How do we organise this multitude of voices, with all its asymmetries of power, diverse disciplinary cultures and governance traditions? This session will feature the exchange of strategies, experiences and examples of collaboration – whether successful or less so – to enhance our engagement with and study of health care innovation.

*Wrap-up/ closing remarks Klasien Horstman* (Maastricht University, The Netherlands).

20.00. Banquet.

**May 18th, 2014 (Sunday)**

*Departure day.*
Interpretation of advances in medicine and biotechnology by Judaism

Quality of the nutrition is of special importance for people’s health. Unfortunately, problem of starvation and limited resources still have not been completely resolved. One of the possible solution is a wide spread of genetically modified (GM) food. The possibility to modify genetically any nutriment leads to the issue specific for Jews – necessity to make a decision whether GM foods is appropriate to eat or not.

According to the Judaism’s tradition, answers for all questions are searched in Halachah. In the conclusion presented by the OU’s Rabbinical Kashruth Advisory Board under the Orthodox Union, GM foods can be treated as kosher, if it is not harmful for human health. Even if genes have been taken from a non-kosher species, they are considered as a template incorporated in the plant, which is no doubt kosher [2]. Rabbi A. Reisner pointed out the decision made by rabbis in 1890s, according to which food should be considered as non-kosher only if non-kosher part of the meal can be seen by the naked eye [1]. At the same time Rabbi S.Z. Auerbach supposes that this criterion cannot be applied to the GM foods, because even though it is not possible to see the genes, they are incorporated intentionally, so we know about their presence for sure [3].

Treatment of the GM foods is also effected by Kilayim – collection of prohibited crossing of the distinct species. According to Kilayim, crossing the animals through sexual reproduction is forbidden, whereas usage of nonsexual methods is not, which open the possibility for genetic modifications of animals.

As for plants, the question is more complicated. According to rabbis A. Kareliz and S.Z. Auerbach, any plants crossing (including those made by genetic modification) is prohibited, as two species would be growing on the field (forbidden by Kilayim). This restriction can be by-passed by synthesis of the replantation components in the laboratory conditions [3]. Reisner believes that there is a gap between concepts of kosher and crossing acceptability, which allow us to consider GM foods to be acceptable for religious person [1].

Study of the viewpoints on the GM food presented in Judaism reveals not only variety of attitudes on this subject, but also demonstrates difficulties in determination of its place in the religious view of the world. Currently, Judaism is in the beginning of the formation of common opinion on GM foods, but the increasing positive tendency is already perceived. At the same time, in order to be accepted, such food has to correspond to the appointed religious demands. In conclusion, the GM foods phenomenon leads to reconsideration of the religious nutrition requirements in the light of the scientific progress 1.

References:
3. Wolff A. Jewish Perspectives on Genetic Engineering Available at: http://www.jcpa.org/art/jep2.htm

1 This research project has been supported by UrFU under the Framework Programme of development of UrFU through the «Young scientists UrFU» competition.
There is general consensus regarding the importance of trust and the central role it plays in biomedicine. For clinical research, trust is a crucial requirement, underpinning many relationally-dependent practices that facilitate experimentation and innovation discovery. The inherent risk in experimental research practices means trust must not only be attained from the public, but also actively maintained. This continues to be a challenge, particularly as clinical research continues to expand internationally to lower-resourced countries. While many populations have often been weary of Western practices and involvement in research, literature has suggested that some lower-resourced population’s taking part in clinical research activities have demonstrated naïve trust of practices conducted by local investigators and institutions and subsequently were perceived as more vulnerable to exploitation. Over the years, securing wider public trust in clinical research has been complicated by the long-documented history of biomedicine which, at times, has been punctuated by ethical controversy, public scepticism and criticism. The Nazi Nuremburg trials in Germany and the Tuskegee Syphilis studies in the United States are two of the most prominent ‘scientific’ atrocities which have contributed to negative public perceptions towards scientific activities, medical professionals and the mechanisms used to protect those involved in scientific research. Regulators of international clinical research have tried to combat negative public perceptions of clinical research by providing a regulatory framework that ensures international guidelines are adhered to and practices are conducted ethically; guidelines derived from notable documents such as the Nuremberg Code, the Helsinki Declaration, and the Belmont report. On the one hand the implementation of these frameworks could be framed as a means of regulating out the liability of exploitable naïve trust in clinical research and those conducting it, by providing internationally recognized ethical guidelines for research conduct. On the other hand, they can be viewed as a way to reinforce the idea that clinical research practices can be trusted by the public. However, little is known about how trust is conceived, established, directed and the mutually significance of these on the operationalization of research frameworks in low-resourced clinical trial settings. This study aims to empirically explore these questions in various Tanzanian clinical trial settings to provide a better understanding of trust and its role in research and how the current research ethics frameworks accounts for trust by exploring the views of investigators, regulators and participants in Phase II and Phase III trials.
Exploring a process of de-stigmatization of mental disorders among professionals: the case of depression in post-soviet Kyrgyzstan

Since the end of the 1980s multiple changes were introduced in mental health services provision in Kyrgyzstan. The traditional diagnostic system was changed according to the ICD-10 criteria in 1990. New approaches to diagnostics and new ways of communication with patients were introduced in medical schools and postgraduate qualification courses. These changes were aimed at de-stigmatization of mental illnesses, being based on elimination of the separate concepts of “psychosis” and “neuroses”. The main focus of this research was on the shift in understanding of the concepts of “mental health” and “mental disorder”. The concept of depression was chosen as a main subject for analysis of this shift. Several focus-groups with professionals and general population were conducted. In general, the results of discourse analysis revealed that there was no common attitude towards “mental illnesses” as a “single concept” among both psychiatrists and among representatives of general population. There were still two major categories of “mental disorders”: with and without psychotic-like symptoms.

Participants of the two focus-groups with psychiatrists represented two different branches of the National Center of Mental Health: first, called “psychosomatic branch” worked mainly with neuroses while the second one dealt with psychoses. Those psychiatrists who worked in psychosomatic branch favored the standard list of criteria listed in ICD-10, while providing their associations with the word “depression”. Among those were suicidal thoughts, duration of symptoms, and incapacity for work. They also paid particular attention to the types of depression, mentioning masked depression, age-related depression, and endogenous depression. The specialists from the second unit appealed to regular, everyday language more often when speaking about this disorder. Actually each of the psychiatrists' groups displayed more concern with regards to disorders they were used to work with, going into details, when describing them. Thus, the psychiatrists cannot be separated from the society and thus share similar discourses.
Patient safety and “the laboratory”:
Designing scenarios for medical simulation

This paper focuses on medical simulation sessions and specifically on the design of scenarios seemingly made to resemble critical situations in actual practice settings. Starting within the metaphor of the laboratory as a space where issues of control play an important role for the design of experiments, the paper draws an analogy with the spaces that medical simulations and designed and performed. The paper involves a particular view on laboratory studies and draws on design studies informed by STS sensitivities (e.g. Binder et al. 2011). Such view allows the exploration of implementation issues that dwell on the complexities that characterize patient safety in large healthcare environments (e.g. hospitals) and patient safety’s representations in seemingly simplified spaces such as that of medical simulation. Moreover, such metaphor serves for understanding the knowledge dynamics that occur while medical professionals learn about patients’ safety by participating in medical simulation sessions. By simulating some aspects of it, they still need to translate such learning experiences to their own everyday practices.

Simulation sessions are used for supporting the training of medical professionals upon issues of communication and coordination. The design of simulation scenarios that supports the performance of simulation sessions requires medical professionals, engineers, psychologists and others to work together under the role of “instructors”. Part of instructors’ work is to envision situations by drawing on their long-term acquired experiences about incidents of error, uncertainty and good practices. Moreover, specialized spaces, technologies and material practices required for the performance of medical simulation sessions need also to be considered in the instructors’ purviews.

Issues of control arise, as instructors need to negotiate their understandings upon notions of patient safety (e.g. prevention) and to reconstitute them by aligning their work with the creative elements that the design of scenarios entails. These could be tensions between the generation of ideas for scenarios and acknowledgement of the rigorous meaning that the notion of patient safety has for medical practices.

By reporting preliminary findings from empirical research conducted at the Danish Institute of Medical Simulation, the paper argues that knowledge about patient safety is not only generated when medical professionals participate to medical simulation sessions. It is also generated when interdisciplinary teams of instructors design the scenarios that medical simulations are based on. Therefore, the cultivation of new practices in-between the design of scenarios and the actual work of medical professionals hint to transformative aspects of medical simulation.

Processual understandings of knowledge creation and transfer describe implementation as stage where plans need to be followed by everyone participating to their execution in the same manner. For understanding the transformative aspects entailed in the design of scenarios and their implications for medical practices, the paper draws on the concepts of domestication of technology and innofusion (see Williams, Stewart and Slack 2005). A focus on the design of scenarios in medical simulation offers insights about the individual and collective generation of reflexive approaches to situations that patients’ safety is compromised.
Institutionalization of Independent Midwifery Services in Russia

Since the 1990s Russian reproductive healthcare has undergone a series of transformations. Liberalization and commercialization of this sphere have led to the development of new types of childbirth services. The introduction of a “natural” approach to labor and the spread of independent midwifery practices are some of the most significant changes and challenges to Post-Soviet maternity care provision.

According to the institutional rules of Russian healthcare, midwives may not play a substantial role in helping women give birth. They can only act as doctors’ assistants, and do not have the right to run independent practices or to attend deliveries at home. “Natural” childbirth activists are trying to alter this situation: to advance less medicalized forms of maternity care and to establish midwifery in Russia as an autonomous profession.

The history of the midwifery (and homebirth) movement in the country can be traced to the late 1980s, when dissident scholar Igor Charkovsky, supported by a small group of followers, staged water births in Moscow. Since the mid-2000s the movement has been steadily transforming itself from an underground dissident initiative into a business. Childbirth has become a field of competition between obstetricians and midwives as representatives of a “weak” profession, who make competing claims for competence in issues of human reproduction and for control over female reproductive experiences.

The goal of my research is to analyze how Russian midwifery attempts to redefine assistance to birthing mothers, to develop alternative (different from conventional medical) forms of control over delivery process and maternal body, and to institutionalize these innovations.

“Natural childbirth” approach and independent midwifery in modern countries appear as an alternative to the hegemonic obstetrical control of delivery. And as medical models of birth vary between different countries, so do modes of midwifery practice. In Soviet and post-Soviet contexts, the medicalization of childbirth followed a path different from that of Western Europe and the United States. In Russia, objection to medicalization is determined not so much by the excessive power of medical professionals as it is by extensive state intervention in reproductive experiences, which is realized largely through an overgrown and inefficient healthcare bureaucracy. Nowadays, local independent midwifery practice is also heavily influenced by ideology and practice of international (mostly, Western) midwifery movement.

Thus, studying independent midwifery in the country one can evidence a unique constellation of politics, ideologies and practices of childbirth that have developed at the crossroads of former Soviet experience, current liberal reforms in national healthcare system and intervention of global actors in this sphere.

My research is based on semi-structured interviews with independent midwives who provide their services in the frame of state birthing hospitals (that is the only (semi)legal way of exercising “natural childbirth” approach in the country) and their women clients. As an additional source of information I use materials of participant observation at three midwifery conferences on “natural childbirth” that took place in Moscow in 2010, 2011, and 2013.
Social sciences and medical innovations: a fruitful and critical companionship?

Medical innovation is hot. The expectations of genomics (and many other omics), ambient care, telemedicine, regenerative medicine, imaging technologies, neurosciences etc. are very high. According to Helga Nowotny, the former president of the European Research Council, the current obsessive interest with innovation articulates a subconscious idea that only ‘the new’ is able to navigate us through an uncertain global world. However, the step from laboratory to practice appears to be more difficult than these expectations suggest. That was already the case with the introduction of anesthetics in the 19th century and X-rays in the 20th century, and it is the case with new medical technologies in the 21st century as well. While the social sciences and medical sciences have lived in two worlds for a long time, these fields have become closer since the 1950's when medical sociology developed. This discipline focussed on the social role of the medical profession in societies, and left the heart of medicine – its knowledge and technologies – untouched. With the rise of science and technology studies in the 1980's, the social sciences also tried to understand medical innovations as they developed in the laboratory and travelled through society. It became clear that innovations do not travel through society because of their effectiveness, but that, to become effective, innovations need to travel and to become adopted by users. This new approach to understand medical innovations resulted in new metaphors like co-production of science and society, interaction, mediation, interdependency, collaboration etcetera. In line with this, philosophers of technology have argued that these kind of collaborations are required to enable anticipation on ethical problems of new innovations. So, the social sciences should not only help to understand medical innovations, but also to organize interactions between ‘the social and the technical’ when innovations are in a still early phase to ensure that innovations will become ‘good innovations’. In this lecture I will reconstruct the dynamics of the relationship between the social sciences and medical innovations by making use of different examples, like for instance genetic technologies. I will also raise the question whether a good marriage does not sometimes need a big row: in other words, we should be aware that a fruitful companionship between the social sciences and medical innovations only can be a critical companionship.
Anna Leontyeva (Lecturer at Sociological Department of the Moscow Higher School of Economics, Russia); e-mail: Anna.a.leontieva@gmail.com

Stigma, trust and self-management in using medical services by drug users in Russia

It is often difficult for people from stigmatized groups such as injection drug users (IDUs) to achieve medical and social services. This report describes variety of strategies used among IDUs who need medical help. It is especially difficult to keep ability for self-management while getting into contact with medics in societies with strong paternalistic social control. It is important to study how do people who have been stigmatized manage to communicate with doctors.

Methodology. My research included 39 deep interviews (45-90 min) with street drug users (20 men and 20 women) in 4 Russian towns (Moscow, Orel, Yekaterinburg and Omsk) in 2011. The guide for deep semi-structured interview included questions on drug use history (“If you write a book about drugs in your life how many chapters it could consist of? How would you name the first one?” etc.). A narrative mode of interviewing was applied. One of the topics was related to strategies of health risk evaluation and obtaining medical help. The analysis included coding and interpretation relied on the context of the interview.

Dehumanization of drug users is widely spread currently in Russia and is extensively used by drug policy (Sarang et al., 2010). In my research I paid special attention to health decisions made during drug use. I found that abstinence for street IDU doesn’t necessarily mean that the person loses ability to control her/his health, or, as they say “stops thinking”. A lot of stories describe transit states when individual realizes she/he has options however deliberately more often chooses quicker although risky injection. Evidences from IDUs’ stories contradict the idea that they are unable to concern health topics during addiction periods of drug use. However, these aspects of their self-attitude often are still underestimated and thus are underrepresented in personal narratives. Thereby, they still reproduce stigma.

The problem of control is achieved in this research in various ways. For example, an interesting perspective is provided by a respondent who compares his ability to management such issues as use of new needles along with HIV-treatment commitment. The former appears to be considerably reachable but not the latter. He speaks of the latter in terms of “easier, freely, more available and independently” (male, 35). Other issue is rejection of official medicine or HIV-denialism as coping strategy. In my research it was presented by a regret: “I’d better didn’t know my number of cells (as HIV-patient), I could consider they are OK and support myself through good emotional condition” (female, 26).

Other results describe strategies in communication with doctors, which included telling lie about drug use; urging for “proper attitude”; avoiding confrontation. One evidence of attribution of social control as a professional position comes from description of a good doctor as one who uses non-official language, even if he is not friendly. These are examples I want to discuss to explore ways in which stigmatized people maintain self-management during interaction with medical services.

References:
Transdisciplinary research in the field of metabolism and diabetes in Polytechnic University

Modern medicine recognizes that global health is facing challenges from a multitude of interconnected infectious and non-infectious diseases. These health issues are occurring in human populations in the context of the interconnectedness of social and ecosystem determinants of health. Just as we need new devices and methods for better treatment, we also need new methodologies to change the way we think about complex health problems. A lot of transdisciplinary research in various fields, including medicine, is conducted in European and American Universities. One of the most well known centers of transdisciplinary research is Swiss Federal Institute of Technology in Lausanne (EPFL) which conducts many studies in the interface of medical, technical and social sciences.

As it was shown in EPFL example, polytechnic university is a great place for transdisciplinary research and therefore in 2012 Perm National Research Polytechnic University (PNRPU) started a new project «Program of collaboration on metabolism and diabetes» in the new center in cooperation with EPFL and Foundation “Neva”. This project is attractive for Polytechnic University, as successful modern research has to bring together knowledge of physicians, pharmacists and veterinarians. On the other hand, Polytechnic University offers open access to its scientific equipment for pharmacists, physicians and veterinarians involved in the project. In addition to a joint Research Program, a Graduate Program has been established, which aims to attract talented Russian students and provide them with opportunities in postgraduate education and research, with the support from one of the leading European Universities (EPFL). The Program will also include an Exchange Program to invite Professors and postdoctoral scientists to come to EPFL for a 4-6 month-long research sabbaticals at the world-class research facilities at EPFL.

Research and Education Center of Applied Chemical and Biological Research (REC ChemBR) was created in 2012 as the structural unit of PNRPU with the aim of developing interdisciplinary interaction between various technical disciplines and life sciences, and toward expanding the boundaries of traditional research fields. It was established with support from “Neva” Foundation. The main objective of the Center is research toward development of innovative medicines and diagnostic devices. To create interdisciplinary interaction the team which works on this project consists of physicians, pharmacologists, veterinarians, chemists and social workers from State National Research Polytechnic University of Perm, Institute of Ecology and Genetics of Microorganisms, Institute of Organic Synthesis Ural Division, Swiss Federal Institute of Technology in Lausanne and others. This group of scientists is working on three main aspects simultaneously: scientific, educational and social one.
Scientific aspect concentrates on three main diabetes fields: special food, medical equipment and pharmaceutical synthesis. The Program joins the resources and efforts of research institutions in diabetes research and in development of novel anti-diabetes therapies. Joint educational program gives the opportunity of training at EPFL for Russian students, scientific staff and researchers. The social aspect of the Program is implemented in coordination with Perm Regional Ministry of Health, with financial support provided by the Neva Foundation and includes informational services to diabetes patients, acquisition of modern diagnostic equipment for hospitals and clinics of Perm and Perm region, establishment of new schools for diabetes patients in the cities of Perm Region and organization of psychological services and support for diabetic patients. Also it analyzes social feedback from the laboratory work.

Integration of the modern scientific program into a State National Research Polytechnic University of Perm format, which has a 50-years history, was the main challenge for the ChemBR laboratory as some conservative scientists do not accept interdisciplinary research. This problem was partially solved with the help of thoughtful policy of university administration, qualified work of all lab participants and interest among students. Moreover the laboratory is open for all students and postgraduates of the University and they can participate in its research as volunteers.
The role of evidence-based medicine in modern society and medical innovating

This paper is based on a review of historical evolution of evidence-based medicine and its basic principles. The role of evidence-based medicine in modern society and medical innovating is discussed. Evidence-based medicine is central for all parts of clinical medicine. Evidence-based medicine aims to objectively evaluate the quality of clinical research by critically assessing techniques reported by researchers in their publications. What advantages can give evidence-based medicine for modern society? This paper further elaborates on the history of and attitudes towards evidence-based medicine in Russia.
Clinic as a “Truth-Spot”: Politics of Theory in After-ANT Studies of Medical Practices

Recently Thomas Gieryn introduced a concept of “truth-spot” as to suggest “that ‘place’ should be added to the list of modulators of scientific credibility”. My presentation will draw on this concept to show some peculiarities of theoretical development of actor-network after ontological turn exemplified in the work of Annemarie Mol.

Since it beginning sociology have tried to locate the social, i.e. to find a strategic place studying which would help to understand other places and possibly whole society. One strategy was to locate the social in virtual space of statistical categories or symbolic systems. (e.g. Durkheim in “The Division of Labour in Society”)

Another strategy was find specific geographical space to study. In the early 20-th century the Chicago School of sociology oscillated between laboratory and field-site conceptions of the city. Each conception allowed them although differently to claim scientific authority to their investigations and so to raise the status of sociology. City as a laboratory purify distinctions, amplify contrasts, speed up changes and thereby allow to study civilizing process.

In the late 1970 science and technology studies turned scientific laboratory into field-site. For STS laboratory has also theoretical significance. As a place where boundaries between subject and object, nature and culture are malleable laboratory become strategic site that helps to understand processes of construction of these distinctions which seem fundamental outside laboratory. Laboratory studies suggested insights about local production of universal knowledge. Besides that there were attempts to translate the logic of laboratory into another sites such as museums, factories, galleries etc.

In STS theories are elaborated not by systematic reasoning but through productive engagement in empirical case-studies. Nevertheless there are differences in this politics of theory. Some approaches proceed from cases to generalizations. Some approaches seek to find such cases that would challenge original framework and would help to transform or transmute it. Actor-network theory is a bright example of theoretical politics of the second type. History of actor-network theory suggests that its frame of reference and conceptual toolbox become more flexible the broader become its scope. Politics of theory in ANT implies “throw-away explanations” and not generalizations but creative translations of lessons from one specific case to another.

Contemporary phase of ANT is called “after-ANT” and is marked by ontological turn. Ontological turn suggest not only change of metaphors from “construction” to “performativity”, from “making” to “doing” but also change of strategic sites of research from laboratory to clinic (among the other places). Annemarie Mol make clinic a prominent place of study in STS a kind of new “truth-spot”. In her work clinic surface as: 1) a locality (e.g. hospital) where different enactments of realities (not always coherently and harmoniously) co-exist with each other. This helps Mol to elaborate the idea of ontological politics. 2) a set of practices located in the hospital. As a set of practices clinic is contrasted by Mol with laboratory practices located in the hospital as well. Partly out of this contrast Mol articulate logic of care that is well suited to deal with specificities of diseased bodies. In recent works Mol and her colleagues suggest to translate the logic of care from clinical context to another sites and situations such as farm, nursing homes, technology, education etc.

My presentation will concern theoretical implications of this change of strategic sites of research in STS. I will try to answer several questions: 1) What study of medical practices in clinical context could bring to general theoretical framework of STS? 2) How logic of care resonate with the politics of one-off explanations? 3) What could be new clinical perspective in social sciences?
Ethical Issues in ART Use: Case of Moscow IVF Clinic

This paper is based on the observations that I made during my work at one of Moscow IVF clinics (from October 2011 till June 2012). Being there I combined my working responsibilities (correspondence and assistance to foreign patients) and field-work research (participant observation) of some of the ethical and social issues appearing in the clinical course. Based on the analysis of this case, I singled out ethical issues arising in ART (assisted reproductive technologies) use in Russia as a kind of "research map" for further full-scale, longitudinal social science studies on this topic. These issues include: adequate informing strategies for patients and oocyte donors; psychological counseling and psychological testing of patients, oocyte donors and surrogate mothers; ART use by people “above certain age”, by gay couples and by HIV-infected people; monetary compensation and anonymity of oocyte donors; mutual obligations of parties involved; the issues of moral status of the embryo and rights of unborn children.

The practice of using ART in Russia is rather novel, although it’s getting more and more available, especially for people in large cities. The current legal regulation of this area does not consider many economic, medical, social and ethical aspects of ART use in Russia. This means that people endowed with power on a local level (first of all, managing staff and doctors in IVF clinics) can/have to resolve many issues at their own discretion. This situation urges social scientists to carefully study and interpret their findings in this area, so that they can inform relevant public policy. In the paper I underline the importance of conducting longitudinal social science studies of all the parties involved in ART procedures: patients, IVF children, oocyte donors and surrogate mothers, medical specialists.

This subject seems to be an essential part of such emerging post-Soviet disciplines as medical anthropology, bioethics, STS, medical sociology. In the course of the paper I also touch upon the issues of conducting social science research in/of Russian medicine. First of all, in the realm of medical humanities there is no unified and agreed upon methodological kit (especially, when it comes to qualitative methods), as well as no renowned research and educational centers in Russia where one can learn how to conduct research in this delicate field. Another essential aspect worth mentioning are the complexities of conducting social research in medical institutions in general: they are still very close and rather unaccustomed to make their insider information public.
Democratizing science and technology policies: advantages and limits of STS inspired approaches

In standard approaches to govern science and technology, the development of technology and the question whether we should implement the technology in practice are often considered as two separated phases. Development of technology is assumed to be an autonomous and knowledge driven process. Whether application and implementation of the technology is desirable is a political or normative question, that should be addressed in the policy arena. Side effects and cost of the technology can and should be weighed against the benefits in the political arena, resulting in controlled implementation or rejection of the technology. STS has criticised this standard approach for several reasons. Firstly, controlling the use of technology almost impossible: once developed technologies will find their way to practice. Secondly, technology development is far more influenced by societal aspects than is assumed in the standard model. Based on this criticism, STS has suggested several alternative models to democratize and govern technology development. In the presentation some of those approaches will be explained and possibilities and limitations will be discussed.
Technologies in Russian maternity hospitals: social practices and negotiations with regards to the application of epidural anesthesia

Technologies are an integral part of the modern obstetrics, however there are areas of contradictions regarding the applications of technologies. One of the important aspects is the pain and anesthesia. On the one hand, the pain is "natural" and does not require interference; on the other hand, it seems to be one of the most important problems in the medical care for women. And epidural anesthesia is one of the popular procedures in obstetrics. This work shows how the technology is used in practice in different ways, and that the practice differs in many ways from the medical standards. The focus of the report is on the negotiations and practical solutions on the anesthesia application by the physicians. In the presentation the different ways of understanding and using of the epidural anesthesia and its rejection will be presented, and also some conclusions about the professionalization and differentiation of the physicians will be suggested.
Exnovation: Towards an alternative understanding of patient safety

For more than a decade a growing number of STS scholars have been moving beyond the boundaries of academia into the public sphere with the aim ‘to make a difference’. This move, also referred to as the ‘interventionist turn’ (Zuiderent-Jerak & Jensen, 2007), involves ‘critical participation’ (Downey, 2009). In this presentation Jessica Mesman will take the opportunity to discuss her efforts to make a difference in practices related to patient safety. She will reflect critically on the dominant understanding of patient safety. According to her the improvement of patient safety should not only be based on error-reducing activities, but also on a sophisticated understanding of the vigor of health care practices. In her work she uses the STS-approach as point of departure to outline an alternative research agenda: one that concentrates on the resources of safety, notably the informal or unarticulated ones. The exploration of latent resources can be considered as a form of exnovation. This approach can be characterized by a conceptualization of ‘safety’ as an emergent property, and of ‘practice’ as being inherently imperfect. Second, it has its focus on the presence of safety and on the competencies of frontline clinicians to preserve adequate levels of safety within real-life complexities. Third, qualitative research is an important method of investigation and intervention. In the last part of her presentation the method of video reflexivity will be discussed as an example of this kind of intervention.
Dissident Credibility: The Food Hourglass

Formal Dutch and Flemish dietary guidelines have been presented in pyramid and disc structures for many decades. In 2012, the young author Kris Verburgh challenged those guidelines and proposed an alternative, the food hourglass, in which he presents dietary advice that differs on key points from existing formal advice. Its claim is to slow ageing, with weight loss featuring as a side effect only. His book sold over 250,000 copies and quickly gathered public support and following despite the Dutch Nutrition Centre’s criticism of Verburgh’s proposed dietary advice.

Understanding the performance, and ultimately the success and failure, of nutritional and public health guidelines requires an understanding of the foundations of their credibility and how consensus and dissident voice struggle for credibility. The distribution of epistemic authority in credibility contests is always changing and most certainly does not rest firmly in the hands of government agencies and scientific institutions. Freidson (1988) argues that certain professionals (or experts) are more credible than others because they are relevant in solving problems. In an effort to develop a more nuanced cartography of credibility, Gieryn (1999) proposed a set of roles that contestants adhere to in credibility contests – to which Shapin added the dissident role, exemplified by Dr. Atkins and characterised by a willingness to make moral claims rather than mere descriptive claims (Shapin 2007).

This paper analyses how a dissident voice –Verburgh’s– gathered credibility to speak with authority over dietary matters, in the face of clear opposition from existing knowledge structures including Dutch and Flemish universities and the Flemish Institute for Health Promotion. Credibility and authority are not intrinsic to scientific arguments and have to be established and re-established continuously. We will demonstrate that Verburgh engineered public credibility for his alternative dietary theory through combining a critique of the dominant scientific paradigm with select enlisting of that paradigm. Verburgh further invests in narratives to establish his arguments’ credibility and to establish his expertise as beyond reproach as well as innovative. He mobilises himself as an expert, but independent from the indoctrination of nutritional lore from which all formal nutritional experts suffer. The latter allows him to enlist those disappointed with existing dietary advice, offering a solution rather than more knowledge.

We chronicle the credibility contest between Verburgh’s Food Hourglass and the Nutrition Centre’s Food Disc, to display Verburghs successful strategies to engineer credibility and unsuccessful opposing de-credibilisation tactics. Understanding this struggle helps us understand the infrastructures of credibility underpinning soft technologies such as nutritional and public health guidelines.

References:
Key challenges to social legitimation of stem cells technologies in Russia

Throughout history the development of medical institution was followed by the extension of medical expertise boundaries. Progress in new medical biotechnologies and the manipulation of human biological material, in particular, raise the conceptual question of how to define the boundaries between human beings and biological material. There is an ethical challenge or even a cultural conflict between medical ideology and social moral norms caused by developments, for example the embryonic stem cells research, the usage of human fetal tissues (aborted fetus), and cloning. The approval of such practices has a number of social risks associated with violations of human rights and questions about the motivations of physicians. Conventionally this biomedical technology is described as socially sensitive. The conjugation of these health and social risks became the impetus for internal and external reflection on the impact of these innovations, it also pushed the development of the bioethics paradigm, which calls for humanistic science in general and in medicine in particular. Media discussions on the social, ethical and legal implications of medical biotechnology play an important role in its social legitimation. Such topics traditionally attract the attention of different audiences. I am going to compare the development of discourse on socially sensitive medical biotechnologies in different field and to demonstrate some peculiarities of social legitimation of such technologies on the example of stem cells.
Between nature and society: conceptual analysis of the body in medical and social contexts

Body is one of the relevant topics in medical practice, ethics and research and also one of the topics in interdisciplinary social and medical studies.

I'd like to start with notion “body” in social sciences. Body was not at the centre of attention in classical sociology. In general sociologists studies social actions and practices but not corporeality of actions and practices. In several cases, for example in Durkheim’s and Goffman’s studies of ritual, body was recognized as one of the relevant elements of social interactions. But as a whole body was not sociological matter.

Scientific interest in body research has been increasing since 1980th. Mike Featherstone and Bryan Turner in Introduction to first number “Body&Society” noticed increase of various social body researches in different aspects varying from biopolitics to modern medical studies. So the increasing interest in body matters requires new theoretical frameworks for definition and study the body in social studies.

Sociologists usually viewed body as agent of power, regimes and social fields. Michele Foucault and Pierre Bourdieu described body and management of body in strict social context. It means that individual operates and perceives its body in connection with observable and unobservable rules, powers and social dispositions. So according to Foucault discursive definition of body depends on social power is underlying social life. In my report I’m going to characterize basically weak aspects of Foucault’s and Bourdieau’s theoretical approaches in context of modern sociology of body.

As a whole according to B. Turner body has two definitions: medical and social. Now we need conceptualize the body in order to explain how people operate, change and present their bodies so as the body norms are transforming in view of new medical innovations and medical knowledge. Several medical innovations influence bodily norms and also help to reveal patterns of the body.

So I consider the bioethics is one of the topics that allow seeing and revealing patterns of body because it require investigating relationships between social and medical aspects. Sociologists define body within social-individual distinctions. I propose to define it within natural-social distinctions because notion “natural” allows for STS, anthropological and phenomenological views on body matters and it also help to avoid the notion “power” and “regimes” in our methodological explanations.

My report will have theoretical and methodological character. I’ll demonstrate basic methodological restrictions of sociological theories of body, describe basic questions of relationship between medical and social definitions of body, conceptualize necessary distinctions of body patterns in modern medicine and bioethics and show several examples on that.
Male or female doctor. Any difference?

How often do we notice the doctor gender? What makes us feel confident of one person and completely vulnerable to another? Is gender the reason of our trust? Is there any difference between male doctor and female one? Who is the best?

Gender preferences were the topic of interrogation, made by the authors of the article within 127 hospital patients of surgical and therapeutics departments in Volgograd city. The questions concerned perception of doctor gender and the preferences about it: “What features of doctor character are preferable for you? What features of character does your doctor have? Do you prefer to be examined by male or female doctor?” Patient’s depression rate was also followed up.

Poll participants were divided into gender groups: men and women. The depression rate was scored with the help of depression scale CES-D. In both groups the depression rate and the severity of illness were comparable. Half of man group mentioned among the best doctor’s features attentiveness and sympathy, quarter of them wanted the doctor to be rapid and determined. Equal percentage (15%) of both groups wanted the doctor to be caring and concerning. While some male participants considered that the best doctor is authoritative and powerful, females didn’t mention these features at all. Among preferable ones they indicated attention and sympathy, then rapidity and determination. The ideal doctor’s portrait for male group was described sequentially as follows: attentive, determined, fast evaluating patient state, confident in making right decisions, caring and concerning. For female group the sequence was a little bit different: attentive, confident in making right decisions, fast evaluating patient state, concerning and caring. The description of male doctor made by male group was as follows: attentive, watchful, calm, sympathetic, thoughtful, empathetic. Women considered that it was typical of male doctor to be attentive, calm, thoughtful, watchful, concerning and empathetic. Men described female doctor as confident in making right decisions, giving psychological support, authoritative, prompt, determined, rapid. Women had another opinion about female doctors. They characterized them as giving psychological support, determined, prompt, authoritative, confident in making right decisions and rapid.

We can conclude that doctor gender as well as patient gender plays an important role in social relations between them. Male doctors should manifest their female patients their confidence in decision-making while female doctors should display less authority. Though all these male and female doctor features are perceptible, doctors should take into account patient’s gender and his or her expectations.
Gender Differences in Healthy Ageing: the Possibilities of Measurement

Understanding and reducing social inequalities have been a central challenge in the public health. Studying factors that impact the length of independent and productive life is particularly important because of the ageing population in Europe and escalating costs of social policy.

Empirical evidence shows that gender gap in life expectancy persists. Scholars talk about “female-male health-survival paradox”, when elderly women live longer (have mortality advantage), while being objectively less healthy (have disability disadvantage). This paradox motivates to focus researcher’s attention on gender differences in healthy ageing (van Oyen et al. 2013).

Different biomarkers (for example, grip strength) are increasingly being used as valid health indicators for the elderly (Hank et al. 2009)). Biomarkers, however, capture only the objective side of health and do not reflect the subjective one. This distinction may be important: some authors in ageing studies point at the “subjective well-being paradox” in the old age, when elderly people retain high levels of subjective health, even when their objective health deteriorates (Perrig-Chiello et al. 2010, Knesebeck Ovd 1998). Theories of gender studies tell us that women tend to accumulate health risks during the life course to a greater degree compared to men (Annandale 2009; Backes et al. 2006; Höpflinger 2005).

The purpose of my research is to test empirically whether and how subjective and objective health in the old age differs by gender. The analysis is based on the SHARE-Data (Survey of Health, Ageing and Retirement in Europe, release 2006, N(Switzerland) =1462). To estimate the impact of different factors on two outcome variables – objective health (biomarker grip strength) and subjective health, I used multivariate linear regressions. To find out if there is gender related interdependences between subjective and objective health, I used bivariate non-linear regressions with objective and subjective health deficits as dependent variables.

The data show that gender and age constitute important dimensions of health inequality in ageing. The social network factors that impact both objective and subjective health are different for men and women. Involvement into primary (e.g. partnership) and secondary (e.g. professional) networks results in better health outcomes only for men. Migration constitutes a risk for women’s subjective health. For both genders an increase in objective health deficit leads to an increase in subjective health deficit and vice versa. But in a similar objective situation, women evaluate their health better than men. Another important finding of my study is related to gender bias of grip strength biomarker. My analysis demonstrates that the decline of grip strength for women is almost linear with age, while for men it is much more abrupt. Even when men are literally stronger, it does not necessarily mean they are healthier.

The contribution of this paper lies in (1) connecting social network factors and socioeconomic status to objective and subjective health outcomes and (2) highlighting the importance of gender-sensitive interpretation of biomarker indicators for understanding health inequalities.

References:


Responsible Research and Innovation: lessons from researching large scale technoscientific initiatives

In recent years, a close attention has been paid by social science researchers to the developments within large scale technoscientific initiatives, such as nano. Productive conversations between Science and Technology Studies (especially its stream known as the sociology of expectations) and Technology Assessment have yielded a number of insights that are informing agendas for Responsible Research and Innovation (RRI). How can sensibilities developed in these areas be transferred to debates around biomedical innovation? The talk will introduce and conceptualise a "technovisionary" approach to researching technoscience and the need to take into consideration practices of construction of credible and compelling narratives in both science and policy.
Ontologies of immune systems: metaphors, images and things

Anthropology of immunology in D. Haraway’s “Biopolitics of postmodern bodies” and E. Martin's “Flexible bodies” shows that immune systems are complex objects (Haraway, 1991). These studies give us some important assumptions about the ontologies of immune systems:

1. Immunology has its place in everyday life, «on the street». It differentiates self and other, health and disease, life and death.
2. The knowledge of immunity and immune systems originates not only from laboratories and clinics but from different reference groups. In this sense, immunology is a fragmented discourse with flexible borders. There are different ontologies and a multitude of immune systems.
3. At the same time, there is unity and identity in these different fragments and effects. There are at least two competing ontological models of immune systems and they can intersect, interlap, enter into conflict or know nothing about each other. The first model is based on the military metaphor of split and counter ‘self and other’ and the ‘immune system and environment’. The second, a holistic model, is based on the metaphor of symbiosis and insensibility of self and other.
4. The explication of immune systems invites some methods of its visualization. In contrast with standard photography, electronic micrographs provide the ontological evidence for the immune system’s existence. Visualization isn’t a translation of things in images and back. Immune systems aren’t localized within the human body and technical objects are components of hybrid immune systems.
5. The main point of contention in immune ontology is the description of immune systems as material or/and semiotic objects. Immune systems are hybrid objects with imaginary and material components.

References:
Informal patient payments in Lithuania, Poland and Ukraine

The socio-political changes and health care reforms in Central and Eastern European societies have not relegated informal patient payment into oblivion. Tips, gifts and bribes paid by patients for health care services are still spread practices in most of the countries in the region. However, the patterns of informal payments seem to reflect the specificity of the economic and socio-cultural environment: some countries are more conducive to “gifts” exchange as a means to maintain the underfunded health care system. In particular, the track of socio-political transition has led to a rise of ‘self-help’ coping strategies as a response to the shift of key structures and agents in the public service provision: the distrust and skepticism towards public institutions and the inability of the state to protect citizens from social risks. Socio-economic and political changes in post-Soviet and post-communist countries have also affected the health care service provision and have underlined the barriers that informal patient payments create in access and quality assurance of health care services. This study - as a part of a multi-country project “Assessment of patient payment policies and projection of their efficiency, equity and quality effects: The case of Central and Eastern Europe” - compares recent experiences with informal patient payments and attitudes in post-Soviet and post-communist countries, namely in Lithuania, Ukraine and Poland.

The data on the scale of informal patient payments and attitudes towards informal payments were collected in nation-wide surveys carried out simultaneously in these Central and Eastern European countries. The survey relied on an identical standardized questionnaire administrated via face-to-face interviews at respondents’ home. A national representative stratified random sample was drawn in each country following a multi-staged random probability method: first identifying sampling points in each country, then selecting the addresses/households at random, and finally selecting one 18-year-adult member of the household using the “last birthday” principle. The objective was to have 1000 completed interviews per country.

The empirical results suggest a lower share of informal patient payments as well as prevalence of more negative attitudes towards informal patient payments in Poland compared to Lithuania and Ukraine. Indeed, anti-corruption measures have been more intensive in Poland, which can explain the lower prevalence of informal payments and more negative attitudes towards these payments in this country. At the same time, policies toward informal patient payments in Lithuania and Ukraine were less consistent. Indeed, in post-Soviet Lithuania and Ukraine, informal patient payments co-exist with other types of patient payments such as quasi-formal and official patient payments. Still, in all countries, informal payments are more common and higher for in-patient health care services in contrast to out-patient ones. It is assumed that patients experience a mixture of payment obligations when a clear regulation of the basic package and formal patient charges is lacking.

About three forth of respondents in the countries support the statement that informal patient payments should be eradicated. Governments should meet public expectations and
implement a strategy for dealing with these payments. In all three countries, informal patient payments (both “bribes and fees”) are a symptom of system failure and provide a means for patients to obtain the health care they desire, which the government is not able to guarantee. Wise regulations coupled with (dis)incentives may decrease the level of informal payments for health care provision.

A bottom-up approach of welfare provision is still quite popular in societies where corrupted elite does not plan to pass the power but also realizes the need for change. Therefore, the possibility to broaden the movement towards transparency - as it has been experienced by Western European countries - to post-communist and post-Soviet societies seems to be one of the major policy goals nowadays.

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**Planet Mars and Knowledge about Health: Lessons from Past Colonizations**

The papers discuss the problem of sustaining and reproducing health-related cognitive practices in small communities cut from larger society for a prolonged period of time. Based on a critical examination of past colonizations (Polynesian colonization of Pacific Islands and Portuguese Colonization of Indian West Coast as model cases) it critically evaluates the resources of institutionalized medical practices against the community-based cognitive practices related to health. Among the later, special attention is paid to those accumulated in the family setting. An attempt is made to reveal the advantages and limitations of both in favor of a more balanced approach that, however, will require substantial modification of the health policy principles behind the future mission in deep space.
Anna Temkina (Professor of the Department of Political Science and Sociology, Gender Studies Program of the European University at St. Petersburg, Novartis chair in public health and gender, Russia); e-mail: temkina@eu.spb.ru

Trust and access to the childbirth service in Russia: Ariadne’s thread

“Which doctor do you have an arrangement with?”

National project “Health” (2010s) in Russia created the conditions to provide high-technology care for pregnant women and women giving birth. But this kind of care is limited. The question is: how is the access to limited resources achieved? I am interested in the reasons to organize the access; the meaning of it for the women and for the medical personnel; the ways of access and the results of this process.

Theories and approaches are the studies of the informal payments in healthcare, the studies of medical professionals as gatekeepers, studies of healthcare reform in Russia and specifics of obstetric care as a gender sensitive sphere including problematization of trust. Empirical data include two perspectives: medical professionals (physicians, obstetric nurses) and women who has given birth (interviews, observation and analysis of internet forums)

According to empirical data, arrangement – guidance through the organizational labyrinth of delivery care includes construction of “good care” as limited, the use of insider’s knowledge and the chain of negotiations within the frame of construction of medical, economical and bureaucratic-organizational uncertainty of child care and the lack of trust
Trauma as metaphor: ontological policy of “traumacentrism”

“Trauma” is one of the most powerful metaphors in modern humanities and social sciences. We use it every time when we are trying to explain something we are not able to explain – as an indication of identifiable representations / consequences of some hidden and mysterious event in past. In 2013-2014 years more than ten conferences and workshops on “cultural, historical and collective traumas” were held in Moscow alone. There are at least two popular strategies of such explanations: representational and causal. “Representational traumacentrism” focuses researchers’ attention on images of collective traumas in arts, historical narratives and popular cultures. “Causal traumacentrism” appeals to collective traumas as covert and self-explanatory determinants of ongoing social processes. No matter how unsatisfactory these research narratives and strategies of explanation are. They still preserve some powerful implications.

How post-ANT studies can help us to re-conceptualize trauma? How the idea of “multiple body” changes our vision of “multiple traumas”? What notion of trauma as “condition of impossibility” brings into theoretical play? In my brief analysis I’d like to focus on the tension between literal and non-literal, metaphorical and metonymical understandings of trauma in sociological explanation.
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Soviet health care is usually associated with the so-called Semashko system (named after the first Soviet People’s Commissar of Public Health), with its centralized planning and administration and the declared equal and universal access to medical and pharmaceutical services. Thus, it is often neglected that the adoption of the New Economic Policy (NEP) in 1921 actually introduced some market elements in the Soviet economy and legalized private entrepreneurship, including in the area of health care. The existence of private medicine and pharmaceutical business in Soviet Russia in the 1920s is unfortunately chronically understudied – and when mentioned, it is often presented with obsolete ideologically charged cliches – as a chaotic conglomerate of hucksters and quacks, driven only by the desire of profit.

In my paper, however, I would like to present private health care in NEP Russia as an alternative to the Semashko system. This will naturally involve the investigation of the evolution of government policy towards private provision of health care and the regulation of private clinics and pharmacies, as well as the issues of financing, work motivation and profit etc.

My hypothesis is that private entrepreneurship in medical and pharmaceutical spheres in early Soviet Russia was not at all doomed from the very beginning. In fact, it performed quite well in the difficult economic and administrative conditions and was able to complement state-funded health care in certain aspects. The reasons for its decline were primarily of administrative nature, since the Soviet state deliberately adopted a policy of prioritizing state institutions and pushing the private capital out of the economy by the end of the 1920s. The rhetoric that accompanied this decision actively employed the above-mentioned stereotypical images of private health care, but in fact disorderliness, incompetence and ineffectiveness remained inherent features of the government-funded medical and pharmaceutical institutions throughout the Soviet era.

In my paper I would also like to pay particular attention towards comparative and transnational aspects of the problem. For example, the health care system in Weimar Germany also experienced socialization, but not to the same extent as in the Soviet Union. A comparative analysis of the status of private health care would contribute to a deeper understanding of political cooperation and knowledge transfer between the two countries in the inter-war period.
Biopower and Precarity: The Discourses of Assisted Reproductive Technologies (ART) In Ukraine

There is a large amount of research accumulated with regard to cultural, political and social aspects of ART in Western academia. However, the implementation of ART in Ukraine is left without deserved attention. Likewise, I am not aware of any reports about Ukrainian infertile women’s experience of negotiating assisted conception.

At the same time, in Ukraine ART have already become part of lived experiences of numerous women and heated a large debate in society about the nature of women, motherhood, national duty, citizenship and demographic crisis. Moreover, as a country endorsing commercial gestational surrogacy and providing cheap donor egg cells Ukraine is a popular destination for couples seeking conception.

My paper scrutinizes the discourses of state, medical professionals and patients about assisted reproductive technologies (ART) in Ukraine to reveal which subject positions are constructed for infertile women who undergo in vitro fertilisation (IVF) by biopolitical and governmentality techniques.

The theoretical framework of my research was inspired by poststructuralism, governmentality studies, new kinship studies, feminist science and technology studies and new feminist materialism. To gather the data I have conducted interviews with directors of infertility clinics and women who completed IVF in Ukraine, as well as with Ukrainian feminists concerned with reproductive politics.

In my presentation I plan to show how biopower and precarity work together to achieve gender normalization through the governance of freedom and promotion of individual independence and self-reliance in infertility treatment in Ukraine.

In Ukraine infertile bodies are extremely diminished under the normalizing gaze, while treatment of infertility is accompanied with the growth of precariousness of reproduction due to the lack of trust in the state and private medical institutions and shortage of financial opportunities.

I conclude that on the level of the state the mechanisms of biopolitics construct the subjectivity of infertile women who undergo IVF treatment as “mothers”, that are supposed to reproduce the “nation”. On the level of medical professionals, the “advanced liberal” governmentality techniques based on individualisation of responsibility construct women who do IVF as “biological citizens”, adopting ethics of self-governance and optimisation of the body.

The structures of biopower produce the norms of motherhood, which infertile women can’t satisfy. The lack of recognition and non-compliance with the gender norms makes the lives of infertile women less liveable as situated in precarious conditions enacted by biopower.

The central to the subjectivation of women who undergo IVF treatment is acknowledgement of precariousness of their body, control and care over living and functional body, procurement of biomedical knowledge about it. As a result, they seek to establish independent governance over their biological lives and act on behalf of their medical condition.

I also would like to demonstrate how the recognition of ones precarious position as infertile helps women to envision new sense of ethical conduct towards the others and growing necessity to expand the networks of interdependence and kinship.
The contribution of balneology into socially-centred and recreation-oriented economy in Siberian region

The humanization of economic development involves increasing attention to society, including guaranteeing appropriate social, economic and ecologic conditions of life and opportunities for self-realization and for development of creative potential of each society member. The analysis of current state of Russian public health showed, that the existing system has a number of drawbacks (in organization and financing) and cannot correspond to healthcare needs of the population, both in qualitative and quantitative aspects. «The conception of development of system of public health in Russian Federation to 2020 year» is aimed to overcome of these drawbacks. The state governance of public health must be modern and capable of providing the population with medical care, using the latest scientific achievements. The increasingly important role of tourism and health resorts in social-economic life of society demands a more profound investigation of economic mechanisms of its functioning. The popular point of view that the health resorts and tourism as of secondary importance does not recognize their importance for societal development and runs contrary to the idea of socially-centred and recreation-oriented economics. The modern reorganization of economic relations in line with market-oriented philosophy has exerted a great influence over the whole mechanism of health resorts and tourism functioning, historic regional connections between service providers and related social aspects.

The medical tourism as a novel part of the health resorts enterprise. The social importance of this new direction lays in the creation of the a new part within the system of health protection, namely the part called ‘rest’ (for healthy people and patients) and in the rise of profitability of health resorts. These effects are achieved due to new market-oriented principles of functioning of health resorts and focus on consumers satisfaction. The development of medical-health resorts tourism in Siberian region is the basis for formation of new tourism-recreative zones in Russia.
Localizing the global: research and treatment in international clinical trials in Russia.

Clinical research conduct is crucial for improving provision of health care. Currently, a particular type of clinical research, randomized controlled trials (RCTs) along with meta-analysis of their results are regarded as the most reliable basis for effective and cost-conscious health care. While being closely connected, research and treatment are often understood as fundamentally different activities. This difference has exercised a significant influence on conceptual work in bioethics and the development of international regulations governing research with human subjects. Furthermore, many bioethicists have been stressing the need for differentiating research and treatment in RCT conduct. It has been argued that scientific characteristics of trials may compromise medical care available to participants, while conceiving research participation as having therapeutic value may foster the therapeutic misconception (confusion of research with treatment). However, other work has questioned whether research can and should always be separated from medical care provision. In this paper I analyze how these concerns play out in practice settings of the three trial sites in Russia, specialized in trials in cardiovascular diseases.

Using in-depth interviews with participants of phase II and III trials and discussions with physician-investigators I show how trial enrollment allowed participants to establish continuous supportive relationships with physician-investigators. In the context of unresponsive healthcare, through such relationships chronically ill participants received regular monitoring, treatment recommendations and help in case of problems and emergencies. I suggest that debates about research/treatment interface in trials need to become more attuned to conditions in locations of their conduct, views and experiences of actors involved and developments in trial methodologies. Too much focus on categorical differentiation of research and treatment obscures the fact that globalizing clinical trials proceed amidst profound health and resource disparities, dismisses diverse convictions and concerns of people on the ground and risks attenuating responsibilities of trial organizers, sponsors and investigators towards research participants.