Agenda

Science, colonialism, & postcolonial science studies

1. Administrative
2. Postcolonial science studies
3. Randomized controlled trials & colonialism
4. Group discussion

Discussion prompts

- Your prompts ***must*** include a "motivation" section.

  Discussed many times in class (e.g. Sept 23, Oct 2, Oct 7)

- Engage with the *substance* of the readings' arguments.

  What *mechanisms* are discussed? Which aspects of an author's approach overlap with and diverge from previous readings? How does what we've discussed so far in the course help us engage more deeply with the current reading?

  (To keep prompts brief, some of this elaboration can be in the "motivation" section.)

- **Do the readings.**

  An increasing proportion of the prompts have little or nothing to do with the text.

Postcolonial science studies

Postcolonialism

- Postcolonialism is a broad approach in the social sciences that looks at contemporary systems, institutions, and cultures in the context of colonialism and imperialism.

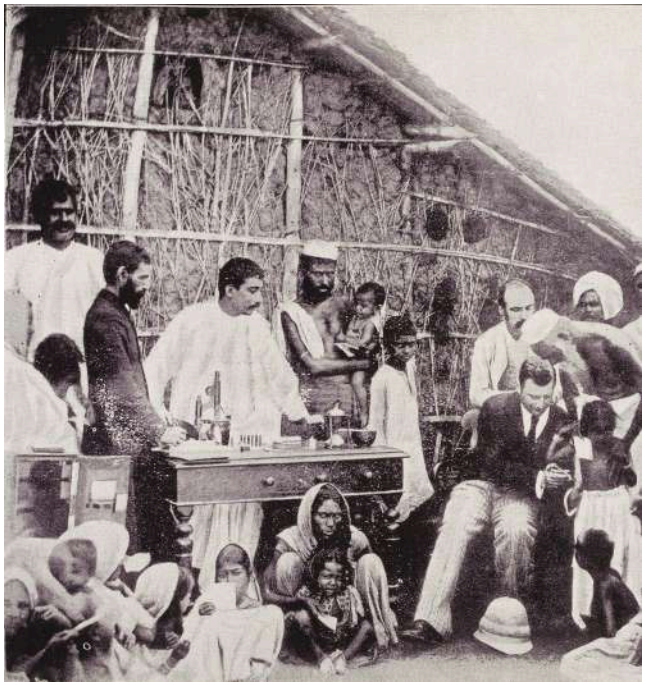
Postcolonialism *in STS*

- How is current scientific knowledge the ***result*** of colonial/imperial institutions?

  e.g. scientific definitions of race

- How do current scientific practices ***exploit and reinforce*** colonial/ imperial systems of power?

  e.g. biocolonialism



Anti-cholera inoculation, Calcutta, 1894

Randomized controlled trials & colonialism

Casino capitalism

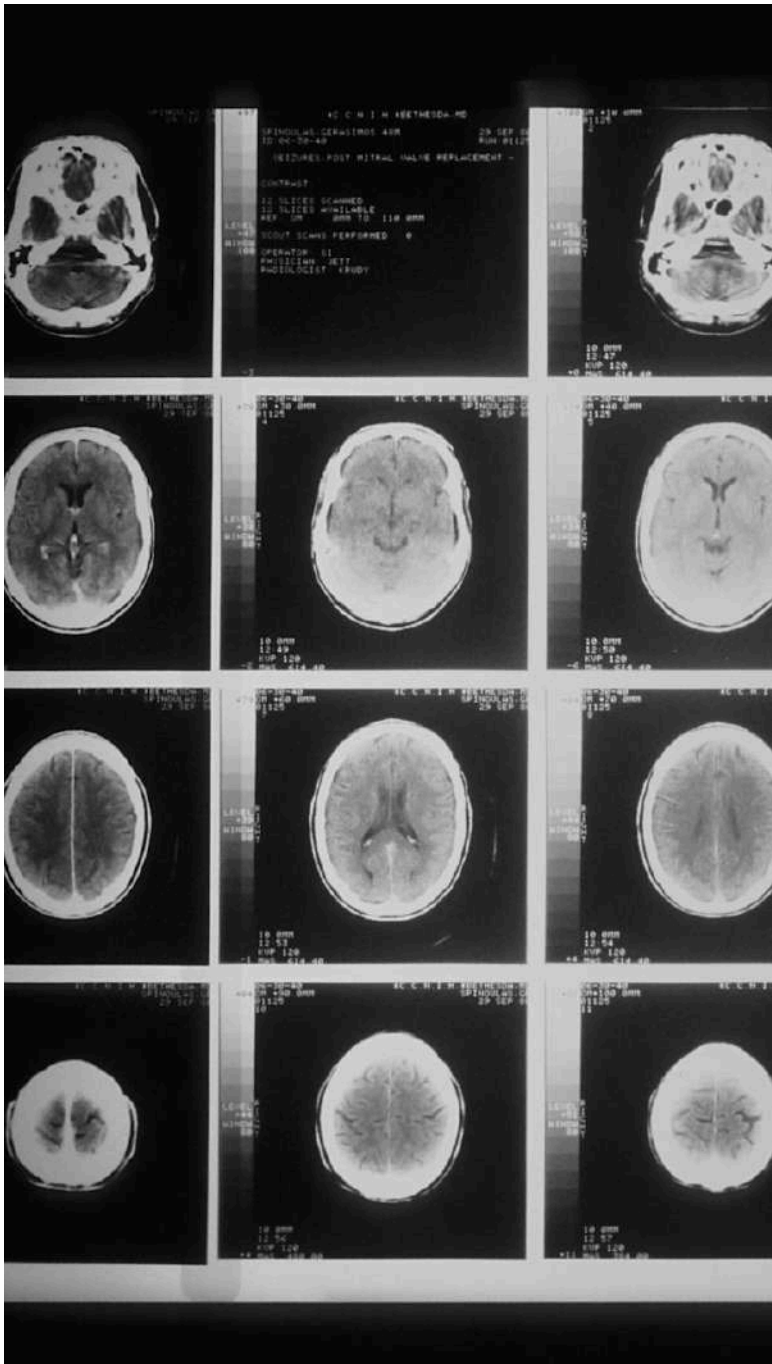
- Vincanne Adams (2002) describes the processes of legitimizing Tibetan medical practices in a Western setting.
- She uses the theoretical frame of "casino capitalism" emphasizing:
  1. the risk-heavy nature of RCTs
  2. the idea that the odds are stacked in favor of whoever decides the rules of the game (the "house")

House rule #1: Categories are universal

> "Because it is assumed that disease labels may change but diseases themselves are universal, few question whose diagnostic instruments or labels should be valorized in clinical research protocols."
> (p. 671)

> The utility of RCTs in determining the effectiveness in treatments pre-supposes the categorization of conditions and symptoms.

> Conditions that are categorized as a single disease in a (Western) biomedical context are understood as multiple distinct diseases in the Tibetan medical context, ***and vice-versa***.



House rule #2: Evidence is unambiguous

- "Here the question that is seldom asked is: 'whose outcomes count?'" (p. 673)
- RCTs assume that the evidence from a trial is incontrovertible and not open to interpretation.
- Tibetan and western doctors center different data and create different evidence when looking at the effectiveness of a treatment.
- When there is disagreement between paradigms about whether a treatment "worked" or not, the House (Western medical practice) determines who is right.

House rule #3: Isolation of active ingredients

> [I]t is generally assumed that reliable remedies can be reduced to a few basic active ingredients that can be evaluated singularly for their effectiveness." (p. 673)

> RCTs like those required by the NCCAM are often incompatible with the treatments in Tibetan medicine, which might include many carefully prepared ingredients.

> Western science is deeply invested in the idea that physiological processes like disease and the compounds that affect / alleviate them are discrete and can be isolated.

Science, race, and health

Poudrier (2007)

The Geneticization of Aboriginal Diabetes and Obesity

A note on terminology
In contemporary discourse within the Canadian context, the term "*Aboriginal*" is used mainly in specific legal contexts. When referring to First Nations, Inuit, and Métis peoples of this continent as a group, and particularly when contrasting with settlers and colonial populations, **the term "*Indigenous*" is usually preferred**.

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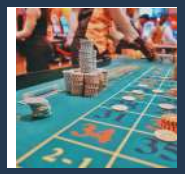

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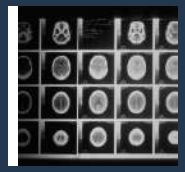

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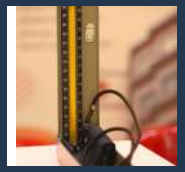

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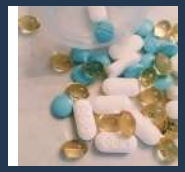

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