CHAPTER FOUR

PRODUCING ALTERNATIVE OBJECTS OF COMPARISON IN HEALTHCARE: FOLLOWING A WEB-BASED TECHNOLOGY FOR ASTHMA TREATMENT THROUGH THE LAB AND THE CLINIC

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Introduction

In medical practice the comparison of effects of specific medical interventions on patients’ health is a sine qua non for decision-making. How do a patient’s symptoms compare to textbook examples? Does a drug, operation, therapy or technology improve or worsen a patient’s condition? Which intervention is comparably most effective? Comparative questions are as central to the mundane clinical encounter as they are to the largest and most rigorous Cochrane studies. The shared ambition in the clinic and in the randomized controlled trials is to create certainty about what to do in a specific situation. Facts in healthcare are mostly comparative facts (Mol 2002). Medical research tells us that to produce facts on which medical decision-making can be based, we must distinguish means from effects and isolate the latter from unintended effects—often understood as biases. Interventions are thus to be made in controlled environments. That which is to be studied must be taken out of unruly contexts and into laboratories so that the knowledge produced can create better effects in the clinic. The spaces of the laboratory and the clinic are thus separated when it comes to producing medical facts, but interlinked when the facts travel out of laboratories in order to be applied in the clinic (see also Latour 1983).

In recent years information and communication technologies (ICT) are increasingly being used in the clinic and calls for evidence-based knowledge of the effects of ICT on organizational and illness-related parameters have intensified among both medical practitioners and policy makers (Robinson et al. 1998, Eysenbach and Norman 2004, Gagnon and Scott 2005). It is argued, that in order to choose the technologies that provide comparatively better health care, studies ought to be conducted that isolate the effects of ICT.
This paper compares the production of evidence for an internet-based tool for the (self-)monitoring of asthma patients called LinkMedica, to the use of LinkMedica by general practitioners (GPs) and their patients. In the spring of 2005 two central events occurred in relation to LinkMedica. The first event was the publication of the scientific results of a randomized clinical study which suggested that the use of this online technology as a means to monitor and treat asthma “at a distance” provides comparatively better results in asthma control than can be achieved by medical practitioners not using the technology (Rasmussen 2005, Rasmussen et al. 2005). The second event, occurring only one month later, was the closing down of the LinkMedica web portal, which since 2001 had provided people suffering from asthma as well as their general practitioners (GPs) with this online monitoring technology. In the GP practices, where LinkMedica had been used during a period of four years, it proved less of a success than in the clinical trial. Why was success produced in one context and not in the other?

This chapter starts from an interest in comparability in medical research and in the ethnography of technology. In medical research, comparability is based on identification of properties of objects found independent of contexts—such as a particular technology or a particular group of patients afflicted with a particular illness. In the ethnography of technology, properties of objects are deeply intertwined with the conditions of their own production and their relations to other objects (Latour 1996). So, considering the story of how LinkMedica’s effects were evaluated differently, we raise the question: How do practitioners know that they are evaluating the same technology? How do we as ethnographers—in our case ethnographers of technology—construct “sameness” across contexts (a question, which all the chapters of this volume seek to answer)? By using the notion of thick comparison (Niewöhner and Scheffer, 2008; introduction to this volume), we suggest that it is possible to produce alternative and additional—not necessarily contrary—objects of comparison to those produced by medical science. Attending to the specificities of the particular settings of the clinic and the lab and to the laborious work of crafting objects that can have comparable health effects, we find other effects are produced as well, for example patients with particular interests, properties and affects (Oudshoorn and Pinch 2003). With our comparative ethnography we are interested in the multiple and often unexpected effects produced by technology and by rendering technology compa-