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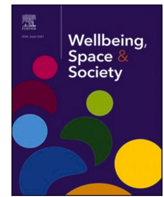

Clinical geography: A commentary response

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Mark Rosenberg's (2021) perceptive feedback on our clinical geography proposal (Finlay and Rowles, 2021) challenges us to further consider the unique contributions and potential future directions for theory, methodology, and growth in health geography. It also inspires us to reflect on the placement of clinical geography. Health geography is the most obvious fit. In the paragraphs below, we explore clinical geography as a catalyst for health geography expansion and growth. But our original proposal deliberately drew upon broader human geography theories (e.g., place attachment, disability, labor, home, emotion, identity, embodiment [Finlay and Rowles, 2021]). Optimizing a person's sense of 'being in place' is indeed an important aspiration within health geography, but it should also be a goal across the entire landscape of human geography to support, empower, and enhance individual wellbeing.

Theory

Both health and human geography are known for theoretical pluralism informed by diverse ideas, concepts, and research questions from across the social and behavioral sciences (Crooks et al., 2018). Contemporary geography focuses heavily upon how structural processes (e.g., residential segregation, neighborhood resources, housing security, social capital, structural racism) underpin societal inequalities and social injustice. Clinical geography should not detract from this important work. Rather, the goal is to inspire geographers to *also* re-engage on the scale of an individual. As noted by Rosenberg (2021), clinical geography rediscovers and embraces contributions from an array of geographers spanning the 1970s to early 2000s who importantly emphasized the *individual* and the *unique*. In this context, a fundamental strength of geography is multi-scalar analysis. A key question becomes, how do structural processes filter down and find expression in the unique experiences of individuals, and vice versa? As sociologist C. Wright Mills (1959, p. 3) classically stated: "Neither the life of an individual nor the history of a society can be understood without understanding both." Clinical geography addresses the struggles of individuals in a manner that can deepen theoretical understanding of underlying structural causes.

Methodology

A clinical lens motivates geographers to address individual-level harm more immediately than waiting for the resolution of macro-level processes. We acknowledge that a methodology of personal intervention as manifest in levels 1 (environmental) and 2 (behavioral) of our hierarchy of clinical geography interventions overlaps existing clinical team efforts (Finlay and Rowles, 2021, Figure 3, p.4). While clinical practices are increasingly sensitive to issues of space (e.g., mobility and access in occupational therapy), this is generally not the primary focus. Sophisticated geographic concepts and nuances of place are rarely addressed. Clinical geographers, particularly those schooled in the humanistic tradition, could bring advanced situational sensitivity to assist clinical teams, in addition to therapeutic engagement to facilitate 'being in place' (Level 3).

We agree that clinical geographers cannot know everything along the causal pathway to intervene in complex health issues, but neither can clinicians in any field. What we can do is contribute our geographic expertise. In the situation of addiction posed by Rosenberg (2021), a clinical geographer could complement and enhance holistic therapy. For example, environmental modifications such as reconfiguration of furniture and changes of ambience (e.g., aromatherapy, white noise) can support exercise and meditation (level 1); behavioral strategies can optimize use of the space and timing of activities to create positive social support (level 2); and in-depth empathic understanding of a person's life and addiction history can help them feel empowered, understood and validated (level 3). On this level, clinical geography involves the major investment of time delving ever deeper into the places of their past and the relationship of these places to present life experiences (Godkin, 1980). Such narrative inquiry extends the practice of holistic medicine

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(Haydon et al., 2018). The issue of compensation constitutes a fair critique. As addressed in the original proposal, we hope that while such intervention may start with out-of-pocket and charitable coverage, its merits will gradually become recognized for insurance coverage. In addition, pilot and demonstration grant funding could be secured from national agencies, internal seed money awards, and charitable foundations.

Rosenberg (2021) also correctly notes that the right process can lead to the wrong outcome. He provides the example of the nursing facility, which was until recently the "right place" for many older adults. During the COVID-19 pandemic, startlingly high death rates, tolls on mental health, and extended lockdowns to curb viral transmission have led to a questioning of this assumption (The New York Times, 2021). While this unprecedented situation has resulted in devastating outcomes, it also makes us wonder if, in the rethinking of nursing facilities (Fulmer et al., 2020), clinical geographers might make important contributions to making the spaces of long-term care facilities safer and more desirable places, even amidst dangerous infectious outbreaks?

Growth

Developing clinical geography does not necessarily take away from current geography programs. As Rosenberg (2021) notes, clinical geography "streams" at the undergraduate and graduate level would likely attract more students to geography. Given the current underlying focus on enrollment as the basis of many college budget allocations, this could translate into future boosted geography department funding with more faculty to teach courses and administrative staff to manage demand. We do not see clinical geography as necessarily involving entirely new courses or streams. Rather, it could be folded into existing health and human geography courses where added focus on applied and theoretical literature pertaining to the "individual", "unique", and "therapeutic" packaged together in a manner enabling students to learn about clinical geography would enrich the courses. As a class exercise, students might take an individual-level struggle (for example, inability to attend a follow-up medical appointment) and relate it to underlying structural processes (for example, the absence of transportation, inability to pay the fare, or lack of adequate health insurance). Addition of a clinical geography lens can also help students to gain deeper lived experience understanding the role of place in shaping their personal and professional lives.

Future directions

We hope this dialog continues to spark conversation and debate. It will not be easy to create a valuable and viable clinical geography. A crucial next step is to explore concrete steps and strategies to develop this lens. One direction would be for health and human geographers to enfold clinical geography into their classes by assigning relevant readings and developing class exercises that reveal the rich personal insight that accrues from studying and intervening on behalf of the individual. A second direction is for geographers to pilot intervention case studies that adopt the philosophy and model of clinical geography. Accomplishing this will require us to have the courage to exercise our geographical imagination in the quest to enrich the lives of individual human beings.

Declaration of Competing Interest

None

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