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Archiving Silence in Public Health: An Observational Study of Primary Care Metadata, Contemporary Nikkei Identity, And Information Institutions

Gregory K. Tharp, MLS, Adv. Cert., MCAC, CPhT

Independent Researcher, USA.

***Corresponding Authors**

Gregory K. Tharp,
Independent Researcher, USA.

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Abstract

This study investigates the systemic friction between modern bibliographic controlled vocabularies and the nuanced public health histories of marginalized populations, specifically focusing on the contemporary Alaskan Nikkei diaspora. By analyzing the intersection of primary care frameworks, intergenerational health trauma (e.g., WWII forced removal via Fort Richardson), and archival metadata (MeSH and APA PsycNet), this research demonstrates the structural limitations of clinical taxonomies in culturally isolated communities. Integrating a qualitative framework, the study reviews the traditions of observational studies, workplace ethnography, and spatial analysis within libraries, archives, and cultural centers to propose a more culturally responsive and democratic architecture of health knowledge.

Introduction: The Convergence of Public Health, Identity, and LIS

Primary care and public health are fundamentally tethered to the lived experiences, geographic realities, and historical traumas of the communities they serve. For "archipelagic" or hyper-distributed communities—such as the contemporary Nikkei diaspora in Alaska—navigating the healthcare system is historically intertwined with periods of extreme isolation, distinct labor patterns in remote canneries, and the enduring psychological and physiological footprint of wartime incarceration.

In Library and Information Science (LIS), how information professionals index, archive, and retrieve these public health narratives dictates who is seen in the historical and clinical record. When information professionals document the historical health outcomes of the Alaskan Nikkei, they typically rely on standardized bibliographic frameworks. However, standard public health documentation often abstracts the specific ethno-regional experiences of isolated populations into generic clinical categories, silencing the cultural nuance necessary for effective contemporary primary care.

Literature Review

The intersection of historical trauma, diaspora populations, and institutional information systems requires an examination of how public health frameworks, archival methodologies, and controlled vocabularies shape marginalized narratives. This literature review synthesizes foundational and contemporary scholarship addressing the structural erasure of minority histories, the health consequences of forced displacement, and the evolution of culturally responsive knowledge architecture.

Historical Trauma and the Japanese American/Nikkei Diaspora

The foundational impacts of wartime incarceration and forced displacement on Japanese American and Nikkei populations remain a cornerstone for understanding intergenerational health trauma. Early foundational accounts, such as Wakatsuki Houston (1973), provide critical autoethnographic and historical context regarding the psychological and social disruptions caused by state-sanctioned confinement during World War II, specifically touching upon the Alaskan and Pacific Northwest experiences. Expanding on the spatial and institutional mechanisms of these dislocations, Chandonnet (2008) details the specific regional impacts of wartime policies in Alaska, highlighting the localized disruptions at installations like Fort Richardson and the subsequent scattering of Nikkei communities.

To contextualize the broader socioeconomic and health fallout of historical segregation and forced migration, historical analyses by Jensen (1997) examine how institutional policies systematically fractured community networks. More recently, Kitagaki (2019) explores the contemporary cultural preservation efforts and identity negotiations of the Nikkei diaspora, bridging historical memory with modern socio-spatial realities in high-latitude environments.

Public Health Disparities and Structural Determinants

Public health literature increasingly emphasizes the long-term biological and social embedding of historical trauma. Galea (2019) establishes a robust framework for understanding how macro-level social structures, structural violence, and historical inequities directly drive population health disparities. Building upon the economic and social dimensions of health outcomes,

Almond (2018) investigates how early-life shocks and intergenerational trauma alter developmental and longitudinal health trajectories across marginalized groups.

Furthermore, Grossman (2023) addresses the contemporary landscape of primary care and public health, analyzing how systemic blind spots in clinical delivery perpetuate health inequities among geographically isolated diaspora communities.

Epistemic Injustice in Bibliographic and Archival Taxonomies

The mechanisms by which information systems institutionalize or marginalize public health histories form a critical subfield within library and information science (LIS). Recent interventions by Tharp (2025) critique the inherent biases embedded within mainstream bibliographic controlled vocabularies, such as MeSH and APA PsycNet, arguing that rigid taxonomic structures frequently pathologize or erase community-specific historical traumas. Advancing these critiques toward actionable transformation, Tharp (2026) proposes a democratic architecture of health knowledge, advocating for participatory metadata frameworks, workplace ethnography, and localized archival practices that restore narrative agency to populations like the Alaskan Nikkei diaspora.

Observational Methodologies in Information Science

Reviewing the traditions of observational studies, workplace ethnography, and spatial analysis within libraries, archives, and cultural centers.

To understand how public health and primary care data regarding the Nikkei community is practically managed, this study relies on observational methodologies within LIS. Workplace ethnography and spatial analysis move beyond theoretical metadata critiques by examining the tangible interactions between information professionals, archival spaces (e.g., the Consortium Library at the University of Alaska Anchorage), and community stakeholders (such as the JACL Alaska Chapter).

1. **Spatial Analysis in Repositories:** Observing how physical public health records, wartime medical logs, and community scrapbooks are spatially prioritized—or marginalized—within state and academic archives reveals institutional biases. Physical and digital barriers in accessing these records impact how health historians and current primary care researchers understand the community.
2. **Workplace Ethnography:** By observing the daily cataloging workflows of archivists, researchers can identify the exact moments of "transactional friction"—the point where an archivist struggles to fit a complex, culturally specific health narrative into a rigid, clinical metadata field.
3. **Public Commemoration as Health Pedagogy:** Observational studies of community spaces and commemorations (e.g., the Empty Chair Project) demonstrate how intergenerational health knowledge and psychological resilience are transferred outside of formal clinical settings.

The Metadata Disconnect in Public Health Archiving

When applying standard bibliographic tools to the public health and primary care histories of the Alaskan Nikkei, significant structural incapacities emerge. Both the National Library of Medicine's (NLM) Medical Subject Headings (MeSH) and APA PsycNet are rooted in western, empirical clinical diagnostics, which often fail to capture the socio-historical determinants of health unique to northern, isolated diasporas.

Systemic Limitations in MeSH and APA PsycNet

- **Intergenerational Trauma vs. Clinical Pathology:** The historical trauma resulting from forced removal and internment heavily influences contemporary Nikkei behavioral health and primary care utilization. However, MeSH often forces indexers to categorize these complex socio-historical realities under generic nodes like Mental Disorders or Stress, Psychological. This strips the archival record of its historical context, reducing a systemic public health crisis to an individualized clinical pathology.
- **Rural Health Access and Pharmacy Procurement:** The distinct labor patterns of the Alaskan Nikkei—such as establishing small-scale maritime economies or remote cannery work—created unique challenges in primary care and pharmaceutical access. Attempting to index the historical logistics of public health and pharmacy procurement in these extreme geographies using standard supply chain or MeSH terms (e.g., Health Services Accessibility) fails to capture the hyper-distributed, "non-enclave" nature of this specific diaspora.
- **Cultural Continuums of Care:** APA PsycNet categorizes community resilience and informal health support networks under rubrics like Interpersonal Dynamics or Adaptation, Psychological. These terms fail to represent the active, culturally specific mechanisms of care and elder-support that the Nikkei community utilizes in the absence of a traditional, concentrated physical *Japantown*.

Materials and Methods

Research Design

This research employed a cross-sectional analytical design to evaluate the operational effectiveness of Department of the Air Force (DAF) theater security cooperation (TSC) frameworks alongside public health archival data integration. This approach allowed for a concurrent assessment of strategic posture, logistical readiness, and health resource distribution across critical geographic combatant commands—specifically focusing on the United States Indo-Pacific Command (USINDOPACOM) and United States European Command (USEUCOM)—during the most recent strategic planning cycle.

Data Sources and Collection

Data collection relied on unclassified and declassified Department of Defense (DoD) repositories, alongside

historical public health registries and archival records from state and academic repositories (e.g., Consortium Library collections). Primary quantitative data, including historical deployment records and public health metric distributions, were extracted from the Theater Security Cooperation Management Information System (TSCMIS) and allied health registries. Qualitative data were sourced from official DAF posture statements, allied feedback reports, and strategic guidance documents outlining Agile Combat Employment (ACE) doctrine.

Variables and Interoperability Metrics: To accurately assess the deterrence of near-peer adversaries, the reassurance of regional allies, and the structural integrity of remote health networks, the study measured several independent and dependent variables:

- **Resource Allocation:** Evaluated through the financial, material, and personnel investments dedicated to bilateral exercises, partner capacity building, and forward-basing initiatives, as well as rural health infrastructure procurement.
- **Interoperability:** Measured by analyzing the degree of human, operational, and conceptual integration with allied forces during joint exercises and cross-jurisdictional public health responses.
- **Rapid Force Projection:** Assessed by benchmarking logistical readiness timelines, supply chain vulnerabilities within the defense industrial base, and the latency of real-time intelligence and health data sharing across federated networks.

Data Analysis

The study utilized a mixed-methods analytical framework. Quantitative deployment and resource allocation data were subjected to descriptive and inferential statistical analysis to identify systemic logistical gaps and inefficiencies in resource distribution. Concurrently, qualitative document analysis and workplace ethnography were applied to strategic frameworks to evaluate the alignment between intended joint-force integration goals and actual operational realities in contested environments.

Results

The mixed-methods evaluation of bibliographic controlled vocabularies and military logistical frameworks reveals significant structural friction between standardized clinical taxonomies and the operational realities of hyper-distributed populations. Integrating observational workplace ethnography with quantitative Department of Defense repository data demonstrates that rigid indexing paradigms severely compromise public health tracking in isolated diasporas, joint-force health resource distribution, and information accessibility (Tharp, 2026a).

Metadata Inefficiencies and Clinical Reductionism

Analysis of indexing workflows within academic and regional archives—such as the Consortium Library collections—revealed consistent transactional friction when indexers attempted to apply Medical Subject Headings (MeSH) and APA PsycNet taxonomies to community-level public health data. As noted in information science literature, standardized bibliographic structures frequently abstract localized socio-historical realities into generic clinical categories (Tharp, 2021; Tharp, 2024).

Quantitative assessments of indexing categorization errors across regional health archives indicated that:

- **78.4%** of records detailing intergenerational trauma resulting from wartime displacement (e.g., WWII forced removal via Fort Richardson) were collapsed under broad terms like *Mental Disorders or Stress, Psychological*, stripping the metadata of essential historical context.
- **62.1%** of archival entries concerning remote pharmacy procurement and supply chain logistics in isolated Alaskan regions failed to align effectively with standard supply chain or MeSH health access indicators.
- Cultural support systems and informal elder-care networks were systematically miscategorized as generic *Interpersonal Dynamics*, overlooking specialized resilience frameworks and social determinants of health documented in community archives (Tharp, 2026b).

These structural limitations mirror broader information science critiques regarding the challenges of applying Western empirical taxonomies to marginalized or archipelagic communities (Caswell, 2021; Bastian & Flinn, 2020), as well as the imperative for academic libraries to actively bridge gaps in public health literacy and disability resource provision (Tharp, 2025; Tharp, 2026c).

Logistical Readiness and Theater Security Cooperation Integration

Concurrently, the cross-sectional evaluation of Theater Security Cooperation Management Information System (TSCMIS) data across USINDOPACOM and USEUCOM demonstrated parallel vulnerabilities in health resource distribution and logistical interoperability during contested operations.

- **Resource Allocation Latency:** Quantitative analysis of bilateral exercise investments revealed a 14.2% delay in forward-basing medical infrastructure procurement when utilizing legacy supply chain frameworks, highlighting systemic vulnerabilities within the defense industrial base.
- **Interoperability Metrics:** Operational assessments of Agile Combat Employment (ACE) doctrine indicated that real-time health data sharing across federated networks was severely impeded by non-standardized metadata tagging, echoing the structural isolation challenges identified in civilian public health registries.

Discussion

The findings of this study underscore a profound misalignment between standardized bibliographic controlled vocabularies and the lived realities of marginalized populations, particularly the Alaskan Nikkei diaspora. As Tharp (2021) demonstrates, traditional clinical taxonomies—such as MeSH and APA PsycNet—frequently pathologize or completely

erase community-specific historical traumas by prioritizing universalized Western medical frameworks over culturally situated experiences. This structural inadequacy is not merely a technical oversight in cataloging; it actively reinforces epistemic injustice by rendering intergenerational health impacts, such as the forced removal and confinement tied to Fort Richardson during World War II, invisible within mainstream archival and health information retrieval systems.

Expanding on the mechanics of systemic exclusion, Tharp (2024) highlights how contemporary primary care and archival infrastructures fail to account for the spatial and cultural isolation experienced by diaspora communities in high-latitude environments. The reliance on rigid, top-down subject headings creates significant barriers to care, research equity, and historical reclamation. When library and information science (LIS) frameworks isolate clinical data from the socio-spatial contexts of workplace ethnography and community oral histories, they perpetuate a cycle of misrepresentation. Consequently, researchers and practitioners navigating these databases encounter structural friction that obscures the resilience, localized healing traditions, and specific social determinants of health unique to the Alaskan Nikkei population.

Addressing these systemic deficiencies requires a paradigm shift toward a democratic and culturally responsive architecture of health knowledge, as advocated by Tharp (2026c). By integrating qualitative methodologies—including community-engaged observational studies, participatory spatial analysis, and localized archival praxis—information professionals and public health practitioners can co-create more flexible metadata schemata. This collaborative approach moves beyond mere remediation of existing subject headings; it re-centers the agency of historically marginalized groups in defining their own health histories. Ultimately, reshaping bibliographic frameworks to honor intersectional and intergenerational narratives is a vital step toward bridging the gap between clinical data architecture and true health equity.

Conclusion

The primary care narratives and public health histories of the contemporary Alaskan Nikkei are not merely subsets of clinical data; they are foundational components of community identity and resilience. This study demonstrates that forcing these complex realities into the rigid schemas of MeSH or APA PsycNet results in a profound loss of semantic and cultural meaning. By employing observational methodologies, workplace ethnography, and spatial analysis alongside strategic logistical assessments, information professionals can identify these systemic gaps and advocate for specialized, culturally responsive metadata structures. Doing so ensures that the archives of public health serve not as silent repositories of clinical data, but as active, democratic resources for community healing and contemporary care.

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