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**Explanatory Necropolitics: Physicians' Perspectives on Compliance, Culture, and
Competence in the Management of Chronic Disease**

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Senior Honors Thesis
Submitted to the Department of Anthropology
Washington University in St. Louis

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Acknowledgments

Piglet noticed that even though he had a very small heart, it could hold a rather large amount of Gratitude. - A. A. Milne

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Introduction

1

“[T]he ultimate expression of sovereignty resides, to a large degree, in the power and the capacity to dictate who may live and who must die. Hence, to kill or to allow to live constitute the limits of sovereignty, its fundamental attributes” (Mbembe 2003, 11).

Callouses and Construction

Pausing with my knuckles inches from the door, I quickly ran through the checklist that counselors like myself had been provided to help patients at a local free clinic manage their chronic conditions. Today, I was seeing one of my first patients, a man in his late forties with hypertension. So, having mentally reviewed the recommendations aimed at curbing sodium intake, I knocked. Seated across from a friendly face moments later, I introduced myself before going through my suggestions, met with his constant smile and occasional nods. When I finished with my spiel, I asked for his thoughts. He looked at me silently for a few seconds. Carefully, he then pulled his hands from his pockets, placing them in the air between us and turning his palms towards me. “Look at them,” he said gently, as my eyes roved over their calloused surfaces dotted with specks of the same paint and dirt that streaked his jeans. “Can you tell I work in construction?” he chuckled after a moment. He told me about his work, sharing details of his schedule packed to the brim, the quick trips to fast food joints during lunch, the physical intensity of his labor, the financial task of supporting his family. Detail by detail, he rendered my advice meaningless. His life beyond these clinic’s walls was filled with challenges, he showed me, filled with structures my suggestions did not acknowledge and a slow violence I failed to comprehend.

I remember this encounter in stark contrast to many of the sentiments and whispers I heard around the clinic. Latinx patients like the man I had seen were tough to work with because

of “cultural” diets, I heard. Some counselors and physicians remarked that non-compliance with dietary regimens was a “culturally” encoded phenomenon. Others stepped in to correct their colleagues. *Adherence* to dietary management routines, they suggested, was not only the more appropriate terminology but was also difficult because Latinx “culture” did not inspire faith in biomedical recommendations. Yet others lamented that Latinx health would significantly improve if only providers were better trained in cultural competence. What did “culture” mean in all these situations, I wondered? What did “culture,” as this versatile linguistic ambiguity, explanatory justification, and barrier to seemingly overcome in the stride towards good care, conceal? Most importantly, what were the dangers of this practice?

In this thesis, I explore the notion of *explanatory necropolitics*, the masking of structural violence within the language of care. I seek to illustrate the way in which moralized conceptions of “good care” have attempted to linguistically outmaneuver paternalistic connotations by ostensibly accommodating patient autonomy and choice. However, these attempts have merely displaced “compliance” into a new form of surveilling and depriving patients’ practical sovereignty. This novel concept of *adherent autonomy* is not uniformly assessed, either. Some patient collectives, or “cultures” are expected and assumed to behave in certain ways, particularly in ways deviating from the biomedical ideal. “Culture” and “cultures” subsume characteristics most salient in clinical encounters and become overwhelmingly explanatory, concealing structural roots of inequities. In this way, they act as especially pernicious necropolitical tools allowing the fracturing of populations into those whose slow death is not only permitted but also normalized. Ultimately, I critique facile efforts of improving care and elucidate performances of *pseudocare* that reinforce the biomedical hegemony and undermine progress towards health equity.

To Care

While “care” and all its permutations—“careful” and “caring” among so many others—are extraordinarily commonplace, the concept of care is difficult to pin down and define. This does not mean, however, that no attempts have been made to achieve this goal. In fact, the anthropology of care remains a rapidly expanding body of thought—one which aims to clarify the many ways in which care manifests within and across cultures. One corner of this expansive debate concerns the ethics of care, a notion originating from the work of Carol Gilligan, who introduced the concept in response to Kohlberg’s model of moral development and the broader theory of impartialism.

Impartialism proposes a constant set of ethical rules that can be applied to all situations and all people in an objective manner. Gilligan’s conception of care differs from this body of thought primarily as it views the “care approach [as] particularized... and involved” and “does not see the person making moral decisions as a radically autonomous, self-legislating individual” (Allmark 1995, 20). From this perspective, individuals cannot be expected to operate devoid of interpersonal relationships, which greatly influence the way one interprets morality and “good care.” Allmark also points out that moral decisions are not undertaken in an emotional vacuum since, as Hume puts it, “reason is, and ought only to be the slave of the passions” (Allmark 1995, 20). These concepts have increasingly framed care as labor with both technical and affective components, each of which construct the relationship between the “one-caring” and the “cared-for.” This carefully governed dynamic becomes regulated by logics, or rationales, of care and choice.

The Logics of Care and Choice

In her landmark book titled *The Logic of Care: Health and the Problem of Patient Choice*, Dutch political philosopher Annemarie Mol expounds care as a “collaborative and continuing [attempt] to attune knowledge and technologies to diseased bodies and complex lives” (Mol 2008). The moralized duty of care is both a technical action and an affective *way* of acting which adapts its form to “rational explications of needs and sympathetic appreciation of emotions” (Tronto 1998, 18). “Good care,” then, must contend with patient autonomy and choice, which can result in tension. To best convey Mol’s point, I will defer to an example she presents. Consider a patient in a psychiatric ward, she says, who wakes up one day and refuses to get out of bed. What might the appropriate moral decision be for a psychiatrist in charge of this patient? There is a logic of choice here, the rationality of allowing the patient to make their own decision in the name of preserving their freedom. Simultaneously, however, there is an opposing sentiment, one which reasons that “[o]ffering him the choice of staying in bed is as much a way of neglecting him as forcing him to get up” (Mol 2008, xi).

To allow the patient to stay in bed honors their autonomy, an important socially defined value, but may also be seen as an abdication of the duty to provide good care. This friction, Mol argues, is why choice can complicate the delivery of care. While all clinical situations may not be as stark or as ethically fraught as the example she presents, physicians must constantly contend with patients’ freedom of choice in their construction of care. To be able to make these judgments, care providers must “understand the complexity of the process in which they are enmeshed” (Tronto 1998, 18). This point concerning intersubjectivity inspires my interest in exploring how physicians negotiate with and explicate the logic of choice in care. As physicians navigate patient autonomy to construct and perform “good care,” it becomes important to assess

these ostensible accommodations for choice. A key examination begins with medicine's growing emphasis on addressing patient autonomy through non-paternalistic care.

The Language of Choice: Compliance and Competence

The concept—and label—of compliance is employed in clinical encounters where patients are expected to follow a prescribed regimen. Increasingly, however, the phrase has become contentious due to complaints that it upholds the imbalance of power between patients and providers. Critics suggest that compliance promotes paternalistic care by overestimating patients' control of performing or *doing* what is asked of them. It thereby undermines the delivery of “good care,” they contend, by leaving little room for patients' decisions.

In response to these arguments, various medical institutions have begun promoting the use of “adherence” instead of “compliance,” hoping to soften the language used to examine patients' actions. This modification forces the question, however, of whether the change in terminology has also inspired an accompanying transformation of the way this concept is applied and assessed in medical care. In particular, I ask how evaluations of compliance, adherence, or “good” patient behavior can be unevenly assessed, expected, and punished, especially when mediated by notions of “culture” and collectives as I have demonstrated in my opening vignette.

The Explanatory Necropolitics of Slow Death

As “non-compliance” is a decried as a problematic label due to its unfair determination of complete patient agency and rational behavior, much attention has been paid to the creation of seemingly homogeneous collectives in the name of “culture.” In her ethnographic work

Reproducing Race, which explores maternal care, anthropologist and lawyer Khiara Bridges unpacks these collectives. She finds that physicians frequently speak about “non-compliance” as a result of patient “culture,” exploiting the term’s ambiguity to justify its conflated use. In treating patients not as individuals but as individuals *from* certain collectives, she suggests “it is the population that is acted upon; those who make up the entity become nothing more than the stuff through which the population can be touched, manipulated, and affected” (Bridges 2008, 146). These seemingly “cultural” populations are not only confused with racial and ethnic categorizations, but they are also assigned imagined attributes used to explain and predict behavior different from moralized conceptions of the biomedical ideal.

As I will explore in this thesis, assumed “cultural” collectives exploit the language of choice to explain all patient behavior, but especially *deviant* behavior, in terms of autonomy and norms. In this way, some groups are predicted to behave in certain ways and health outcomes, too, are ascribed to these “culturally” directed actions. The downward prognosis of some individuals therefore becomes normalized and even justified, revealing the necropolitical power of these ostensibly explanatory collectives. The resulting slow death is “a violence that occurs gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all,” making it especially sinister (Nixon 2013, 2). Those who are insulated by whiteness, privilege, and power are left to see slow death as a theoretical phenomenon, an inevitable and invisible casualty. However, to those who are subject to this drawn-out violence, slow death is anything but imagined. This is the dangerously concealed extension of structural violence that I seek to investigate through my work.

My analysis of physician perspectives on the role of “culture” attempts to challenge the pervasive reluctance to confront institutional policies and linguistic maneuvers not in the hopes of demonizing individual providers or hospitals, but rather to establish routes towards equitable care. Through critical reflection, I hope to illuminate the ways in which attempts to eliminate disparities through adherence and competence may exploit established power dynamics to further oppress rather than liberate individuals. In order to explore the concepts I have outlined thus far, I narrow in on one form of clinical encounter: chronic disease management.

Chronic Disease Management

Chronic disease management serves as a valuable field of study for several reasons. Firstly, it offers a particularly salient relationship with prescribed regimens and instructions. The applications of compliance or adherence can frequently be observed during the treatment of conditions like diabetes that may require patients to take medications, routinely check various bodily parameters, and otherwise adhere to physician-provided instructions. This set of clinical diseases is also a commonly encountered topic in clinics across the nation.

The American Diabetes Association, reports that 10.5% of the American population - 34.2 million individuals - had diabetes in 2018 (American Diabetes Association 2018). Similarly, a 2019 study by the Centers for Disease Control and Prevention revealed that almost half of Americans - 108 million people - have hypertension. Both these conditions not only increase the risk of potentially fatal heart disease, stroke, and other complications, but also continue to cost the healthcare system trillions each year. While genetics and environmental factors play a significant role in the genesis of these diseases, studies show that lifestyle modifications—particularly dietary changes—may be sufficient to markedly decrease the conditions’ impact and

prevalence (Lean et al. 2019, 344). For this reason, dietary changes are frequently incorporated into patient-physician discussions of chronic disease management. However, these routines must negotiate with a landscape plagued with systemic problems and inequities.

According to the United States Department of Agriculture, for example, a staggering 10.5% of American households - 5.3 million families - experienced food insecurity for all or part of 2019 (USDA Economic Research Service 2019). Food insecurity is defined here as “access to adequate food for active, healthy living ... limited by lack of money and other resources” (USDA Economic Research Service 2019). This hunger epidemic is explained by a variety of social determinants ranging from low wages to social isolation and disproportionately affects low-income, Black, and Hispanic families (Feeding America 2020). The ability to enact dietary changes or even access healthy food, therefore, is uneven across the patient population. This disparity offers just one example of the structural factors with which chronic disease management must contend.

The last factor that makes chronic disease management a pertinent field to investigate is its long-standing relationship with dialogue concerning agency and sovereignty. This is especially true for the dietary component of management, which social theorist Lauren Berlant has discussed in extensive detail. Capitalist systems such as those we are surrounded by demand and profit from longevity, not of life, but of the body. This is to say that the market depends on an individual’s capacity to work and not so much on an individual’s ability to exist. As an exploitative force, then, capitalism strips an individual of their *practical sovereignty*, or sense of power, while shrinking the experience of life such that it “feels truncated—more like doggy paddling than swimming out to the magnificent horizon” (Berlant 2007, 779). Subscribing to this perspective reframes one’s understanding of food. Eating becomes more than breaking bread. It

is in many ways an attempt at breaking or interrupting the temporal squeeze of daily life. It is an attempt of self-abeyance, of “floating sideways,” of reclaiming that lateral agency and practical sovereignty which permits an individual to, for even a moment, slow the constant forward rush of life (Berlant 2007, 779).

Located at the intersection of these discussions, chronic disease management presents a critical sphere for my research on explanatory necropolitics. While I began my research focused on the dietary component of management, my work expanded to incorporate several facets of these routines beyond food, as I will illustrate in the coming chapters.

Setting

I performed my research in the St. Louis region, an area that has a long and significant history with racial, socioeconomic, and health inequities. These disparities are revealed by a closer look at the region’s racial makeup, concentration of poverty, and rates of death from heart disease. A 2015 report titled “For the Sake of All,” exemplified the mapping of these inequities onto St. Louis County’s landscape, showing the existence of continued and tightly linked geographic segregation of race, socioeconomic status, and health inequity (Purnell, Camberos, and Fields 2015, 30).

The distribution of deaths from heart disease in St. Louis is especially relevant to my work with chronic disease. Between 2014 and 2018, heart disease was the leading cause of death in St. Louis county, taking an average of 2,436 lives annually (St. Louis Department of Public Health 2020). A report by the Department of Public Health notes that Black residents are “disproportionately affected by heart disease to a staggering degree, consistently having higher mortality and hospital visit rates compared to other racial/ethnic groups in the county (St. Louis

Department of Public Health 2020). While disparities in insurance and access to healthcare contribute to these statistics, food insecurity plays an underappreciated role in these inequities as well.

A 2019 study by the Missouri Coalition for the Environment, for example, revealed that 26.8% of St. Louis city residents, a staggering 85,400 individuals, were classified as food insecure (Missouri Coalition for the Environment 2017). Stark racial divides dominate this conglomerate statistic. Compared to 15.34% of white residents of St. Louis city, 38.41% of Black residents live in poverty. In addition, 14% of white residents reported difficulty purchasing healthy foods in their neighborhood whereas this number was 34% for Black residents (Missouri Coalition for the Environment 2017). To underscore the distinction even further, one can look at yet other factors that may impact food security. 30.9% of white city residents reported low incomes and low food and vehicle access (Missouri Coalition for the Environment 2017). For Black residents, this statistic was startlingly bleaker: 62.7% (Missouri Coalition for the Environment 2017).

My aim in presenting this discussion of St. Louis County is to briefly underscore the magnitude of structural violence that goes on within its boundaries. The racial and socioeconomic discrimination that pervades the region and its citizens' health is critical to my analysis of explanatory necropolitics as it exemplifies the intensity of systemic power concealed by the practices I present in the following chapters.

Methods

Since I was interested in the intersections of culture, compliance, and competence in the field of chronic disease management, I reached out to physicians who would frequently

encounter these conditions among their patients. This meant that I focused my efforts on endocrinologists at first, recognizing that their interaction with conditions like diabetes would make chronic disease management, nutrition, and diet common topics of counseling. From here, I selected other interviewees through a process of snowball sampling. I asked each of my interlocutors for the contact information of colleagues who they believed might be interested in speaking with me for my project and emailed potential interviewees with information about my study. With everyone I spoke to, I held a 30–45-minute virtual semi-structured interview probing for their thoughts on the various concepts I hoped to explore. A few of the sample questions that I asked my interlocutors are provided in the Appendix.

Over three months, I spoke with ten individuals: six endocrinologists, two primary care physicians, one registered primary care nurse, and one bariatric surgeon. Interestingly, while I reached out to a variety of providers, all my physician interviewees were female. These care providers practiced in a variety of locations in the St. Louis region, with most alternating between hospitals in St. Louis City and affiliate practices in West County. Many, by virtue of their affiliation with a large teaching hospital and university, were engaged in training programs and served dually as physicians and resident educators. Furthermore, several pursued public health research and efforts to address disparities in their specialty. After all my interviews were complete, I compiled my fieldnotes and reviewed physicians' responses for qualitative patterns. Placing these themes in conversation with burgeoning anthropological literature has allowed me to present this analysis.

Outline

In Chapter 2, I begin by exploring physicians' framings of the term "compliance," not only to understand their ideas of what ideal management of chronic disease looks like, but also to elucidate their conceptions of care. I review the ways in which the challenges of compliance, or adherence, are deconstructed into coded components of *knowing*, *wanting*, and *doing*. This pattern, I suggest, has created a new form of *adherent autonomy*, which offers the freedom to choose as much as it surveils, expects, and moralizes "good" choices in the pursuit of good care. Consequently, adherent autonomy deprives patients of practical sovereignty and continues to objectify individuals in more indirect and ostensibly acceptable forms.

Chapter 3 delves into physicians' definitions for culture, which range in scope and content, much like the historical anthropological debate on the matter. I identify several important patterns in responses, revealing a prominent framing of culture as one's beliefs on normalcy. This conception becomes salient in the clinical encounter through characteristics presumably creating resistance to successful chronic disease management.

In Chapter 4, I expand this argument by discussing the way this pattern of thought manifests in descriptors used to delineate patient "cultures." I demonstrate how "culture" and "cultures" become explanatory and exculpatory linguistic devices used to mask structural violence.

Chapter 5 takes a deeper dive into the most frequently offered stand-in for culture: race. I provide an overview of the ways in which biomedicine reifies race before exploring the assumptions that may become tied to race in clinics given physicians' conceptions of what culture means. I conclude this chapter with an analysis of why culture-qua-race functions as an especially effective necropolitical tool that legitimizes socially constructed categories and inequities while normalizing the slow death of groups on this basis.

Throughout these chapters, I analyze physicians' thoughts on cultural competence and place their definitions and explanations in the context of competence's goals. I discuss the ways in which competence exoticizes and pathologizes not only culture, but all the characteristics that culture is conflated with. I explore the effects of competence on exculpating physicians and medical institutions, allowing them to create the appearance of equitable care without the true substance necessary to dismantle systemic roots of inequity. In this way, I consider the role of performativity and *pseudocare* underlying competence and contributing to its dangerous effects as diagnostic of the larger issues with the "happy" language of medical care.

“Noncompliance may be the most significant problem facing medical practice today. As one reviewer notes, “In an era when efficacious therapies exist or are being developed at a rapid rate, it is truly discouraging that one-half of patients for whom appropriate therapy is prescribed fail to receive full benefit through inadequate adherence to treatment.” - Eraker, Kirscht, and Becker (1984)

The Controversy of Compliance

Before investigating physician responses, it is critical to become more familiar with the reasons that compliance has become so heavily denounced in the medical arena. Primarily, critics of the label have argued that compliance and non-compliance can become tools to reinforce the hegemony of physicians by “assum[ing] and justif[ying] physician authority” (Ferzacca 2000, 29). This position acknowledges that clinical encounters are frequently, if not always, characterized by a knowledge and power imbalance in the favor of physicians. Patients must consequently yield their power in several ways, one of which is the offering up of the self for judgment. Here, one must reframe clinical encounters as more than conversations between patients and physicians and instead recognize the breadth of influences that impact patient-provider interactions, as Ferzacca does in his article exploring the clinical management of diabetes:

The clinical encounter is a punctuated moment of experience during which cultural ideals and social values that have currency in our society at large become crystal clear, and are thus held up as standards by which to measure idiosyncratic cultivations of the self and the degree to which each case adheres to its obligations. These markers of the "ideal man" are also signs of salvation from the throes of disease due to an unhealthy lifestyle. (Ferzacca 2000, 35).

From this perspective, judgment of compliance can be considered as the diagnosis of the *patient* rather than of the patient’s *disease*. Take, for example, a patient with Type 2 diabetes. A

physician's assessment of the severity of this condition relies on quantitative indicators like A1c, which is a measure of one's recent average level of blood sugar (American Diabetes Association 2015, S8). In contrast, evaluation of the patient's compliance to an anti-diabetic regimen depends upon far more qualitative factors and draws on qualities of the patient rather than their body. Whether or not the patient regularly checks their glucose levels, takes prescribed medications, and eats at consistent times may all factor into this appraisal. Compliance, then, compares patients' behavior against that of an "ideal" patient whose characteristics are shaped in the biomedical imagination not only by objective or, at least, numerical markers, but also by moralized qualities concerning willpower, indulgence, and "unhealth." In this chapter, I will explore the ways in which physicians I interviewed deconstructed the challenges of dietary management into *knowing*, *wanting*, and *doing*, each of which negotiated the boundaries between care and choice yet spoke in coded terms about moralized deviance. I suggest that erasing compliance from medical terminology has only enabled the creation of a new, indirect form of *adherent autonomy*, which continues to assess patients' behaviors and to expect the performance of good care as self-surveilling physicians. Ultimately, I contend that it is difficult to escape the biomedical gaze which sees patients as subjects to diagnose and control.

A 2017 article in The New York Times, titled "The Cost of Not Taking Your Medicine," declared that "[t]here is an out-of-control epidemic in the United States that costs more and affects more people than any disease Americans currently worry about. It's called nonadherence to prescribed medications, and it is—potentially, at least—100 percent preventable by the very individuals it afflicts" (Brody 2017). This assignment of intentionality to non-compliance, "invites moral assessments" because this behavior is framed as "wasting resources and encouraging avoidable disease, with associated higher societal and individual costs" (Hawking

2020, 2317). In this way, compliance shifts the burden of responsibility for both personal and societal health onto individual patients. It becomes one's moral duty to comply. Under this neoliberal regime of "healthism," any non-compliance then, is deviance that summons blame and that can affect a patient's perceived deservingness for care.

Compliance, alongside illnesses, becomes medicalized and brought within the hegemonic jurisdiction of biomedicine; it becomes something to diagnose, something to treat. It is this paradigm that critics point to when decrying the concept of compliance. Compliance overestimates patients' agency and exposes care recipients to unjust, excessively moralized evaluation of behavior in clinical encounters where they are already in vulnerable states. It follows that if one is interested in deconstructing paternalistic care and instead pursuing partnerships between patients and providers, one must evaluate whether linguistic transitions to "adherence" have also promoted the decentering of the practices that made compliance controversial. To investigate this question, I decided to inquire physician interviewees about their definitions and perceptions of compliance, discovering several patterns in perspectives on the term that explained either its sustained application or its gradual erasure. To my surprise, only one of the ten physicians with whom I conversed even came near to endorsing the continued use of compliance in clinical care.

Overcoming Deviance

Appearing on screen, Dr. Ash waved warmly, dressed in scrubs each a different shade of blue. The machinery surrounding her made it clear she had just wrapped up her morning surgery. "I hope you don't mind, I'm in the OR," she said, reaching up to quickly adjust her cap. Assuring

her that the location was fine, I expressed my gratitude for her time and her enthusiasm to speak with me. After all, hers had been one of the fastest replies to my recruitment email and, in it, she had remarked that she found my subject of research a “very interesting topic and certainly a struggle.” She served as a bariatric surgeon, she explained as I began inquiring about her role, and this meant she worked with patients who qualified for weight loss surgery by being “morbidly obese,” a clinical category defined by a body mass index (BMI) greater than 40 or a BMI greater than 35 coupled with chronic conditions like diabetes and hypertension. She frequently spoke with patients about nutrition, she shared, “because they have to lose weight,” not only because it made the bariatric operation easier, but also because many insurance companies—her tone sharpening in a way suggesting she had shared this message frequently before—would not approve the surgery if patients gained weight in the lead-up to the procedure.

As we discussed the longitudinal nature of Dr. Ash’s interaction with her patients, both before surgery and after at checkpoints ranging from one week to one-and-a-half years post-surgery, she was approached by a colleague with a question. Pausing to answer, she picked up her laptop and walked to a new location within the operating room as I asked whether she discussed food at all the visits she mentioned. “Hands down,” she replied. Probing further to clarify whether Dr. Ash discussed food with patients mainly in the context of weight loss, I grew curious about her thoughts on the notion of compliance and asked her about it. “I think it's twofold,” she explained after silently contemplating. “I think it's the patient understanding the instructions that are given to them, and then following those instructions to the best of their knowledge and ability.” Expanding on how her patients fared with compliance as she defined it, Dr. Ash provided a nuanced assessment:

From a surgical standpoint, knock on wood, they do well, okay. From patient compliance and patient understanding, I think it's not as well as the surgical outcome [sic]. And I think that it is...a lot of it is not necessarily education, I think, as the complexity of understanding food, right? And what is good and what is bad is much more complex. Especially for these patients who may not be educated, they just don't know. And so, I think that's what makes it harder. Okay. And also, I think sometimes these patients do have a component of addiction to food. And so, if I say, two weeks after your surgery, I only want you to have a pureed diet, and you give them applesauce...can you know the breakdown? They eat, you know, a fried fish sandwich. You know, I think it's just they fall into those bad habits again, right? So, it's kind of complex in that regard.

Within her explanation, Dr. Ash created two critical distinctions revealing concepts critiqued by opponents of compliance. First, Dr. Ash separated “surgical outcome[s]” and “patient compliance,” underscoring the previously discussed idea that quantitative diagnoses of disease are divorced from qualitative diagnoses of patients’ behavior. Further exploring this point, by noting that surgical outcomes are often *better* than patient compliance and understanding, her account suggested that a degree of non-compliance can be overcome. This process of overcoming non-compliance is achieved by the biomedical apparatus—a collaboration between medical knowledge and physician operators. Care recipients’ deviance, therefore, is to be treated by the care provider, offering an example of the condemned medicalization of non-compliance. Framing non-compliance as something to diagnose and address objectifies patients, critics suggest, inflating the perceived authority and power of the physician over the patient.

Dr. Ash also created separation between knowledge and knowledge creation. When she mentioned patient understanding, she paired the notion with compliance, as if to suggest that the two were codependent. In other words, one must understand the instructions and rules in order to abide by them. Since the rules themselves come from biomedical knowledge, one may reasonably suggest that the delivery of these instructions, then, is the responsibility of physician

operators. However, Dr. Ash's broad reference to "education" detached this role from care providers and instead abstracted away the burden of knowledge creation. This form of self-exculpation is another decried aspect of compliance as it permits physicians to ignore important external limitations and hold patients entirely responsible for their capacity to comply with recommendations. While Dr. Ash's explanation of compliance in bariatric surgery offers insight into some of its critiques, I must also note that her use of the term may also be complicated by the setting in which she practiced.

When Dr. Ash noted that insurance companies will deny funding of patients' operations if they gain weight prior to surgery, she offers insight into a potential reason for the sustained employment of the term "compliance" in clinical care. Increasingly, the delivery of care has become regulated by external, capitalistic, forces. As Kleinman and van der Geest argue, "[t]he bureaucratic structures and financial constraints of care undermine the art of medicine and interfere with the ancient task of caregiving" (Kleinman and van der Geest 2009, 163). One example of this, I argue, is these external determiners of what procedures can be funded for patients, like insurance companies, since they may encourage physicians like Dr. Ash to assess non-compliance as patients cannot receive surgery if they do not achieve weight loss.¹ In making this point, I aim to reinforce the notion that my critiques of compliance do not seek to demonize individual physicians, whose ability to gatekeep care may be overestimated considering growing bureaucracy, but rather to dissect the structures within which they operate.

¹ While a more detailed exploration of financial institutions' role in defining and problematizing "unruly" or "risky" patient behavior is beyond the scope of this paper, such analysis is necessary.

Ambivalence and Adherence

After my conversation with Dr. Ash, I believed that I might see similar responses about the use of compliance from my other physician interviewees. However, I quickly found that no other physicians were as accepting of the concept. Most refused to directly answer my question about their definition for the term and, in fact, many interviewees paused upon hearing my question, some going so far as to visibly grimace. Since I gave no indication to my interlocutors about my engagement with literature criticizing compliance so as not to add any pressure on them to denounce the concept, several physicians used the opportunity to educate me on shifts away from compliance. Dr. Donahue was one such individual.

I had met Dr. Donahue once before when she had helped create a smoking cessation protocol now in use at a local free clinic. During that meeting, I had been introduced to her genial and straightforward way of speaking, an equally warm and assertive tone that immediately divulged her extensive experience in the field. It was this expertise that manifested in the variety of roles Dr. Donahue played. Not only did she see her own panel of internal medicine patients at her West County practice, but she also supervised care of patients in the residents' clinic, playing a guiding role in the training of new primary care physicians.

During our conversation, Dr. Donahue brought up the dissonance that she frequently observed between residents' suggestions to patients and patients' following of these recommendations. Feeling that this would be a natural transition point into a discussion about compliance, I inquired about her thoughts on the term. Immediately, Dr. Donahue winced on screen before letting me know that the preferred term was adherence. Compliance suggested doctors were in charge, she remarked, before interrupting her own pattern of thought to muse

aloud that despite this impetus behind the change in terminology, adherence too effectively suggested the same paternalism.

From Dr. Donahue's perspective, regardless of the language used, it was important to remember that doctors were not perfect and often did not understand everything about their patients. While there were certainly times when physicians were convinced that their suggestions would be the best course of action, there were also times where multiple options were equally viable. "We can use motivational interviewing techniques, we can encourage, we can be supportive, but we can't make them do any of those," she commented. Dr. Donahue's sentiment aligns with arguments advanced by critics of compliance that the term implies paternalistic care and falsely inflates physicians' authority and ostensible omniscience. Note, however, that she was not convinced that "adherence" linguistically outmaneuvered these problematic connotations either. Her offhand comment reveals an interesting perspective echoed by her colleagues who also antagonized compliance yet approached the new terminology with a critical sense of skepticism.

Dr. Engles, who also served as a primary care physician at a satellite practice in St. Louis's West County, expressed sentiments like Dr. Donahue's. While discussing compliance, she was vocal about the controversial label and promptly made clear that she did not use the term because of its patient-blaming implications. She felt that the way medical education had historically framed the term was problematic and that in primary care, the most important thing was to remain open and non-judgmental whereas the term stripped patients of their agency. To my surprise, Dr. Engles too shared without being prompted that while the preferred term was adherence, she felt that this new word did not sufficiently improve upon compliance. More

specifically, she shared, adherence did not indicate the necessarily shared nature of decision-making with patients.

I highlight Dr. Donahue's and Dr. Engles's accounts here because their doubts about adherence are critical sentiments overshadowed by institutional projections of confidence behind the linguistic shift. By this, I mean that while large biomedical institutions market adherence as the optimal successor to compliance, uptake of this term has not come without consideration and criticism by physicians. Most physicians I interviewed acknowledged compliance as an outdated term and employed adherence instead while remaining unconvinced that the term sufficiently overcomes patronizing implications. Therefore, it is worth interrogating the reasons that physicians offered for their use of adherence. In other words, what goals, beyond an escape from the implications of paternalistic care, could motivate and justify the shift in terminology? My investigation into this question revealed an additional perspective from which compliance could be critiqued, providing insight into my interlocutors' conceptions of care.

Informative Care

While some of my interlocutors explained the transition to adherence as a consequence of personal or institutional recognition of the power imbalance that compliance implied, Dr. Greer did not rely on this rationale. "Oh, I talk about stuff liberally," she said with a laugh after she let me know she was perfectly fine having our interview recorded. Dr. Greer was an experienced physician and, of all my interviewees, had spent the most time in the medical field. As a result, her roles extended to a variety of leadership positions in her workplace's endocrinology department and in national endocrinology organizations. As we began discussing her clinical

experience, I also discovered that of her patients, some had been with her for as long as 30 years. Patient visits almost always involved a discussion, beginning with the initial appointment where Dr. Greer conversed with patients about pre-visit questionnaires inquiring about food frequency, diet history, and a 3-day food record.

When we began discussing Dr. Greer's thoughts on compliance, she responded first that she had never thought about the word's meaning. To her, compliance looked like people following recommendations as much as they could. "For medications, it's taking [them] every day. For eating, no one is perfect, and it is, you know, probably following recommendations about eating most of the time," she added. While Dr. Greer had rarely used the term in her work, she noted that "most people" now preferred the word adherence. She felt that the labels of compliance and non-compliance, or adherence or non-adherence for that matter, did not provide sufficient detail. So, she opted to use more descriptive language in her notes such as specific references to the high saturated fat or high sugar nature of patients' diets. This information, she felt, had more relevance to actionable steps. I asked Dr. Greer at this point whether she knew why the shift in appropriate terminology might be occurring, then. Commenting that she was not entirely sure, she postulated that perhaps individuals believed that adherence might be a less negative term, without expanding any further on this thought.

While Dr. Greer never explicitly expressed her doubt about adherence as the preferred linguistic successor to compliance, she made her feelings known in other ways. For example, she grouped the labels together when speaking about the problems of this terminology, as if no distinction existed between the two. Furthermore, she distanced herself from adherence by suggesting other "people" motivated this shift for reasons she could hypothesize about but of which she could not be sure. Instead of decrying compliance's condescending implications, then,

she approached the matter from an informational standpoint and chose to focus on the more immediate definition of the word. Importantly, her explanation that the labels offer little information reveals her belief that the utility of language used in medical care should lie in helping direct “actionable steps.”

As I performed my interviews, I found that Dr. Greer was not alone in holding this belief. Dr. Cordero, for example, did not mention paternalism and instead justified her disinclination towards compliance by explaining that the term described “patients following a particular regimen, could be like a medication recommend or dietary regimen.” “So, I think it's a term that doesn't really tell you much. I mean, do they follow it, or they don't follow it [sic]. But it doesn't really tell you the why,” she added, nodding to the same non-informational binarization critiqued by Dr. Greer. For these physicians, compliance and adherence offer dichotomous detail of whether patients are performing provided instructions but do little to *explain* this behavior or inform future directions. The arguments expressed by Dr. Greer and Dr. Cordero, like the viewpoints shared by Dr. Donahue and Dr. Engles, critique compliance from the perspective of ultimately improving clinical care. However, the two diverge in their approaches. Synthesizing these perspectives offers insight into my physician interlocutors’ deconstruction of care into a pair of components.

The Affective and Technical Labors of Care

When Dr. Donahue and Dr. Engles underscored compliance’s paternalistic connotations, they suggested that erasing the term from medical language is motivated by a desire to provide care that places the provider and recipient on more equal ground. Good care, they suggested,

requires physicians to remain non-judgmental, supportive, and motivating. Dr. Greer and Dr. Cordero instead employed a utility-focused standpoint to interrogate the information offered by compliance. They suggested that eliminating the term compliance is important because it offers no valuable or, more specifically, applicable insight for care. For these physicians, improving care requires informed decision-making towards actionable steps, prescriptions, or procedures for patients. These reasonings are different but not mutually exclusive. The dissonance between these physicians' reasonings for critiquing compliance do not construct entirely different meanings for good care. Instead, I suggest that they point to distinct affective and technical components that make up the moralized act of caretaking.

As theorists have framed and reframed care across time, the characteristics assigned to this interaction have evolved. Early conceptions of care centered the perspective of impartiality, which suggested that a uniform set of ideals could be applied to all moral scenarios. However, scholars responding to this deontological position argued instead that care was a dynamic, individualized, and severely partial act. The resultant body of thought, known as ethics of care, holds, among other contentions, that care, as an interpersonal relationship, demands an attention to individual subjectivities. These subjectivities detail the “complex ways in which people’s inner states reflect lived experience within everyday worlds as well as within temporary spaces and transitions” (Biehl, Good, and Kleinman 2007, 5). Care, in this way, becomes a bidirectional process of making and understanding meaning.

The phenomenon of intersubjectivity, or “the ways in which we come into being through the mutual recognition of another,” demands a dynamic and constant negotiation between the “one-caring” and the “cared-for” (Burke 2014, 32). Consequently, scholars rebuke the notion that care can be neutral and suggest instead that care is inherently an interpersonal process of

meaning-making. From this standpoint, several features emerge to characterize care, best outlined by gender and care theorist, Joan Tronto. In her chapter from *Feminist Theory: A Philosophical Anthology*, Tronto argues that care is both an act and a *way of acting*. It is both an affective “mental disposition of concern” and the technical or “actual practices that we engage in as a result of these concerns” (Tronto 1998, 16). Most relevant to my own work with clinical dietary management, she points out that a physician’s care is not only the “concrete practices of prescribing medical treatment,” but also the “attentiveness and concern” that they must possess (Tronto 1998, 16). This breakdown parallels my interlocutors’ comments. Dr. Greer and Dr. Cordero include the visible portion of care in describing the utility of medical language as a director for future steps. This technical component is partnered then with the affective work highlighted by Dr. Donahue and Dr. Engles. Physicians must be motivating and pay particular attention to the individual challenges faced by patients, they suggested.

Swapping Places

In this way, my exploration of physician perceptions of the terms compliance and adherence begins to elucidate their construction of good care as a way of both feeling *and* behaving. However, this analysis concerns only one dimension of care, focusing on the “one-caring.” This prompts a discussion of the other side of the interpersonal, intersubjective experience of care. Thus far, I have explored what physicians believe good care looks like in terms of the “one-caring,” or the care provider. Having unpacked my interviewees’ construction of care as a duty for the physician with affective and technical components, I am left with exploring what they believe then to be the duty of the *patient*. The examination that follows rests on the assumption that if there is a proper way of *caring*, then there must also be a proper way of

being *cared-for*. In fact, this paradigm has been surveyed by theorists in the past, giving rise to a critical perspective centering two relevant logics: the logic of care and the logic of choice.

“The focus of subjectivity is a distorting mirror.” - Hans George Gadamer

Transference

One of the primary challenges of intersubjectivity in the clinical encounter where a frequent imbalance of power and knowledge dominates is the relative ease of conflating action with choice. In attempting to diagnose patient behavior, “[i]t is often far from easy to differentiate between what you do not want and what you cannot do” (Mol 2008, 52). In fact, one of my interlocutors, Dr. Iver expressed this understanding. After sharing her thoughts on the paternalistic nature of compliance, she explained that adherence was a more comfortable term for her to use and went on to outline barriers to adherence she commonly saw in her work:

Part of the reason people struggle with adherence is that physicians and providers seem unable to practice transference where you try to be in the other person's shoes. So, for instance, my trainees have been taught to default to sending patients home on four injections of insulin a day, and then wonder why they can do that. We are all educated people, you know, good means. And if someone sent me home and told me to take four injections of insulin, I would tell them to take a hike. So, I mean, I think the fact that we can't even attempt to understand what the patients are going through, it's no wonder that they're unable to follow these very complex instructions.

Dr. Iver noted that as a physician, she and her colleagues are “educated people,” alluding to the concept of understanding “very complex instructions” referenced by several of my interlocutors as being both a challenging and important part of chronic disease management. She also suggested that the task of injecting oneself with insulin daily may not be a task even she would be motivated to perform and that if one were to prescribe her this regimen, she might “tell them to take a hike.” While Dr. Iver steps into patients’ shoes and offers potential explanations for the

difficulties of adherence, she also reflects on the difficulty of doing just that, reinforcing the common difference in experience, perspective, and life itself between physician and patient.

While probing my interviewees' thoughts on the linguistic shift in terminology from compliance to adherence and their perceptions of these terms offered insight into what they believed proper *caring* looks like, a different set of questions elucidated their beliefs on proper forms of being *cared-for*. Instead of asking physicians to answer from the one-caring's shoes, I asked what challenges their patients might face when asked to comply, to adhere, or, for those who preferred using neither term, to manage chronic disease through diet. This question prompted my interviewees to present the perspective of the cared-for as they understood it. Many responded with anecdotes and examples they had collected through their counseling.

In this chapter, I discuss interviews revealing that physicians commonly deprioritized the action or *doing* component of chronic disease management, instead focusing on the *knowing* and *wanting* that they believed were necessary to achieve good care on the part of the patient. These coded terms created a new evaluation of *adherent autonomy*, which ostensibly accommodated choice yet still demanded moralized behavior aligned with the biomedical ideal as a self-surveilling physician. This behavior was assumed in differential ways, with patients being conceived of in groups or collectives whose characteristics could predict the probability of deviance.

Understanding the Rules

Many of my interviewees echoed a common sentiment that what patients were being asked to do to manage their chronic condition through diet was simply a very difficult procedure.

I probed my interviewees further on this point, inquiring whether they might be able to share the most common barriers they saw patients face when attempting to manage their condition. I recognized that most explanations outlined a variety of components, beginning with an understanding of what exactly management entailed.

Dr. Cordero was a familiar face. She was the advisor for the nutrition counseling program run at the local free clinic where I volunteered. When not in endocrine service, Dr. Cordero was involved with her public health interest of improving diabetes care for populations with low access to healthcare. She commonly discussed food with her diabetic patients to understand what they were eating before she provided specific recommendations. As I mentioned previously, our discussion of her feelings towards compliance revealed that she did not use this term, nor its successor, adherence, in her work due to the binary information she felt they provided. Instead, she preferred to speak in general terms about chronic disease management and how her patients fared. So, I inquired what factors commonly explained situations where patients had difficulty with this task.

Many times, the answer lied in patients' lack of understanding of the instructions, which could be difficult, Dr. Cordero replied. "I mean, after the hospital, a lot of patients that don't follow, for example, their insulin regimen, they just said they were really overwhelmed. And then when they got home, they just couldn't remember how they were supposed to do it." Later in her answer, she returned to this idea of understanding, but this time discussed it in the context of medications. Dr. Cordero shared that she found it shocking when patients were unaware that they needed to get refills. Especially her Latinx patients, she commented, would instead attempt to make appointments with her once they were completed with their first bottle of pills. Only being able to schedule a visit for months later, this meant they frequently missed many critical

doses. “I was like, yeah, so it says refills here,” she added, gesturing to an imaginary prescription bottle.

At its base, Dr. Cordero’s explanation is a simple one. The greatest difficulty for managing diet or disease is knowing what that management means and entails, she suggested. However, this notion of understanding, and furthermore remembering, as a challenge is complicated by the ways physicians speak about and assess it. Dr. Cordero’s comments, for example, make it clear that while some understanding is deemed complex and struggling with this knowledge is acceptable, other information should come easy. This concept is evident in Dr. Cordero’s suggestion that while remembering insulin regimens might be acceptably challenging, refilling prescriptions should not be a struggle. So, while framing understanding as a barrier, and portraying chronic disease management as a vast body of knowledge, may serve as reasonable attempts to identify with patients, the categorization and ranking of this information undermines the endeavor to empathize.

Deepening my point is Dr. Ash’s previous explanation for the difficulties of patient compliance with pre-surgery weight loss. “I think that it is...a lot of it is not necessarily education, I think, as the complexity of understanding food, right? And what is good and what is bad is much more complex. Especially for these patients who may not be educated, they just don't know,” she stated. It is difficult to understand the instructions, Dr. Ash says, because understanding food is inherently a complex task and struggling may be reasonable. Simultaneously, however, Dr. Ash dances around the term “education,” first stating education has little to do with the challenges of compliance yet very shortly after suggesting that education plays a marked role in patients’ capacity to understand. At first, understanding is specifically tied to nutritional information and the complexity of food. Quickly, however, understanding slips into

a much broader, yet more formalized sense of the term. It becomes not just about a patient's *ability* to grasp the rules, but about their pre-existing body of *knowledge* gained through formal systemic and institutional schooling. In this way, discussions of understanding give way to latent implications, to socioeconomic indicators of education level, and to judgments of socio-moral values.

Dealing in Collectives

The challenge of chronic disease management, my physician interlocutors suggested, is grasping the rules. Deeper analysis, however, reveals that whether it be through Dr. Cordero's example of Latinx patients or Dr. Ash's use of the term education, this problem is more about *knowing* than *understanding*. My interviewees maintained that there is a level of "basic" biomedical information or familiarity with technical actions that patients must know. Only above a threshold of information complexity does difficulty with understanding or grasping this material become acceptable. In this way, the deprioritizing of *doing* to highlight the challenge of *knowing*, while intentioned to empathize with patients' challenges, struggles to overcome moralized judgment of the cared-for. In addition, these responses reveal that compliance, adherence, and assessments of chronic disease management are unequally applied across patients. My physician interlocutors appeared to think about patients in collectives, grouped by attributes which made them more or less likely to behave at odds with the biomedical ideal.

The cases most illustrative of this notion were those where physicians directly incorporated evaluations of patients' inclination towards understanding the rules of chronic disease management into their approach to care. Notably, Dr. Greer, an endocrinologist with a

specific focus on lipid science, mentioned that she considered this factor when speaking with her patients. It was important, she shared during our conversation, to understand what kinds of meals patients ate frequently, much like Dr. Cordero had stated. With her South Asian patients, for example, Dr. Greer commonly found herself discussing ghee, a clarified butter. So, she would make sure to underscore its high saturated fat content and explore alternatives. While with most other patients this type of discussion would entail a simple conversation, she pointed out that with South Asian patients, she would commonly delve deeper and spend more time involving scientific publications. She would regularly bring up papers from organizations like the Indian Medical Heart Association because she found that many of her South Asian patients were “a lot of professional people who are...very interested, and we can actually have a very thoughtful discussion about what they’re eating at home.” Understanding, in Dr. Greer’s response, is tied to the socially coded “professional people,” reinforcing the notion that *knowing* is not innocuous, neutral, nor uniformly applied.

As I have demonstrated in these responses, my physician interviewees employed collectives when speaking about and interpreting patient behavior. Recognizing the attributes used to differentially predict behavior is critical to understanding care. Primarily, understanding the terms used to define these groups, whether racial, ethnic, or “cultural,” and their ostensible ties to deviance permits critique of these common practices. Importantly, these groupings underscore the resulting shift of focus from individual patients onto imagined and assumed categories to which they belong. This concept becomes even more obvious with another component that my interlocutors mentioned as part of the challenges with chronic disease management.

Desire, Decisions, and Donuts

To be capable of managing chronic disease, it was not enough for patients to understand the rules; they also had to be invested in following these instructions. Dr. Greer's response, for example, hinted at another important factor that several of her colleagues also included within their constructions of adherence: interest. She pointed to one example of patients who possessed this investment in managing their condition:

I do have a fair number of patients who are very interested in prevention, because they have a lot of familial disorders, cholesterol, and very bad family histories. And in many of those people, they've already had heart problems or other vascular problems. There's a big interest in doing everything they can. Now they will come in and say, "I didn't do well," or "I think I'm doing well," or this, that or the other. So, I would say, probably half of my patients actually are actively really trying to do something and another 25% are sort of sometimes trying, and then...

Here, Dr. Greer painted a picture of an active patient, one who is "interested in prevention" because of personal or familial history with chronic disease and enthusiastically appears at visits assessing their own behavior and management. The way patients' motivation is assessed is thereby their self-presentation and willingness to judge their own behavior. In other words, Dr. Greer suggested that interested patients are those who hold themselves accountable, effectively equating motivation with self-appraisal against standards of management. Furthermore, there are gradations to this motivation, Dr. Greer implies, in the form of those "sort of sometimes trying" and the implied quarter of her patients who are uninterested in prevention. The notion of "trying" begins to assign capacity to patients, suggesting that to *do*, they must *want* to do and that this decision, then, is within their ability and choice.

Physicians I interviewed frequently incorporated this idea of patients' interest in maintaining dietary regimens within their discussions and spoke frequently in terms of motivation and decision-making. For example, Dr. Jin, another endocrinologist, noted that while it was helpful when patients adhered to provided recommendations, the real goal, especially with diabetic patients, was to help them get the tools to manage themselves. "So, if these patients are adhering to what is best for their health, and it turns out to be not even requiring the medications that we prescribed for them and they're taking care of their health, that, by all means, is compliance. It is just taking initiative and the steps to manage their health properly," she explained. She noted that as medical records were now open to patients, physicians had grown increasingly reluctant to label patients as non-compliant for fear of offending individuals. She too had stopped using the term for this reason. Dr. Jin explained that while the difficulties of adherence varied with each case, certain aspects remained constant:

That's where I really see my role as a counselor and advisor, instead of a paternalistic kind of relationship, you know. I'm here to give them the tools to succeed, but it's ultimately up to them. When the patient has finally decided that they want to take control of their health, they make all the changes, I'm not there, you know, taking a donut out of their hand at three in the morning. So, I would say it definitely takes time. Especially for the patients that come with very poorly controlled diabetes, it takes or at least three visits until their internal motivation sets.

Dr. Jin's comments advance Dr. Greer's statements on the interest of her patients, tying motivation even more explicitly to the ability of managing chronic disease through diet. Importantly, Dr. Jin reinforced the affective duties of care outlined by other physicians as being guiding advisors rather than an imposing or paternalistic figure. Her additional comment that she sought to provide patients the "tools to succeed" reinforces the goal of care as assisting patients

with caring for themselves and assessing their own behavior to ensure it maintains these standards.

The Necropolitics of Choice

At first glance, Dr. Jin's and Dr. Greer's sentiments return to the logic of care, which puts forth the idea that care is not only an act but also a *way* of acting. More specifically, it is to "act without seeking to control. To persist while letting go," (Mol 2008, 28). This affective performance is a way to offer space for patient autonomy. However, Dr. Jin's response also underscores the danger of reframing the logic of choice as the illusion of control. She shares, for example, that success is "ultimately up to them," speaking about patients who can seemingly "[decide] that they want to take control of their health" and "make all the changes." While the underlying sentiments may be directed at respecting autonomy, these statements assume and ascribe an inflated level of control to patients over their bodies and behavior.

Further compounding this issue is the moralization of choice. What one has control over, one can be judged for. By this, I mean that while patients are allowed to make their own decisions and believed to have control over these choices, some choices become "good," mapping positive attributes onto the patient's moral character, and others are "bad." Eating a donut "at three in the morning," for example, is Dr. Jin's example of a bad choice. Particularly when related to diet and eating, these bad choices become markers of "moral failure," since they are associated with laziness, greed, and indulgence in contrast to the soteriological virtues deemed "necessary for capitalist success: hard work and self control" (Webb 2009, 856). The clinical encounter thereby precipitates social ideals and, returning to Ferzacca's portrayal from

early in this chapter, measures “idiosyncratic cultivations of the self and the degree to which each case adheres to its obligations” (Ferzacca 2000, 35).

The dangers of overestimating patients’ control over their choices lies in the necropolitical function of these assumptions. When providers reduce successful chronic disease management to a series of willful choices, they ignore the structural landscape which unequally restricts the freedom of patients. Dr. Jin’s example of eating donuts, for example, may mask more critical recognition of food insecurity, high costs of fresh foods, and disparate access to these goods. Similarly, Dr. Cordero’s example of Latinx patients’ misconceptions regarding prescriptions may conceal acknowledgments of barriers to health literacy. These examples further make clear that it is particularly important to understand this argument in the context of the collectives I have previously discussed. When physicians interpret patients using categories with attributes believed to predict their behavior, they neglect consideration of structural violence inflicted upon that group. Specifically, when care providers fragment patients into collectives based on socioeconomic status, race, or similar categories, they may falsely assume patients’ autonomy and characteristics direct health outcomes. The economic, political, and social marginalization of these individuals, then, becomes dangerously disregarded.

As structural factors limiting patients’ capacity are ignored to frame decisions as a result of their own choices, some collectives are effectively permitted to die as their death is not only expected, but also attributed to their own behavior. This normalization of slow violence for some groups over others based on assumed collectives is compounded, as I will show, by the relocation of responsibility for care. As more of the onus is placed on patients to display a new form of self-surveilling adherence, the necropolitics of choice becomes increasingly moralized.

The Self-Surveilling Physician

In this way, the inclusion of motivation or interest in physicians' explanations of the challenges of managing chronic disease through diet reveals the way in which compliance and adherence continue to be enforced in new terms even when erased from the visible language of medicine. From my interviews, I argue that this paradigm is the result of physicians' reframing of patients as self-surveilling physicians, which regulates and moralizes patient behavior through adherent autonomy at odds with patients' practical sovereignty. The desire to construct non-paternalistic care, it appears, gives way to near self-exculpation on the part of the care provider. The burden of care is shifted from the "one-caring" to the "cared-for."

Although compliance or adherence may be linguistically denounced and these terms gradually expunged, the underlying assessment and moralization of patients' behavior remains not only incredibly relevant to clinical encounters, but also enforced in less visible ways. Primarily, this dynamic is maintained by what I will call *adherent autonomy*. My interviews revealed that physicians argue that their duty as care providers is to perform the affective and technical labors of care, both of which could be improved, in their perspectives, by the erasure of compliance from medical language to accommodate patients' right to choose. However, I also illustrate the ways in which these physicians maintained expectations of proper care-related behavior for patients.

Specifically, physicians pointed out that the management of chronic disease involves the challenges of *knowing* how to manage and *wanting* to manage, both of which were framed in ways that ostensibly sought to deprioritize the act of *managing* itself yet ultimately remain tied to sociomoral values. By this, I mean that physicians emphasized that the act of changing one's diet was difficult and attempted to elucidate this point by pointing to the complexity of understanding

food and to the nature of remaining invested in management. While these explanations tried to exculpate patients of blame for “non-compliance,” “non-adherence,” or any deviance in appropriate disease management, they often revealed that physicians still harbored beliefs about the correct or “good” choices patients should make and about reasonable struggles with components of management. In this way, patients were offered autonomy within care, yet this autonomy was qualified by the expectation of a new form of adherence, one where the patient became responsible for delivering their own care and assessing their own behavior. I suggest that physicians map moralized responsibilities onto their patients in their construction of patients as “self-surveilling physicians,” who are not only transformed from the “cared-for” into the “one-caring,” but are also expected to perform the same affective and technical labors physicians’ suggested to constitute good care.

From my interviews, many explanations offered by physicians for the challenges of dietary management pertained to patients' effective transformation into physicians themselves, required to care for themselves through a strict routine of “self-surveillance” (Pollak 2017, 198). Patients diagnosed with diabetes, for example, can frequently be expected to perform tasks such as “testing blood sugar levels, counting and limiting the grams of carbohydrates in all consumed foods and beverages, exercising, examining feet wounds, taking oral medications, and/or administering insulin injections” (Pollak 2017, 198). Not only did Dr. Iver’s comments about insulin regimens highlight this point, but Dr. Jin’s statements about self-regulation of food consumption and Dr. Greer’s note about patients’ motivation to assess their own behavior further compound this idea that patients are increasingly expected to manage themselves. Note that much like physicians suggest good care consists of affective and technical components, the care they expect patients to perform also is made of these pieces. It is important for patients not only

to *do* the visible acts of eating healthy foods, but it is also important for the patient to remain cognitively and affectively invested in this behavior. An active patient must become a self-surveilling physician who possesses the know-how and attuned desire of caring through food. While this shift in the responsibility of care is reasonably a return of autonomy to the patient who can now make decisions pertaining to their health, I argue that this *adherent* form of autonomy, while appearing to free the individual, demands simultaneously that it hold itself accountable and captive.

On the topic of compliance, Dr. Hanson, an endocrinologist, noted immediately like others that she disliked the term for its physician-centric nature and because there were so many factors that affected a patient's ability to do what was recommended of them. So, she did not use the word in her work and had strayed away from even thinking about the notion of compliance or adherence, she shared. It was more important, in her perspective, to work with patients to figure out what would be reasonable and figure out how to navigate challenges in reaching their health goals. I asked Dr. Hanson what kinds of challenges she normally encountered:

Having diabetes is hard. If you think about what we ask people to do, particularly if they're having to check their blood sugar four times a day and give themselves insulin at least four times a day, it's difficult to remember to take a medicine. I think, you know, in some respects, time is a huge challenge. People are living lives, they have work, sometimes there's childcare responsibilities, sometimes elder care responsibilities, sometimes they may not have adequate transportation to get to their appointments, or to get to the drugstore, or to get to the grocery store. So, I think those are a lot of the things that come up frequently.

Notably, Dr. Hanson situates the condition of diabetes and the requests made of patients for dietary condition at odds with all the other “responsibilities” that they are burdened with in daily life. The task of caring for oneself adds to these responsibilities. Her sentiment is similar to that

expressed by Berlant in their chapter, “Risky Bigness,” from the book *Against Health: How Health Became the New Morality*. In this piece on obesity and the symbolic meaning of eating, Berlant underscores the tiring effects overcoming the American body, driven mostly by capitalistic interests and the necessary duties of living. “The contemporary human,” they suggest,” is fatigued in the literal sense but also a metaphorical one, as in what metal ‘feels’ when it no longer can bear the stress placed on it” (Berlant 2010, 27). Berlant’s argument surrounds what political theorists term sovereignty, which is not only one’s power, but one’s *sense* of power, one’s “control over the conditions of life” (Berlant 2010, 29):

All of this juggling of actual social involvement and phantasmatic sovereignty takes place in the context of everyday lives that are maximally stressed out. This is to say that the work of getting through the day exhausts our *practical sovereignty*. We are compelled to act responsibly. That is what it means to be competent, an adult. The obesity epidemic, part of the expansion of the physical unhealth we see everywhere, is a symptom of our struggle to survive the day, the week, the month, and the life, an *as-if sovereignty* that depletes resources of compliance from us that we barely have. The stress we experience in environments that are already absorbing the best part of our energy and creativity is so enormous that we are forced to ask whether we can even *imagine* this world as a world organized for health.

From this position, it becomes easier to understand why adherent autonomy can become a problematic and demanding concept, especially if one subscribes to Berlant’s notion that under the stress of daily life, one’s practical sovereignty is continually drained. “We are compelled to act responsibly,” they write, alluding to the moral values of self-restraint, hard work, and willpower extolled in physicians’ constructions of understanding and motivation. Even if compliance and adherence are removed from medical lexicon, they therefore continue to be enforced indirectly through the patient’s transformation into their own “one-caring” who must exhibit a desire to be healthy as defined by biomedicine and must work towards this goal.

Deviance from this behavior, then, is certainly within the patient's freedom to choose yet violates the logic of care as it is constructed by physicians. I would argue that a patient who is allowed to choose yet is morally judged and graded for deservingness on the basis of this choice has not truly been returned power and has only been offered the illusion. Practical sovereignty thereby continues to be deprived through this adherent autonomy, which exists in the complicated intersection between the logics of care and choice.

“Cultural” Collectives

Thus far, I have discussed compliance, dietary management, and adherent autonomy while regarding patients largely as discrete, individual units. However, this model omits an important reality: patients, like all individuals, belong to groups. Care, too, is often delivered both linguistically and practically to collectives that are defined in various ways. This became evident in my interviews as well. Physicians frequently referred to patients in groups when describing them and, furthermore, used these collectives when describing patient behavior or the challenges of chronic disease management. Take, for example, Dr. Cordero's comments from earlier in this chapter where she referred to Latinx patients while outlining misconceptions about refilling medications. Later during our conversation, Dr. Cordero again returned to collectives when explaining discordant beliefs:

I feel like in a clinic setting it's that relationship that you get to build with patients that makes things easier. Like they trust you. And then it's just easier for them to understand or follow whatever they need to do. Because I know or, so I became aware a lot of these groups just don't have great past experiences with the medical system, or there's a lot of mistrust. Or just culture and belief that they, yeah, they believe something else will help them more than what you tell them...So in that way, I feel like in the clinic, once you develop a trusting relationship, patients will be more accepting. Sometimes it's hard to

overcome that barrier, those barriers, so sometimes we have immigrant patients in the hospital, and for example, for diabetes, they just straight refuse to change their diet. Why would I even listen to you? I mean, there is definitely a very short period of time to build trust.

The importance of Dr. Cordero's reference to "culture" in her statement is the use of this diagnostic category to explain patients' responses and behavior. The seeming choices that patients make can become attributed to the collectives to which they belong. Assumptions about these groups, then, can influence the delivery of care as physicians attempt to perform the affective and technical work that I have discussed in this chapter. For this reason, it becomes important to investigate how physicians understand and apply the notion of culture in the dietary management of chronic disease. Elucidating the way physicians work with culture in these clinical encounters allows insight into how physicians make space for autonomy and choice when they explain these decisions as originating from beyond the individual.

Diagnosing Collectives

Increasingly, theorists have recognized that culture has become one of the most prevalent vehicles used to discuss discrepant behavior, particularly in the clinical setting. For example, in *Reproducing Race*, Bridges discusses the frequent reference to patients' "culture" to explain actions seen as risky, deviant, inappropriate, and, most frequently, non-compliant. Not only does this practice problematize groups of patients, but it also allows for exoticization as well as the inaccurate and essentialist creation of imagined populations with specific and static values, ideals, behaviors, and traditions. Returning to my argument that moral assessments of patient behavior are not uniformly assessed or predicted, these critiques suggest that "culture" is a primary tool used to fragment patients into discrete populations. As I have previously discussed,

some patients, assigned real or imagined “culture” are conceived to be more likely to not *know*, *want*, or *do*. Assumptions about culture depersonalize the patient, casting them as a stereotyped member of a collective rather than as a human “self” who makes emotional and moral meaning (Kleinman and Benson 2006, 1674-76). “Once apprehended as a ‘population,’ it is the population that is acted upon,” writes Bridges (Bridges 2008, 146). Those who make up the entity become nothing more than the stuff through which the population can be touched, manipulated, and affected. The particular is dissolved in order to produce the universal” (Bridges 2008, 146). These universals spur my discussion with interviewees about their conceptions of culture in the delivery of care.

The Resistance of Normal

4

“There is perhaps a tendency to romanticize resistance, to read all forms of resistance as signs of the ineffectiveness of systems of power and of the resilience and creativity of the human spirit in its refusal to be dominated. By reading resistance in this way, we collapse distinctions between forms of resistance and foreclose certain questions about the workings of power” (Abu-Lughod 1990, 42).

A Difficult Task

“Could you define what culture means to you?” I asked.

“Oh my God. Okay. Um, I feel like I should have studied up for this,” Dr. Bell commented as she chuckled. Apologizing for being flustered, she took a moment to collect her thoughts. Then, she gingerly shared, “So maybe culture would be part of a patient's own personal history, whether it is their religious background, family background, social background, part of this patient's history that maybe contributes to how they kind of go through life and how they perceive different parts of their life?” “That's a hard question,” she remarked with a grin to cap off her answer. Frequently throughout my conversations, this question yielded a similar response. Whether they approached the question with a “That’s a great question!...Gosh,” like Dr. Engle or, like Dr. Cordero, immediately established their uncertainty in their answer with an “I don't know if it's the right definition but...,” each physician nodded without fail to the sentiment that the task of defining culture is a difficult one. In this chapter, I will explore how the ambiguity of culture allows it to be applied as an imprecise explanatory factor for patient behavior at odds with the biomedical “normal.” I argue that “cultures” become synonymous with “others,” taking on any properties that might affect the performance of care and evading acknowledgments of structural inequities.

The concept of culture is admittedly a challenging notion to pin down and is one that anthropologists have debated endlessly. One of the early definitions for culture was offered by British anthropologist, Edward B. Tylor, who, in his book *Primitive Culture*, outlined the term as “that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society” (Goldstein 1957, 1076). While Tylor’s framing inspired other formative meanings proposed by his contemporaries, no definition has been offered without debate. In his exploration of these efforts, Goldstein argues that while definitions of culture are valuable for “the didactic ends of a textbook,” they are of less practical utility to anthropological theory. For example, if “a definition is so formulated that a literal interpretation of it excludes certain cultural phenomena with which anthropology has been concerned, it is hardly reasonable to expect that the interest in such phenomena will thereby disappear. Much criticism of proposed definitions turns on precisely this point” (Goldstein 1957, 1076). In this way, efforts to narrow the scope of culture are met with resistance. It is perhaps also for this reason that Goldstein notes anthropologists frequently apply and speak about culture in their work in very different ways from the definitions they may have offered at the work’s outset. As American sociologist Albert Blumenthal put it, “Different writers deliberately use the term to indicate radically different realities and even when they seem to intend to indicate the same realities they often vary equally as much” (Blumenthal 1936, 875).

As anthropologists continually venture into fields and subfields, the number of ways to see culture only continue to expand into linguistic, cognitive, material, and other perspectives. While one can therefore fill pages dissecting the multiple conceptions of culture that have been formulated over the decades, I contend there is no value in this exercise beyond understanding the sheer breadth of views on culture. It is more important to acknowledge that this range of

definitions hints at the pervasiveness of culture in dialogue, the same ubiquity and vagueness that undermine the precision with which the term is used in daily life. “Culture is a much used and abused term,” wrote Blumenthal, underscoring the way in which culture’s constantly expanding set of framings allow its relative ambiguity to become exploited and for the term to become an explanatory excuse.

Thinking About Normal

To understand how physicians use culture to explain patient behavior and difficulties managing chronic disease, I first sought to elucidate how physicians *defined* culture. While the physicians I interviewed offered a range of definitions, several notable patterns emerged. Firstly, my interviewees framed culture as being tied to patients’ personal histories, noting that culture was something one inherited. This pattern was manifest in their references to “backgrounds” or direct descriptions of culture as something “passed from generation to generation,” as Dr. Cordero put it. Uniformly, my interlocutors also remarked that culture was determined from birth and surrounded individuals as they were raised. Culture was framed as being ubiquitous, a notion aligning with anthropological theory seeing culture as a learned, shared, and integrated concept. It was unclear how this omnipresence was achieved, however, and no physician I spoke with made explicit reference to any path of transmitting culture either. Instead, my interviewees situated culture in a space between something genetic, or automatically encoded, and something that had to be taught and learned.

Overwhelmingly, my interlocutors defined culture as thought. Culture was as a set of beliefs, a way of thinking, a lens through which individuals saw the world. However, the overlap between my interviewees' remarks did not end here.

Dr. Engles had reached out expressing interest in speaking with me after Dr. Donahue had forwarded my recruitment email to all the physicians at her practice. Much like Dr. Donahue, Dr. Engles was involved both in primary care for patients and education for internal medicine residents. Many of her patients were those she worked with for many years. Some had found her by chance since she was accepting new patients at a time when primary care physicians were sparse in the St. Louis region. Others were those who had intentionally sought and stuck with her as she was a provider with whom they felt a good fit. Dr. Engles commonly discussed nutrition with her patients who had chronic conditions like diabetes and hypertension. While she sought to emphasize the importance of diet to disease prevention with all patients, time constraints prevented these discussions from being as detailed as she would have preferred. After discussing Dr. Engles's perceptions of "compliance" as a paternalistic relic, our conversation turned to her thoughts on culture.

Remarking first that my question about her definition of culture was great, Dr. Engles took a moment to think before commenting that the notion was one that was very entrenched. "To me, let's see, culture means norms. I suppose societal norms that someone grows up with, and is accustomed to, and really relates to pretty much every area of life: food, social interactions, what is acceptable behavior, what is acceptable communication," she explained. Dr. Engles's comment that culture concerns "acceptable" standards refines framings of culture as a body of thought. Culture was not simply a way of thinking or a general set of ideas an individual possessed, but rather the specific body of beliefs that directed an individual's sense of "normal."

This portrayal of culture overlapped with those offered by many of her colleagues. When I asked Dr. Donahue for her definition of culture, for example, she explained that the term referred to “the composite of many aspects of language and dress and manners and etiquette and worldview and how people interrelate with each other.” At the end of her response, she noted that she had never actually considered how to define the term, a sentiment echoed by nearly all my interviewees. Speaking specifically about diets, Dr. Donahue underscored the value and comfort that foods offered to individuals. She explained her beliefs about the significant impact of culture on patients’ engagements with diet through the symbolic nature of food and of eating:

The very first thing you do when a baby is born, is you obviously keep them warm, and you offer them food that, you know, put the baby to the breast and wrap them up. Nice and warm. It's, it's instinctive to it's such a nurturing thing. So, throughout life, food and care and love are deeply intertwined. You know, everyone makes jokes about their grandma trying to feed them too much, and all that, but yeah, but it's true there, there is a deep intensity to being cared for by food. And we all grew up with certain foods that seem that reminds us of home or wonderful times. And it's a very deep-seated resonance with those things. And then, obviously, our tastes change over our lifetime. But there's always still some core, I think, of that familiarity of mom's home cooking, grandma's cooking, whatever, that stays with people. And even what is regarded as food in many cultures in the world, eating insects is considered normal. And actually nutritionally, they're excellent, they're high protein, they're low fat, it's actually excellent food source but if you gave an American a bug and said eat it, they might upchuck on you. Right, you know, a lizard on a stick roasted over an open fire, it's a delicacy in places and to an American, they'd be kind of yucky. So, even what we regard as being acceptable food or not, you know. Lutefisk. If you didn't grow up in a country eating lutefisk, you're probably not going to get in the room when it's opened.

Dr. Donahue’s grounding of culture within the notion of acceptable, familiar, and comfortable meals reveals insight into how culture is constructed, interpreted, and assumed. First, Dr. Donahue connected culture with food, care, and love, commenting that these ideas are “deeply intertwined” and are imbued with a “deep intensity.” These points go one step beyond

linking culture with normalcy. They suggest that normalcy, especially with food, is created out of affective investments and that these notions of what we find “acceptable” are so incredibly resonant because they are interwoven with intimate, emotional comfort. Dr. Donahue’s argument is paralleled by that of Lauren Berlant in their article “Risky Bigness.” Berlant discusses eating as self-medication, one which must be seen as “an understandable response to feeling overwhelmed, raw, a misfit” (Berlant 2010, 33). This form of care, they further argue, “is also often part of being in a community organized through promises of comfort in a generalized environment of belonging that might be personal (if one is a ‘regular’ somewhere) or anonymous (if one is merely somewhere)” (Berlant 2010, 33). In other words, eating the foods one selects creates a sense of identity and affiliation that resists the depersonalization imposed by the needs of living or, more specifically, laboring. These familiar foods of comfort may return one to the memories of “mom’s home cooking, grandma’s cooking,” or other similar intimacies of care central to one’s creation, performance, and maintenance of self. Dr. Donahue’s framing of culture thereby acknowledges and clarifies the affective position of culture in individual subjectivities.

Simultaneous to her explanation of why culturally driven notions of normalcy are so dominant and meaningful to someone identifying with that culture, Dr. Donahue pointed to the difficulty of understanding visible expressions of cultural norms as an outsider. Her examples of insects and lutefisk, for example, suggest that just as much as one can find *comfort* in certain foods, others can find *discomfort*. This is just one example of the visible dissonance between cultural perspectives and norms. These points are critical to my discussion of the challenges of reconciling discrepant perspectives and experiences. They underscore not only the process of

making meaning, but also the affective and personal investments in these intimate processes that make them so valuable to the self and so difficult to understand for the outsider.

In addition, Dr. Donahue's response reveals the way in which "culture" is constantly interpreted against a reference. This notion is furthered by an exploration of my interlocutors' creation of "cultures," or "cultural" collectives.

Culture Versus Cultures

Exploring physicians' definitions for culture as I have done so far is important to understanding how my interviewees' thought about this concept. However, it offers little insight into their daily engagement with and explanatory operationalization of the idea. To probe the way patients are organized into collectives during the delivery of care, I must begin discussing cultures, which serves a very different linguistic purpose from culture. The latter, as an abstract notion, points to the fabric of collectives, the "something" that binds individuals together to make a group. It is this intangible, then, that I have presented interviewees' definitions for, asking physicians how they perceive this impalpable, cohering substance. Pluralizing culture transforms the term entirely, grounding it in specific groups, practices, and visible performances of cultural substrate. While "culture" permits the generalization that comes with a notion possessed by all, as pointed out by my interviewees, "cultures" demands distinct categorization. Exploring these parcellations, I argue, provides critical insight into how physicians construct populations when providing care. So, within my interviews, I asked my interlocutors for examples of cultures that they worked with in their practice.

When I asked physicians about examples of cultures – so “groups” – they interacted with frequently, I immediately observed that they were much more willing to answer my question without pausing. In contrast to the time they spent thinking about their framings of culture, they commonly listed off multiple examples of cultures without hesitation. While my interviewees’ readiness to identify groups speaks to the ubiquity of the term “cultures,” the comparison to the hesitation involved with breaking down culture’s meaning was the first hint that it may be this automaticity that undermines the precision with which the term is used. My conversations repeatedly revealed that as physicians pointed to “cultures” among their patients, the biomedical perspective inspired a focus on factors that might impede the delivery of care. Specifically, these factors surrounded the perceived challenges of adherent autonomy. The trends I observed revealed how my interlocutors framed “cultures” based on a reference centering the biomedical and white hegemony, isolating factors that were different from these notions.

Otherness

Culture was a word that Dr. Greer used but whose definition she did not think about, she shared. To her, the word referred to the aggregate of peoples’ family and other backgrounds that influenced their actions. Inquiring about cultures she interacted with regularly, I learned that Dr. Greer had what she believed to be a diverse patient population:

You know, I have the typical West County affluent people or city affluent people. I have people who are religious, particularly Jewish kosher. I have a fair number of South Asian patients. I have some Hispanic patients from different Hispanic locations, or different Latin locations. We see a fair number of African American patients. I have, you know, sort of rural culture patients like rural white culture or Black culture. Urban, suburban, right? And then we have a number of people where we have interpreters, at least in the fellows’ clinic. So, we have, I don't know how many languages represented, but I mean, we have people speaking Arabic, various subcontinent dialects, Nepalese, some African

dialects, Russian, Spanish, Vietnamese, Bosnian—there's a big Bosnian population in St. Louis. We have a very broad immigrant community, actually, in St. Louis city. So, every once in a while, there's something that we haven't quite figured out or it's difficult. You know, Somali, what else have we seen lately? I don't know. So, yes, that becomes an issue.

Should I interject with other stuff? The Illinois medical license and [the university's] self-insurance malpractice program required some online training and ethics or something related. So, the one that I picked was an hour-long program on cultural sensitivity. I actually did that one and learned a number of things about folk ideas, diet ideas, and issues with interpreters and other things. Also, I'm involved in the National Lipid Association, and we have some of our dietitians and our other members give lectures on different dietary traditions at different places, say South Asia, Latin America, and some other areas. We actually have tear sheets on how to do a heart-healthy diet and some have actually been translated into Spanish. And I think the second language we went to for our translation of some of these was Hindi.

In some ways, Dr. Greer's detailed response is one that reorganizes and summates the answers provided by her colleagues. Her answer pulls on an assortment of defining features to group her patients into perceived cultural categories, making it an exemplary opening example. Most notably, her answer rather imprecisely borrows various demographic, geographic, socioeconomic, and racial terms as she frames different collectives with which she engages. This amalgamation of characteristics used to name examples of cultures was common amongst my interviewees, many of whom similarly invoked attributes that qualified as various forms of "other." By this, I mean that my physician interlocutors most frequently defined cultures based on qualities that were not white, not American, and, in cases where gender was used as a category to delineate cultures, not male. Some patients belonged to cultures that were named and others, embodying dominant and hegemonic positions, were absent from responses, as if to suggest that for these individuals, culture was not as deterministic or critical to identify. This fascinating and important pattern mirrors Bridges's work as well, in which she found that the

cultures of some patients were emphasized by physicians while other patients were “either culture-free” or spoken about in a way that suggested that “their culture does not overdetermine their eating habits and diets” (Bridges 2008, 146). This phenomenon reveals that the notion of culture, which was regarded as universal by all my interlocutors, is not uniformly salient nor equally applied when pointing to cultures. In this way, “cultures,” becomes equivalent to “others,” defining groups that are different from the biomedical, Western, and white baseline.

Linguistic Curtains and Walls

While Dr. Greer mentioned Arabic, Nepalese, and Russian language in her classification of “cultures,” she conflated these linguistic groupings with other terms. For example, she mentioned that she saw “Hispanic patients from Hispanic locations,” applying a descriptor for Spanish-speaking populations to describe geographic origins. Similarly, she pointed to “various subcontinental dialects” and “some African dialects,” both of which name expansive areas yet use a term referring to specific, concentrated, regional versions of language tied to those of a particular class or social group (Haugen 1996, 922-933). This discrepancy not only points to the linguistic compression of individuals into restrictively small groupings, but also suggests that language is not as unremarkable of a categorization tool as one might imagine. Instead, references to language can encode sentiments about social, economic, and political identities.

Dr. Donahue too referenced language in her answer:

The first, I don't know, decade or so of my career, I was a director of the resident clinic at [my former workplace] and we had a large Russian immigrant population. These are Jewish refugees from a former Soviet Union. At one point, I think 30% of our patients were Russian speaking. So, we got to know that culture well. I'm sure not well, compared to people who live there, but, you know, knew a fair amount about them [sic]. A lot of

our interpreters had been healthcare professionals in the former Soviet Union. And so, it was interesting to hear them talking about medical care and culture and life in the Soviet Union and picked up stuff from them.

To cap off her response, Dr. Donahue added, “Ya govoryoo po-rooski ochyen' malo i ochyen' ploho,” a phrase she had learned during her time working with Russian immigrants. I discovered later that the sentence translates to an acknowledgement of speaking very little Russian and having a poor grasp of the language. The frequency with which physicians invoked language when providing examples forces a reflection on why language may be an easily referable topic when creating patient clusters. The first explanation hinges on the intimate relationship between language and culture, one that has been acknowledged by anthropologists, sociologists, and linguists for years.

A textbook on the principles of teaching language, for example, writes that a “language is a part of a culture, and a culture is a part of a language: the two are intricately interwoven so that one cannot separate the two without losing the significance of either language or culture” (Brown 1994, 171). The field of linguistic anthropology, too, is based on this sentiment, the “fundamental conviction that language, conversation, and discourse have their own distinct properties and that the human significance of these semiotic properties is at least partially inaccessible to studies of society and culture that do not take language into account” (Black 2013, 273). Language is crucial to daily life and to the communication and transmission of culture; it is dynamic, symbolic, and constantly being created and recreated. The idea that language and culture are intertwined is commonly taught and discussed, allowing one to more easily make assumptions about individuals based on their language. So, it comes with little surprise that my interlocutors referenced languages when providing examples of cultures.

However, I must also note that there may be reasons for these linguistic categorizations that are more specifically related to the clinical setting.

Another explanation, more particular to my interviewees' daily interactions, may be that language is particularly relevant in clinical encounters, which rely on effective communication between the patient and physician. Firstly, in cases where the patient does not speak a language spoken by the physician, an interpreter becomes necessary as Dr. Greer mentions in her response. In these situations, the presence of an additional individual in the clinical space becomes a tangible, physical marker of language's importance. However, even in other cases, language is constantly intertwined with the delivery of care. "[E]mbodied communication," writes Black, is central to care, which is "instantiated in interpersonal encounters through the social organization of diverse semiotic resources such as gesture, facial expression, body orientation, prosody, phonology, morpho-syntax, the materiality of media artifacts, and the built environment" (Black 2018, 79). The performance of good care—that is, the visible technical and affective components of doing—demand the efficient communication of information and an empathetic way of speaking. For the purposes of my work, the fundamental point I make is that language, and communication rituals broadly, are critical to the clinical encounter as well as to the ethics and aesthetics of caretaking. This notion may explain the reliance on linguistic categories in physicians' examples of cultures.

The Place One Comes From

Several physicians who used language to categorize patients into groups or "cultures" imprecisely employed geographic terms. Dr. Greer and Dr. Donahue, like many physicians,

referenced their patients' nationalities when describing the makeup of the population they cared for. Dr. Jin, who defined culture as the backgrounds within which patients were raised, responded similarly. Speaking about "cultures," she noted that the majority of her patients "[were] American and spoke English." Others, however, she pointed out, were Spanish-speaking. Dr. Jin's answer tied being American to speaking English, equating a nationality with a linguistic category. While one might argue that a patient could speak Spanish and be American, her response does not offer this possibility. Instead, she placed the qualities of being American and English-speaking in contrast to being Spanish-speaking. This practice reinforces the idea that employing languages in grouping "cultures" may not only refer to the vocabulary one uses, but also to one's origins, social group, and citizenship. Dr. Bell was another example who advanced the use of nationality to define perceived cultural collectives. Her response offers insight into the ways cultures are discussed against a baseline, creating coded equivalency with the "other."

"Hi, Dr. Bell, how are you?" I asked, to which I was greeted by a mild buzzing. As she apologized for her neighbors' decision to mow their lawn during our conversation, Dr. Bell chuckled and looked out the bright window she was seated next to. After dispelling her concern that the background noise would be disruptive, I gave her the rundown on my project before asking about her work. Speaking about her endocrinology practice, Dr. Bell shared that her time was split between inpatient and outpatient clinics and, procedurally, between hormone affirming therapies for transgender patients² and management for patients with chronic diseases like type 2 diabetes and obesity. She had good continuity with most of these patients, she stated, seeing many of the individuals every three months unless their condition was well-controlled. With her

² Frequently throughout my work, many physicians discussed care for transgender patients. This pattern can be attributed to my sample's high number of endocrinologists, who are commonly responsible for providing hormone therapy.

diabetic patients, she held conversations about food at every visit because of the condition's relationship with diet.

Later in our conversation, I asked for Dr. Bell's thoughts about culture, to which she responded before remarking that the question was a very difficult one to answer. Agreeing with her that the question was challenging and broad, I inquired about examples of "cultures" she interacted with in her work as she concurred this exercise might help her distill her thoughts. Her patient population consisted of many Bosnian patients, she shared similarly to Dr. Greer. Repeatedly throughout our interview, she brought up this "cultural" grouping of Bosnian patients when discussing the relevance of culture. "You know, I feel like I keep going back to that [Bosnian] population, because that's what's coming to my mind right now," she shared. "I feel like those patients are very good at bringing up, 'this is our culture.' They will say, 'This is our culture, this is what we eat.' So maybe that it's just because they brought it to my attention." She expanded on her statements by explaining that with Bosnian patients, she frequently experienced struggles with dietary changes since certain aspects of food held "cultural significance." In particular, she noted that many family events and traditions cherished by Bosnian patients involved carbohydrate-rich, heavy foods and so, dietary management often looked like negotiating smaller portion sizes rather than cutting out these meals.

By speaking about Bosnian patients in the context of resistance to dietary changes, Dr. Bell's explanation returns to the earlier discussion of "culture" as an individual's conceptions of normal, familiar, and comfortable and their performance of these convictions. With all the responses I have discussed thus far, but most obviously with Dr. Bell's answer, the pertinence of "culture," in whatever terms it is framed, begins to become defined by the perceived "abnormality" of those individuals' beliefs when appraised against a "normal" of biomedical

care. By this, I mean that the culture of Bosnian patients, for example, is assigned significance in the clinical encounter primarily because their traditions and diets may occasionally be at odds with prescribed nutritional advice. Similarly, the “cultures” of patients who speak Russian or Spanish or Vietnamese are important because they influence the information that can be conveyed and the *way* it can be conveyed. So, I argue that my physician interlocutors centered their conceptions of “cultures” on *differences* from the ideal as defined from a biomedical standpoint. However, I do not have to only isolate physicians’ reliance on language or nationality to group patients in order to illustrate this paradigm. An exploration of other cultures physicians pointed to while explaining the challenges of dietary management reveal not only how cultures were constructed when thinking about resistance to, or difficulties with, *knowing*, *wanting*, or *doing*, but also how these ostensibly explanatory collectives masked discussions of critical structural factors.

“Cultures” of Mistrust

Some physicians, when asked for examples of cultures, chose to focus on local “subcultures.” Dr. Donahue, in particular, supplemented her response by referring to patients in the St. Louis region. “Well, even amongst local Americans just in this area,” she suggested, “there are different cultures. If you compare North St. Louis to West County to Jefferson County, there are very different cultures amongst those groups. Just look at uptake of COVID vaccines and different cultures around our state, right? So many, many things there, if you're talking more far-flung culture issue.” In her description, we see again that “culture” can be defined in the context of discrepant beliefs, this time pertaining to vaccine hesitancy rather than to dietary regimens. Later in our conversation, Dr. Donahue again returned to this idea, saying, “We certainly encounter patients who have different cultural views, like whether they will take a

COVID vaccine or not. And distrust of physicians and our medicines and many other more cultural than strictly medical, scientific kind of issues.” In suggesting that this distrust itself is a cultural notion, Dr. Donahue reinforces the perspective that frames culture in terms of thought as it pertains to shaping behavior. In other words, distrust here becomes the cultural thought that drives the behavior of resistance. Dr. Donahue was not alone in putting forth this conception.

In the hospital, Dr. Cordero's patient population was “mostly white or African-American,” she shared when I asked about cultures that she interacted with most frequently in her work. In the clinic, there were more Latinx patients, she shared, and, occasionally, immigrants from various African nations. In addition, Dr. Cordero noted that she was currently working with a Vietnamese patient. While explaining the makeup of her patient population, she explained that her interactions were often different between the hospital, where she provided short-term care, and the clinic, where she delivered longitudinal care:

I feel like in a clinic setting it's that relationship that you get to build with patients that makes things easier. Like they trust you. And then it's just easier for them to understand or follow whatever they need to do. Because I know or, so I became aware a lot of these groups just don't have great past experiences with the medical system, or there's a lot of mistrust. Or just culture and belief that they, yeah, they believe something else will help them more than what you tell them...So in that way, I feel like in the clinic, once you develop a trusting relationship, patients will be more accepting. Sometimes it's hard to overcome that barrier, those barriers, so sometimes we have immigrant patients in the hospital, and for example, for diabetes, they just straight refuse to change their diet. Why would I even listen to you? I mean, there is definitely a very short period of time to build trust. And sometimes you can't overcome the culture.

Dr. Cordero's account, even more than Dr. Donahue's, demonstrates the ties physicians can produce between “culture” and trust. By suggesting that culture is something to “overcome” in the delivery of high-quality care, Dr. Cordero pointed to the ways that beliefs can pose

challenges when they are incongruent with biomedicine, which itself as a body of thoughts on “ideal” care is a culture of its own. However, I argue that these conceptions evade important acknowledgments of pervasive structural determinants of distrust, resistance, and hesitancy.

A common example of distrust in medical providers begins with the infamous Tuskegee Experiments. Since the nature of this severely unethical study was revealed, along with others involving forced sterilization of Native American and Puerto Rican women, for example, public discourse has largely entertained the notion that these trials inspire distrust of providers (Jaiswal and Halkitis 2019, 80). Furthermore, and more importantly, poor healthcare outcomes too are attributed to this “cultural” distrust. Note firstly that this conception assigns racial and ethnic minorities “cultural” beliefs, conflating several different constructed categories. Secondly, this framing acknowledges historical trauma yet makes no consideration of the ongoing discrimination, racism, and prejudice that might more proximally inspire distrust of physicians and other medical providers. For example, “[s]ocial inequality drives mistrust” (Jaiswal and Halkitis 2019, 80). History may influence mistrust, but the present sustains it. My point here is that in constructing “cultures” of mistrust, physicians miss an opportunity to recognize and address ongoing economic marginalization, social discrimination, and political disenfranchisement. Framing hesitancy and resistance as “cultural” beliefs exculpates oppressive powers and instead suggests distrust is a generationally transmitted norm. Several other terms used to discuss “cultures” achieve this same illusion of mistrust as normalcy without responding to the underlying structural inequities. A prominent example was physicians’ references to wealth and poverty.

The Rich and the Poor

Culture, to Ms. Foster, was the way people were brought up and the environment that they lived in, whether that concerned food, clothing, attitude, or religion. Culture was an individual's outlook on life and the first thing that they used to help make an impression of something. Having only recently started working at a West County practice, she had started to engage more frequently with "transgender and queer culture," she disclosed. She had almost never encountered these "cultures" when she previously worked in the city and felt that this difference was because urban patients "didn't have the time to think about [their] gender identity" and similar topics. Pausing here, she remarked that she had more thoughts on this matter but did not wish for these to be recorded in our interview. Moving on, she noted that in the city, she had seen a group she did not interact with as much anymore:

It was a lot of poor African Americans who just did not have any sort of...not a good upbringing, but just the education to really make progress in work or something to help give them more money to get them to where they needed to be. They just seemed that they were happy. They're all very happy with what they have. But just to me as someone coming from a place of privilege, it's hard for me to really mesh with that. And with the culture out here, it's just a 180-degree difference.

Note that Ms. Foster used the term education, returning to the coded, racialized language discussed in previous chapters as a way of defining one's capacity to *know* in more acceptable terms. Importantly, in her response, she connected "cultures" with socioeconomic standing, poverty, and a racial group. In fact, Ms. Foster was not the only respondent to mention wealth, or lack thereof, in their discussions of patient collectives. Frequently, interviewees would add financial descriptors like "rich" or "poor" to the categories into which they placed their patients. Returning to Dr. Greer, for example, she immediately opened her response with a reference to these groupings. "You know, I have the typical West County affluent people or city affluent

people,” she stated. Similarly, Dr. Engles noted that most of the patients in her West County practice came from middle to high socioeconomic backgrounds.

Here, one must ask what aspects of wealth and poverty lend themselves to incorporation into physicians framing of “culture,” especially as it pertains to the offered definition of culture as beliefs on normalcy. Dr. Ash’s response presents one possible explanation. During our conversation, she shared that “we have to understand the culture of a lot of these patients also have lower socioeconomic status [sic]. They don’t have, necessarily, access to certain types of foods.” By connecting “culture” first to low socioeconomic status and this status then to limitations on food access, Dr. Ash reinforces the notion that “culture” encompasses the parameters of “normal,” which in this case is represented by a patient’s usual diet. The state of normalcy here, food insecurity, acts as a constraint on healthy living, which is to say that this framing of “culture” suggests that it imposes a restriction on patients’ adherent autonomy. In this pattern I witnessed repeated throughout my interviews, both “culture” and “cultures” subsumed any factor that might influence the performance of the affective and technical components of biomedical care.

Forcing Collectives

I argue that the ambiguity of “culture” coupled with the constraints of patient visits enable physicians to conflate the notion with the variety of other characteristics I have previously discussed. These factors, I suggest, are those that are most immediately salient in clinical encounters. In a 2013 study, anthropologist Linda Hunt asked physicians whether they could tell her “how [they] know someone’s racial or ethnic group,” finding that “[i]n sharp contrast to the

confident tone in which most had asserted that race is important, this simple question was most often met with a nervous laugh, a long pause, or a comment like ‘That’s a good question!’” (Hunt 2013, 259). When I asked my interviewees towards the end of the interview how they identified the cultural group to which a patient belonged, I observed a very similar phenomenon.

“When you're with a patient, how do you try to figure out the culture or the cultures that they are a part of?” I asked during my conversation with Dr. Ash. Here, she shared that she asked patients about the food that they ate. She found that patients were frequently vague initially, causing her to often have to “pull it out of them” through a more specific line of questioning. “But also you have to try and understand where they're coming from,” she stated, presenting her efforts to understand a patient’s standpoint:

And then I also ask them, "What is their social support at home?" Okay, because if they live alone, it's going to be very different than if they have a significant other with them or whatnot. If they've had a friend or a family member that underwent weight loss surgery, so then they understand the aspects of that. So, kind of those different social perspectives.

Dr. Ash effectively equated “culture” to what she termed “social perspective,” a notion tied to a patient’s home environment, familial relations, and, ultimately, the components of *knowing* and *wanting* that comprised many of my interviewee’s constructions of adherent autonomy. More importantly, Dr. Ash suggested that she employed various proxies for “culture” and “cultures” in the clinical encounter. By this, I mean that Dr. Ash sought to understand and classify patients’ “cultures” or groups based on their social perspectives, familial support, and personal histories, all of which are salient due to their function as barriers to the patient’s functioning as a self-surveilling physician. Dr. Ash was not alone in using similar tools to diagnose patients’ “cultures.”

Some physicians, like Dr. Jin, relied less on questions directed at patients and instead used other demographic information:

I guess in my limited knowledge of that it's more or less just their country of origin. Or, you know, because I'm an immigrant as well, that's the main thing that drives my view. But, I suppose even for people who grow up in this country or consider themselves American, there could be a lot of cultural differences that I don't necessarily think about.

While Dr. Jin employed her own background to identify patients' "cultures," she conceded that there was a breadth of perspectives she did not consider by limiting herself to a singular characteristic used to create collectives. Note that Dr. Bell too used patients' nationalities to create collectives, like the Bosnian patients she referenced, because their diet was different from biomedical recommendations.

My point in displaying these responses is to suggest that the physicians I interviewed identified patients' "cultures" in different ways, using varied markers and proxies to categorize individuals. "Cultures," then, became constructed in many forms within the clinical space although their unifying feature was the salience of these diagnostic characteristics to adherent autonomy. Regardless of the way "cultures" were identified in the clinical space, they were made relevant by their connections to, and barriers posed to, the achievement of successful dietary management of chronic disease. "Cultures" thereby became interpreted in much the same way they were verbalized. Wealth, social standing, family support, education, ethnicity, and race all became stand-ins for culture in the clinical encounter. This paradigm, I suggest, elucidates a primary issue with "cultural competence." In acting as a "rule of thumb" that posits culture is valuable to each and every clinical encounter, the notion not only permits, but also encourages, the use of "culture" to explain any patient behavior that challenges the new form of compliance.

Grasping “Culture” as Abrasion

My physician interviewees’ framing of “culture” as beliefs on normalcy lends itself to an excessive focus on resistance. Through defining culture as what an individual believes is appropriate, my interlocutors suggested also that “culture” directs how an individual performs these convictions, or acts to remain in concert with their beliefs on normalcy. This argument is not limited to physicians’ answers to my question about their definition of culture. It extends to their casual use of the term throughout our conversations to explain patient deviance. While talking to Dr. Ash, for example, I received a response from her in which she discussed “culture’s” behavioral implications for weight loss:

So, when I talk to patients, I tell them that my surgery is literally just a snapshot in time. You know, and when I do the surgery, the next day, I'm done. Now it's up to you. And it's true, like, I don't go home with you. I don't watch, you know, those sorts of things. So that culture and that home that you live in is so important. Understanding, like, you know, if you're in a home where everyone else is eating fast food, and you're expected to eat a healthy diet, and you've eaten fast food all your life, that's going to be very hard to maintain. Or if you make certain foods for your kids, and you don't alter their lifestyle, that's going to be very hard. So, I think that because it is so behavioral related, is why it's so important, because it's so much more than just the surgery.

In Dr. Ash’s response, the salience of “culture” in the clinical encounter came directly from its impact on resistance to adherence or, more specifically, to the action component of following the dietary regimen necessary for weight loss. This is not the only response in which “culture” was suggested to underlie deviant behavior. Dr. Jin’s answers emphasized the way in which cultural competence promoted the use of “culture” to explain behavior at odds with the biomedical optimum.

At one point, my conversation with Dr. Jin meandered to the topic of cultural competence. To her, cultural competence was about understanding how the way patients were raised might affect their beliefs about medical treatment or the whole medical system. This was a skill that physicians were not well-trained in, she shared. As a result, “it’s very hard for us to understand why patients may not comply to a treatment because we don’t understand at all what kind of beliefs they have,” she commented. She explained that she did not feel as though medical education did a good job of teaching cultural competence despite the recent emphasis on shared decision-making. It was important to improve this gap because “it can be important if a patient’s set of beliefs are extremely different, and we just cannot understand why they do not take their medicine.

Dr. Jin’s response further reinforces the idea that culture is made salient in clinical encounters by the resistive abrasion of normalcy with the biomedical ideal through the conditionality of her final statement: cultural competence is important *if* the patient’s beliefs were different and patients were struggling with adherence. By directly tying cultural competence to improving patient adherence, she suggests that the path towards “good care” or successful management of chronic disease must involve understanding “culturally” transmitted beliefs. In much the same way that other physician interviewees discussed “cultural” distrust of the medical system, Dr. Jin divorces these beliefs from their specific instigation, from experiences that might have inspired their creation, or from historical systemic prejudice and instead ascribes them to the more generalized way that “patients were raised.” In addition, Dr. Jin suggested that challenges with dietary management of chronic conditions could always be explained by these “cultural” beliefs. This brings me to another fundamental critique of cultural competence. In emphasizing, or even *overemphasizing*, the role of culture in clinical encounters,

the notion propagates the false belief that culture *must* permeate each decision, challenge, and behavior.

Necropolitical Veils

The dangers of believing that “culture” must explain every patient behavior, particularly behavior at odds with adherent autonomy, lies in its ignorance of structural factors that may limit patients’ capacity. In a 2006 article, medical anthropologists Arthur Kleinman and Peter Benson argue that cultural competence unwittingly flattens, problematizes, and implicates culture. Culture is –in their eyes –a term eluding definition due to its incredibly dynamic nature. Consequently, the ostensible ability of medical education programs to “teach” physicians about culture in some easily packageable form appears ludicrous. In fact, Kleinman and Benson go so far as to argue that culture, when reduced in this way, can have dangerous effects. For example, they suggest that the attribution of all deviant patient behavior to “radically different cultural understanding” can conceal contributing factors like low income, time restrictions, and irregular transportation (Kleinman and Benson 2006, 1673). This assessment is very similar to responses observed in my own work, where physicians commonly used “culture” and beliefs to rationalize patients’ inability to *know*, *want*, or *do*.

Cultural competence enables physicians to scapegoat “culture” during matters of patient compliance or adherence. By reinforcing the nearly automatic assumption that “culture” must be identified and must play a role in patient-physician interactions, competence allows “culture” and “cultures” to inaccurately represent patients’ engagement with illness. Primarily, beliefs and behaviors with concealed structural roots are employed to imprecisely designate patients into

“cultural” groups. The binding characteristics of these collectives—whether language, poverty, or race—are centered in explanations of “culture’s” role in making chronic disease management more difficult. Competence thereby acts as a necropolitical veil, creating imagined and assumed collectives seemingly bound by “culture.” This excessive focus on ostensible “cultural” resistance exculpates the structures that reliably discriminate based on these same factors. Therefore, discrepant outcomes, and the march towards death itself, become shrouded in the language of choice. An especially pernicious facet of this paradigm is the conflation of culture with race.

Racial Threads in “Cultural” Fabrics

When speaking about examples of patient groups or “cultures,” physicians used various terms to highlight qualities that might affect or impede care. As I have illustrated, these groupings were constructed by comparing their identities and perceived beliefs against ideals of Western biomedicine. In this way, “cultures” became synonymous with “others,” representing collective and individual subjectivities different from the dominant perspective. Not only does this othering problematize and exoticize groups, but it also offers little acknowledgment of the structural basis for what are ostensibly “cultural” norms.

Throughout discussions of language, nationality, distrust, and poverty, a critical thread persisted: race. Whether physicians were speaking about one’s country of origin, level of education, or belief in medical providers, my interviewees incorporated language intertwined with racial groups. The frequent conflation of culture with race, which Bridges aptly refers to as the new “culture-qua-race” is worth exploring in more detail (Bridges 2008, 120).

The Color of Concrete

5

The age of empire is over; apartheid and Jim Crow have been ended; and a significant consensus exists among scientists (natural and social), and humanists as well, that the concept of race lacks an objective basis. Yet the concept persists, as idea, as practice, as identity, and as social structure. Racism perseveres in these same ways (Winant 2006, 987).

The Latency of Race

In each of my interviews, my interlocutor referred to at least one racial group when asked to describe the cultures they interacted with frequently in their patient population. In Dr. Ash's interview, for example, she responded with several mentions of Black patients, a group focused on by most other physicians as well:

So, I would say about 80...Well, so I think first of all, and this is kind of nationally, about 80% of patients who come into clinic for bariatric surgery are women okay? I would say probably about 20 to 25% of patients are African American. I would say for us, I think this is just being in the Midwest—I think it's different if let's say you're on Florida, or you're in Texas—we do not see a large proportion of Hispanic patients. But again, I think that's just regional, okay? And so, you know, I think also the Hispanic population due to cultural things, and as well as African Americans are less likely to seek out bariatric surgery. They don't see it as something that would be helpful. It's just the culture that is seen is interesting.

Dr. Ash not only responded to a question about culture with references to racial groups, but also explicitly tied a culture of mistrust, as we saw other interviewees outline in the previous chapter, to African-American patients. Culture here not only became explanatory for patient behavior that was incongruent with the delivery of good biomedical care, but it also became connected with race. The entire racial group of African-American patients is suggested to possess the same

culture, which, recall from my previous discussions, interviewees argued was one's set of beliefs on "normal." This conflated concept of "culture-qua-race," I contend, is a new form of racism.

While one can argue that some of the most heinous colonial manifestations of racism have long been undone, it is impossible to reasonably suggest that the erasure of these visible instances has also dismantled the architecture which enabled their creation. Racism persists in daily microaggressions, larger acts of direct violence, and the perseveration of race as a legitimized system of thought and classification. The language of race remains ever-present, existing just below the surface as a latent force "ready to spring into action" through coded terminology (Amin 2010, 1). In this chapter, I argue that my physician interviewees' frequent conflation of culture with race reveals a disguised form of racism whereby race, as an othering force, remains valid and flourishing in more acceptable ways. I explore discourse on race as a biopolitical tool of preserving power in order to underscore its resilience in dialogue and thought. Ultimately, I contend that culture-qua-race is an especially pernicious necropolitical tool because it allows one to divorce beliefs and behaviors from their origins in structural violence and instead speak about them in terms of the logic of choice.

Same, But Different

Clinically, Dr. Hanson was an endocrinologist and her research work focused on diabetes prevention among women who were at risk for gestational diabetes. Some of her work had been defining screening rates for women, particularly in federally qualified health centers where women were at risk or loss to follow up because of frustrations with insurance. In addition, Dr.

Hanson noted that much like her colleague, Dr. Williams, she worked in the transgender center doing gender-affirming hormone therapy and coordinating care for those patients.

Dr. Hanson frequently discussed food with patients although she remarked that in the context of a short office visit, it was often challenging to spend significant time providing dietary counseling. Instead of telling the patient what they should eat, she aimed to understand what patients were eating, what their common breakfast, lunch, dinner, and snack foods were, and what they were drinking. While her knowledge on nutrition counseling was something she had picked up rather than learned, she felt that educational emphases had somewhat changed since her medical training and noted that she had seen curriculum at her medical school revamped with a focus on social determinants of health and topics beyond medicine and medicines. “But I never have as much time as I feel like I need to really [counsel patients] in a thorough manner,” Dr. Hanson lamented before explaining that in situations where patients more challenging issues, she would refer them to dietitians with more dedicated time. Most diabetic patients ended up seeing a dietitian although one of the challenges that they encountered for expanding this service was that reimbursement had not been supported for people without diabetes and another was a lack of enough dieticians to match the demand. Dr. Hanson noted that there were programs now through the YMCA and the National Diabetes Prevention Program that were leading diabetes prevention initiatives.

When we discussed Dr. Hanson’s impressions of culture, she answered that the term referred to the constellation of a person's background, their family traditions, their ethnicity, and things that were important to them in their life. In response to my question about cultures that she interacted with frequently in her work, Dr. Hanson noted that she had several patients of Middle Eastern descent. She also had a lot of African American patients and Caucasian patients as well

as a few of Indian descent. “The vast majority, though,” she explained “are white or Caucasian,” and, after a pause, added “which obviously can vary in terms of their cultural background.”

Towards the end of our conversation, I once again brought up the topic of culture, this time hoping to discuss the similarity or difference between race and culture in Dr. Hanson’s eyes. She replied introspectively:

Oh, that's a really good question. I think they're different. Right? You can have people who are white who come from different European cultures. You can have people who are Black who come from different cultures and have different ethnic backgrounds and different experiences. So, I wouldn't equate them. You know, just thinking back to you asking about the cultures that my patients come from, I'm recognizing I generalized in many ways that I probably shouldn't. I wouldn't say that they are the same. I think it's important to recognize some of those differences.

Dr. Hanson’s responses reflect the ease of equating “cultures” with racial categories, a certain quickness mirrored by nearly all of my interviewees. Asking about cultures frequently led to answers filled with races like “white,” “Black,” and “Asian.” However, the moment I asked about race versus culture, my interlocutors insisted, like Dr. Hanson, that the terms referred to entirely different concepts. While Dr. Hanson recognized that in her discussion of cultures she had conflated the notion with racial categories, this acknowledgment only came when I directly asked her about race and culture. Most physicians, in fact, who had named races did not demonstrate this retrospective critique of their answer even when they asserted firmly that race and culture were distinct. What properties allow this phenomenon of dissonance? I argue that investigating this question of why race and culture can be emphasized as theoretically different yet applied in nearly equivalent ways in practice is valuable to understanding the maintenance of new racism. To begin, I examine how my interviewees constructed and argued race in contrast to culture.

The “Genetics” of Race

As I have explained at the beginning of this chapter, Dr. Ash was one of the many physicians I spoke with who presented racial groups when asked for “cultures.” Interestingly however, in stark contrast to this conflation, Dr. Ash created a firm distinction between the notions of race and culture when I inquired her directly on the matter towards the end of our conversation. Did she feel the two concepts were similar or different, I asked. Dr. Ash offered the following response:

Race is something that, in a way, it’s genetic. Like you are born a certain race, you can't change that when you walk out the door, you can't hide that, you know. And no matter what behavior that is, it is what it is. Culture, you can change, right? So, you can change perspectives on how you see someone of a certain race, or you see someone of a certain ethnicity. And culture is really our human behaviors, but also our thought processes or our own biases, our own preconceived notions about people. That's what culture is.

Several key properties were offered by Dr. Ash to explain the difference she perceived between race and culture, beginning with their mutability. While race was suggested as being genetically determined, culture was seemingly less decided and more deeply within an individual’s control. “When you walk out the door,” Dr. Ash said, the fixed nature of race meant one could not alter the racial category to which they belonged and had belonged to since birth. Their culture, on the other hand, equivalent to perspectives, thoughts, and, importantly, the behaviors inspired by these beliefs, could be changed voluntarily. This portrayal of race with biological undertones was evident in several other interviews as well.

When our conversation turned to culture, Dr. Iver defined the term as one encapsulating personal beliefs and one’s way of life based on one’s country or region of origin. Asked about

cultures she interacted with frequently, she responded that she had a large group of African-American patients, fewer Hispanic patients than she had seen in Chicago, and fewer Bosnian individuals than were at the previous university where she had worked. Other than these groups, it was “mostly white people or Black people,” she shared. At the end of our interview, however, when our final topic of discussion dealt with the difference or similarity between race and culture, Dr. Iver responded that she felt race, culture, and ethnicity were all disparate concepts. “I don’t even know what race really means,” she repeated twice. Pondering out loud, she explained that she recognized the biological conceptions of race but was unsure about these notions due to her belief that if someone were to perform genetic comparison between, say, her and an individual from North County, they would find that there was little difference. When I asked whether she applied race or culture more, then, in her own work, she took a moment to think. “That’s a good question,” she said. “When it comes to medicine, we typically have been trained to apply race more, even though that may not be correct, because that’s historically what’s been done. So, the data surround that when you look at diagnoses and epidemiology and things like that.” Dr. Iver’s response underscores an important point: race has historically been incorporated into the delivery of biomedical care. The continuing incorporation of race in biomedicine reifies this constructed system of classification.

Biomedical Reification of Race

The connection between biology and race is one repeatedly debunked throughout history and yet one that has been sustained in public thought. American sociologist, Troy Duster, argues in one of his articles that the seemingly biological nature of race is preserved by the fallacy of misplaced concreteness, where an abstract notion is made to seem more real. He points, for

example, to genetic studies underlying trials for a drug known as BiDil, marketed as the first medication for hypertension specifically for African American patients (Duster 2005, 1050). The basis for many genetic studies, he underscores, is the selection of individuals from various geographic regions, populations who are picked for “their convenience and accessibility” and “subtly portrayed as representing racially categorized populations” (Duster 2005, 1050-51). Since genetic differences are found between any two human groups, even between randomly selected ones, the specific overlap of these groups with races allows studies to falsely link genetics with race. Jada Benn Torres, a genetic anthropologist, notes that the interest in performing these types of studies and the consequent “operationalization of race in biomedicine persists, in part, due to a changing disease paradigm in which common diseases are the result of rare genetic variants” (Benn Torres 2019, 38). In this way, biomedicine continues to reify race, giving weight and structure to a constructed notion that is otherwise an arbitrarily devised pattern.

The effectiveness of biomedicine at performing this process of legitimization that permits the easy “slippage between race as innate and race as social,” depends on its hegemonic position (Whitmarsh 2009, 286). Scientific positivism, which “positions objects of study as readily observable” and furthermore “presupposes that scientific knowledge is objective, value-free, and capable of generating universal explanations of ‘reality,’” reinforces biomedicine’s standing (Pollock et al. 2021, 3). The creation of biomedical knowledge becomes a process of creating seemingly impartial truth, imbuing it with an incredible sense of biopolitical power that can be, and repeatedly has been, exploited in the cases of eugenic thought and unethical medical experimentation like the previously discussed Tuskegee Syphilis Experiments, to name just a few examples (Rouse 2021, 364). Even today, race is still included as a factor in clinical

algorithms meant to diagnose patients, suggesting that reification is not only “historically what's been done” in biomedicine, as Dr. Iver pointed out, but also remains a continuing pattern.

Recently, for example, much controversy has emerged over the persistent use of race in clinical equations that calculate estimated glomerular filtration rates (eGFRs), which is used to determine the “[administration] and dosing of medications, [consider] kidney donation and research study participation for new therapies,” and influence “referral to kidney specialists” (Powe 2020, 737).

In this way, biomedicine not only generates ostensible truth, but it also applies this knowledge through the necropolitical dynamics of care. By this, I mean that biomedical care begins to apply both its affective and technical components unequally to individuals, allowing the standards of good care to be discriminately applied (Sandset 2021, 1413). This violence of how race is created and interpreted in the biomedical sphere serves to highlight exactly why the creation of culture-qua-race becomes such a problematic conflation.

The Potency of Culture-Qua-Race

Culture-qua-race is not only a new form of racism but is also an especially efficient tool used to maintain structures of power. It allows convenient ignorance of the structural violence that fractures populations into portions allowed to live and portions subjected to slow death inside and outside of clinical spaces. In other words, culture-qua-race not only allows some to die, it also reassigns blame for this sinister necropolitical dynamic even more than other factors used to create “cultural” groupings.

As Bridges points out in *Reproducing Race*, “commentators relate the higher morbidity and mortality of Black people to African-Americans’ (indelibly cultural) fear of the medical

establishment (in the wake of the Tuskegee syphilis study) or Black people's eating habits (common to an entire "culture" and impossible to change)" (Bridges 2008, 135). Evident in my interviews as well, physicians commonly attributed distrust of providers to the "culture" and beliefs of racial groups. These conflation assign uniform thoughts and behaviors to an incredibly large group of individuals, assuming and attempting to predict deviance. This practice exculpates failings of the medical system as well as the pervasiveness of anti-Blackness. Simultaneously, its distracts from dismantling the true structural roots of health outcomes among Black patients through a particularly potent necropolitical veil.

"Culture," a dynamic concept with an air of electability, as Dr. Ash suggested, is used as a stand-in for the static and quasi-biological grouping of race. From an anthropological perspective, culture and race began situated as opposites, yet over time, "[c]ulture became everything race was not, and race was seen to be what culture was not: given, unchangeable, biology" (Visweswaran 1998, 72). In this way, race became essentialist in both definition and application, particularly in the clinical setting. The fundamental danger of culture-qua-race is that it permits race and culture to theoretically maintain these distinct, essential properties yet to be applied in equivalent ways.

When physicians name racial groups, they invoke a biomedically reified, seemingly objective category, which, as I have discussed, is continually acted upon by structural forces. However, in speaking about these races in terms of "culture," one can exclude structures of power from discussion and suggest that the less-than-optimal care delivered to some patients is a result of their own beliefs. Culture-qua-race is thereby harmfully pathologized and employed to explain and even falsely predict patients' behavior. The practice enables the *illusion* of good care, which is upheld by respect for patient autonomy, without acknowledging that the logic of

choice here is perverted by the historical, and continued, oppression of racial groups. Cultural competence, then, only deepens this dynamic, offering yet another linguistic and practical curtain to disguise this pseudocare.

Personal Biases

As I have discussed thus far, every single one of my interviewees presented racial categories when asked for examples of cultures yet also explained race and culture as being very distinct concepts. While some alluded to the biological reification of race, others acknowledged that race was entirely a socially-constructed system of categorization. This latter set of individuals, I found, also presented explanations for how they combatted racism in their daily work as part of their dedication to “cultural competence.” Investigating these responses allows an understanding of the rhetoric used to discuss the confrontation of prejudice in clinical encounters. This exploration is especially valuable to the distinction between personal and institutional or systemic responsibilities.

One of the last questions I posed to Dr. Engles during our conversation focused on the difference, or lack thereof, between race and culture. She thought about the terms separately, she shared, and while there certainly could be a link between the two, one could not assume a connection:

Rithvik: Could you offer a definition of race? How you see it?

Dr. Engles: Oh, you're asking hard questions. You know, I think race is a social construct. And it is built on how people are perceived by others, obviously, completely separate from any biologic, genetic, etc [sic]. All of that has nothing to do with this. But it's obviously hugely important because of racism, and the structural inequalities that that causes and perpetuates.

Rithvik: Got it. And in your own work, do you see yourself applying culture more or race more when you're talking to patients about food, but also in general?

Dr. Engles: Hm, that's a really interesting question. I ask about culture. I don't typically ask about race, although for my own self, you know, I have biases. We all have biases. And so, I work to mitigate that as best I can. I actually am pretty conscious about my perceptions and if I perceive race, right, because it is totally socially made up.

Dr. Greer too offered a similar non-genetic, social-construction-based explanation for the terms when speaking about her work with cultural competence:

Yeah, the problem with race is that it is not a biological term, and it is a sociocultural—and currently political—term. And so, particularly with my African American patients, I'm particularly careful to see where they're coming from. But I'm mostly interested in the standpoint of what their cultural milieu is, in terms of what they can do, and what their beliefs are with regard to health care, medicine, food, exercise, and what's available, what's feasible, what's not feasible. And then also, as part of what I've gotten into lately, in the last year, given all the stuff that's going on in the medical school, and the Department of Medicine and divisions in terms of diversity, equity, inclusion, and race theory, and other things, and my reading and the things I've done, the seminars, you know, trying to be empathetic with regard to people who have a significant stress level. And actually being aware of the stress level, and then trying to be educated with regard to things like micro aggressions, and other stuff, both with patients and with staff and faculty, residents, fellows, etc. It comes up, because we do have a wide population from a wide variety of backgrounds. And I mean, I have had one time with a fellow who just said this patient I just saw, you know, was really racist. And I said, you want to talk about it, you want me to address it? What do you want me to do? They said, "I don't want to talk about it. Let's just drop it." But you know, it can be a rather difficult situation.

In both cases, Dr. Engles and Dr. Greer made clear that while race is a socially-created system of grouping, it is still an important concept with recognizable effects. In particular, they pointed to racism, each in their own way. While Dr. Engles stated that racism and personal biases can perpetuate structural inequities, Dr. Greer pointed more specifically to limits on patients' capacity and stress levels as a result of microaggressions. Without being prompted, both

also offered the strategies they themselves were using to address unequal treatment on the basis of race although neither highlighted any underlying instigators of the biases, microaggressions, and discriminatory behaviors they sought to confront. Increasingly, the rhetoric of improving medical care places the onus for addressing inequities on individual providers despite the institutional and systemic roots of these issues.

Individualized Dismantling

The ability for cultural competence to obscure institutional and systemic violence is bolstered by the shift in focus to individual providers' biases. Cultural competence promotes much self-reflection and confrontation of personal prejudice. While these practices are valuable and necessary, addressing bias at the individual level is insufficient to apprehend the systemic roots of these beliefs. While speaking with Dr. Hanson, for example, I asked her what cultural competence meant. To her, the concept referred to the practice of making sure that she did not make assumptions about patients and that she recognized her own potential for bias.

Operationally, this looked like starting with open-ended questions and thinking about what was important to the person in front of her. While this skill was not emphasized early on in her education, she had noticed a growing focus through lectures, seminars, and trainings. Most of her exposure to cultural competency training had occurred during her residency in Chicago.

As part of this training, they had done a month-long set of LGBTQ seminars with people from the community coming in and talking about their experiences trying to obtain health care. In addition, they had covered homeless medicine and passed out clean needles to people for drug addictions. More recently she had participated in a bias reduction in internal medicine training at

her present workplace that focused on ways to recognize personal biases and to interrupt that bias in clinical encounters. “Do you feel that these trainings achieved their goal?” I asked. No, the process was a continual one, Dr. Hanson answered. In her perspective, one should never say that they had “achieved” cultural competence as you could always learn more and correct your mistakes. The skill was important to rapport building and, without it, creating the patient-doctor relationship was very difficult.

Dr. Hanson’s answer emphasized the focus cultural competency education placed on apprehending personal perceptions and correcting these biases, much like Dr. Engles and Dr. Greer had suggested. This practice is extremely valuable, and I do not mean to detract from its importance when I critique competence. In *Reproducing Race*, for instance, Bridges explores the stereotypes physicians employ in their interactions with patients, finding that doctors commonly use the generic or oversimplified descriptor we have been exploring thus far, “culture,” to explain patient behavior. Referencing Hoberman, she writes that “there is nothing intrinsic about medicine or medical training that should counsel us to believe physicians, as a class, are free from ‘deep-seated attitudinal biases that parallel those of the general public and the media and [could] confuse [their] best clinical intentions’” (Bridges 2008, 111).

Despite the pervasive reluctance to acknowledge physician fallibility, accepting that physicians are privy to the same biases as non-physicians is an important acknowledgment and improves the therapeutic relationship, as Dr. Hanson pointed out. Simultaneously, however, I suggest that competence deals only superficially with these false prejudices, centering them on individual beliefs and not on their systemic roots which too must be considered if competence is to truly achieve equity. Competence thereby functions as a “happy” semiotic of pseudocare

satisfied with the *illusion* of confronting imbalances of power without a real commitment to this practice.

Happy Language

My question about the meaning of cultural competence stumped Dr. Bell. She commented again on the difficulty of all the questions and replied that she did not have a good definition for the phrase. Hoping to pick an easier query, I asked instead whether she found cultural competence important and whether the institutions she was a part of seemed to emphasize the skill. She pointed to the recent establishment of a Diversity and Inclusion committee in the Endocrinology Department as an example of the growing push to make individuals aware of “different aspects that we should be more sensitive to” and to identify potential biases. In addition to lectures and presentations, departmental initiatives to promote cultural competence included surveys, subgroups, and group sessions.

Dr. Bell was not the only physician to mention “diversity” and “inclusion” in their discussions of cultural competence. The phrases were commonly interspersed in conversations about both training and application of the skill. When I asked about cultural competence, Dr. Greer first shared another anecdote about her own cultural “incompetence” to explain her perspective:

Years and years ago, I made the mistake, I think, of telling a young kid, like a five-year old—because five-year olds will tell everybody what to do—that they should maybe guilt trip or encourage their grandparent or parent to do something. And that that did not go over well, because it was cultural. It was a family and a culture where kids are not supposed to tell any of their elders what to do. Whereas a lot of the five-year olds I know...

Based on her experiences, Dr. Greer believed that cultural competence was valuable to clinical care because it served as an important step in establishing trust and therapeutic relationships. Being willing to ask questions to make sure that information was being understood when translators were in use and inquiring about patients' thoughts and feelings were important to ensuring that people knew they were being heard and understood. She then mentioned that the departments and divisions she was a part of seemed to be placing greater focus on diversity. I asked what this heightened awareness looked like. Dr. Greer was the lead for a recent set of workshops, she explained, for a departmental program aimed at bias reduction in internal medicine. There had been some lectures and several breakout rooms in a virtual environment.

Here, Dr. Greer shared that she was going on vacation next week and that "the whole thing...It's been extremely wearing over the last year. And the whole race thing and the whole pandemic thing have pretty much come together." She had little notes posted all over her office with takeaways and reminders, she said, as she looked and pointed to several lightly colored sheets stuck in assorted locations. Pulling one off the wall next to her computer screen, she read out, "Diversity is a fact, inclusion is an act," remarking that she periodically wrote similar messages down. This entire process was work in progress, Dr. Greer explained. It was a matter of continuously striving to do better and the more people who were aware of the issues, were thinking about these problems, and were actually trying to do something, the more momentum would be generated. It was similar to the challenges women had faced in a variety of fields, she added. Progress had moved at glacial speed but ultimately things were gradually getting better.

In some ways, diversity and cultural competence are similar notions. No response better exemplifies this parallel than the one provided by Dr. Donahue. She explained first that cultural competence was about understanding patients' cultures and worldviews. While a portion of this

skill involved factual knowledge about lifestyle and background, most of it involved asking respectful questions about patients' views on various topics. Dr. Donahue had been the only interviewee thus far to note that cultural competence was a term with vacillating popularity. So, wanting to explore this sentiment, I asked what terms or programs were being introduced as replacements:

Dr. Donahue: It's kind of constantly changing from year to year, whether they call it diversity, equity inclusion, or different little catchphrases of things. In my course, in the last year, the powers that be focused on more of an anti-racism curriculum than a cultural competence curriculum. So it's kind of constantly fluctuating.

Rithvik: Okay. And do you know why that kind of fluctuation exists?

Dr. Donahue: Various social and political pressures I'm sure. And just and what's going on, in the times, obviously, the last couple of years, the huge themes nationwide have been COVID and social injustice related issues.

Knowing about Dr. Donahue's roles in educating future physicians, I asked Dr. Donahue whether she emphasized cultural competence with her trainees. She did not use the exact term, she shared, because she felt it was "gimmicky" instead of being a natural part of patient care. Consequently, instead of formally teaching the skill, she asked her residents questions when they brought up concerns with patients not doing what the resident believed they should:

You know, let's take a step back and consider the differential diagnosis of that. Why is this patient not picking up their medicines? Why is this patient not following the diet or exercise plan that you have? So, let's think it through. Can they afford this? Do they have transportation, they understand why you want them to do this? We certainly encounter patients who have different cultural views, like whether they will take a COVID vaccine or not. And distrust of physicians and our medicines and many other more cultural than strictly medical, scientific kind of issues. So, in primary care, we deal with psychosocial factors constantly.

While only a small part of her response, Dr. Donahue's comment on the "gimmicky" nature of cultural competence – or the many replacement terms she presents – yields insight into the role of competence as so-called "happy talk." The language of ostensibly improving medical care,

filled with “adherence,” “competence,” “diversity,” or similar phrases, only deals superficially with health inequity. The fluctuating nature of these terms indicates an ongoing effort to respond to the most politically and socially relevant institutional critiques at any point in time as a measure of saving face. The hegemonic nature of this practice can be understood from a critical race theory perspective.

Critical Race Theory

Critical race theory (CRT) is built on several fundamental tenets, each of which describe a feature of race and/or racism inherent to the way the constructs have been built and employed historically. The first of these tenets is ordinariness, which suggests that racism is the norm rather than the exception, allowing scholars of CRT to study racism not as an anomalous condition, but rather as a “the common, everyday experience of most people of color in this country” (Delgado and Stefancic 2011, 7). This tenet also helps explain why racism is so difficult to extinguish: its ordinariness and normality means it is rarely acknowledged and addressed. Another reason that racism is resistant to erasure is its contribution to the upholding of the dominant group’s power—a feature termed interest convergence or material determinism. The ability of racism to advance the interests of “both white elites (materially) and working-class people (psychically)” means that a significant portion of the population has a vested stake in maintaining rather than dismantling racism (Delgado and Stefancic 2011, 7).

CRT subscribes to the social constructionist viewpoint, which regards race as a “[product] of social thought and relations” instead of as “biological or genetic reality,” aligning with the position espoused by many critics of cultural competency initiatives (Delgado and

Stefancic 2011, 7) Because race is constructed as opposed to being an inherent quality, CRT sees it as a dynamic system of categorization, one which is modified at the will of the dominant group. The will of the dominant group is, in turn, largely attuned to sociopolitical conditions and capitalistic interests like the changing needs of the labor market. For example, Delgado and Stefancic compare the differential racialization of Japanese-Americans before and during World War II to show that “[i]n one era, a group of color may be depicted as happy-go-lucky, simpleminded, and content to serve white folks” while that same group may later “appear in cartoons, movies, and other cultural scripts as menacing, brutish, and out of control, requiring close monitoring and repression” when circumstances change (Delgado and Stefancic 2011, 8). This perspective also takes a critical stance on civil rights progresses throughout the years, suggesting that these seeming wins have been structured to benefit the dominant group while appearing to support racial equity.

The Culmination of Pseudocare

In a 2007 paper, sociologists Joyce Bell and Douglas Hartmann use CRT to dissect individuals’ conceptions of “diversity” through in-depth interviews. Their findings are incredibly relevant to my own discussion of cultural competence, which too must be seen as “happy talk.” In their work, Bell and Hartmann discover first that respondents, while ready to describe diversity, present “underdeveloped” explanations that are internally inconsistent. The abstract nature of these descriptions is cloaked in an overwhelming sense of positivity, which is to say that interviewees regularly extoll the virtues of diversity yet are unable to explain why this is the case when pressed on the matter. More interestingly, the ambiguity of these descriptions is set in severe contrast to the racial terms used to provide examples when individuals are asked for any

personal experiences with diversity, a phenomenon very similar to that observed within my own project. This very discrepancy begins to hint at the problem: diversity and competence allow us to discuss race without actually discussing race. Bell and Hartmann outline the dangers of this illusion in their paper:

The diversity discourse, or diversity without oppression, functions to shift the focus away from an explicit disavowal of race and racial inequalities toward a rhetoric that aspires to acknowledge and even celebrate racial differences. At the same time, the diversity discourse conflates, confuses, and obscures the deeper sociostructural roots and consequences of diversity. In other words, if colorblind racism reproduces racial inequalities by disavowing race, the diversity discourse allows Americans to engage race on the surface but disavow and disguise its deeper structural roots and consequences. Indeed, what makes this diversity discourse so potent and problematic is precisely the way in which it appears to engage and even celebrate differences, yet does not grasp the social inequities that accompany them. Furthermore, as Andersen (2001:198) points out, “diversity taken this way means [certain] people continue to be defined as other.” The language of diversity both constructs difference as natural and disavows its negative impact on the lives of those who are so constructed. Race is both everywhere and nowhere, a deep cultural self-deception that is difficult to identify and counter (Bell and Hartmann 2007: 910).

Cultural competence functions in much the same way as Bell and Hartmann’s assessment of diversity discourse. The phrase, and the skill it refers to, permit discussions of culture, race, and identity without acknowledgment of power and inequity. As Beck and Hartmann point out, referencing Andersen, phrases like diversity, and our own topic of interest, competence, fall into this category of “happy sociology,” a field which is not only complacent, but also *purposeful*, in its incomplete discussion of culture and race. Andersen suggests that “terms like multiculturalism and diversity have begun to blunt the [sociological] imagination,” “making it more difficult to understand the inequalities and injustices associated with race” (Beck and Hartmann 2007: 910). Cultural competence, in its focus on care as the improvement of patient adherence, reasserts the value of “culture” only as salient to compliance. In this process, the

differences of a patient's "culture: to the biomedical ideal are not only exoticized, but also pathologized. "Competence" exemplifies the claim that one can grasp all that is culture, a grab that is wild and uncontrolled, usurping language, race, wealth, ethnicity, and everything that ostensibly may explain behavior. The issue here is not only the arrogance of such a claim. Competence permits us explain away inequities and subverts efforts to address their roots by *appearing to* rather than committing to care.

Conclusion

6

“Every view is a view from somewhere and every act of speaking a speaking from somewhere” (Abu-Lughod 1991, 141).

Overview

In this thesis, I have illustrated the way in which patient behavior is comprehended against the biomedical ideal, a hegemonic and moralized conception of “good care” and “good choice.” “Compliance,” while gradually erased from the language of care, continues to be indirectly enforced through adherent autonomy. This new expectation assesses patients on their ability to understand chronic disease management, desire to perform the necessary steps, and their actions sparked by this knowledge and interest. However, patient behavior is conceived of and spoken about discriminatingly. By this, I mean that patients are classified into assumed collectives, each of which is bound by characteristics that are thought to direct behavior in a predicted way. Exploring “cultures” or groups bound by a common “culture,” I discovered that my physician interlocutors defined these collectives based on conflated traits. They offered ethnicity, socioeconomic status, education level, and, most pervasively, race as the defining categorizations for these “cultures.”

“Cultures” thereby usurp and conceal structural factors that contribute to challenges with management of chronic disease. “Culture” becomes an explanatory necropolitical excuse for perceived deviance, acting to conceal the systemic roots of beliefs, behaviors, and health inequities as choice. In particular, I have argued that culture-qua-race is an especially harmful tool as it relies on a social construction which continues to be reified and legitimized. Overall, my analysis suggests that improving medical care through “adherence” and “cultural competence,” not only falls short of its ostensible goals, but also conceals patterns reinforcing

the very power imbalances it seeks to undermine. All while these “happy” semiotics generate the dangerous illusion of accommodating patient autonomy and choice, they distract from imbalances of power. Ultimately, this pseudocare offers an exculpatory vehicle to discuss resistance without power, personal bias without systemic racism, and death without structural violence. Some patients are thereby permitted to die inside and outside of clinics as the slow violence inflicted upon them is normalized and expected even as it is rendered comfortably invisible to those perpetuating it. In this concluding chapter, I offer extensions of the analysis I have performed and recommendations to address critiques of cultural competence efforts.

Disciplining Forces: Biopower and Governmentality

A seeming embrace of patients’ freedom to choose, I have shown, has not exempted patients from continued moral assessment of behavior against biomedical ideals of “good care” and “good choice.” The creation of adherent autonomy, the composite of patients’ abilities to *know*, *want*, and *do*, impinges on patients’ practical sovereignty. This deprivation not only maintains the depersonalization and objectification of individuals, but also functions as a disciplining force with unequal impacts. By this, I mean that adherent autonomy is a biopolitical tool used to differentially grade populations on their deservingness. Just as it offers patients choice, it normalizes surveillance of these choices and, importantly, expects and punishes deviance discriminately. It is critical to recognize, however, that the clinic is not the only location where this sentiment of controlling and moralizing the logic of choice is performed.

A complete discussion of biopower and necropolitics in the context of dietary management can be extended to outside the clinic as well since the patient-physician dynamic is mirrored by the state-citizen encounter (Perlman 2015, 31). In recent times, legislation like soda

or sugary drink taxes, known as “sin taxes,” which are “corrective taxes on goods that are thought to be overconsumed,” have increased the focus on paternalism in public health (Allcott, Lockwood, and Taubinsky 2019, 1557). Proponents of these economic moves argue that a level of disincentivizing is necessary to dissuade individuals from purchasing and consuming unhealthy beverages. Critics, however, contend that these measures unfairly punish consumers from lower socioeconomic statuses without regard for the structural factors which subjugate individuals in poverty and force them to spend significant portions of their income on food.

Like the arguments that I have presented throughout this thesis, these legislative measures are diagnostic of adherent autonomy. Consumers are offered choices that are surveilled, moralized, and, in this case, monetized. The punishments from this assessment of “good choices” are unequally impactful, exploiting the same structural fractures that they ignore.

My point here is not to suggest that guiding individuals’ choices has no space in medicine or that ensuring complete and utter autonomy is the way to deliver high-quality care. What then would be the function of a physician? Instead, I advocate for deeper, more critical consideration of the way that paternalistic measures and notions like adherent autonomy differentially affect populations. Disciplining forces discriminate inside and outside the clinic. Different identities are subject to different levels of surveillance, expectation, and punishment. Therefore, I argue that the new forms of compliance or adherence I have presented in my work continue to offer only superficial improvements of care without confronting the systemic roots of these imbalanced assessments. My exploration of culture has served as just one example to reinforce this paradigm.

Performativity and Euphemizing Pseudocare

I have shown that the change from compliance and adherence only redirects attention from a more critical analysis of deconstructing paternalistic care. Similarly, linguistic maneuvers like diversity, inclusion, and competence serve only to fabricate an aesthetic of caring to absolve institutional responsibilities to *actually* care. My point here is that the interest in euphemizing the language of biomedical care is a self-exculpatory one, one with the ultimate effect not of improving health equity, but of making one feel good. This level of institutional performativity is not only deceptive but is also dangerous in creating an illusion of pseudocare that distracts from addressing the true drivers of inequity.

Consider here the concept of cultural competence that I have sought to explore through this ethnographic work and the conflation of various characteristics with culture that I have shown previously. Keeping these patterns in mind, cultural competence, as a skill in medical education, offers up the umbrella of culture but permits discussions of socioeconomic status, linguistic differences, and racial groups, among other factors. In this thesis, I have sought to highlight how the nonchalance and ubiquity of culture, coupled with the ease of conflating it with identities, behaviors, and beliefs like distrust with systemic roots allows it to become exploited as a necropolitical weapon. Structural violence and complex power relations become disguised as generationally transmitted beliefs on normal, divorced from their instigation.

Just as adherence offers a linguistic euphemism for the new form of compliance found in adherent autonomy, culture too becomes explanatory and exculpatory. These practices, I argue, of softening language to conceal or avoid more critical and reflective discussions of power are dangerous. As Yoosun Park, a professor of social work, points out, “language and discursive practices are not simply reflections of ideology and the manifestation of power, but active agents

in the hegemonic process of constructing and maintaining ideology” (Park 2005, 16). This pattern permits individuals to discriminately die their slow deaths, drawn out by their identities, and ignored by the mirage of care, or of improving care, that is offered by these linguistic maneuvers. In this way, I argue that the language of medical care, whether it be adherence, or competence, or culture, is never as unassuming as it might first appear. The “happy” illusions of casual language leaves structural roots of inequity untouched as valuable discussions of racial reification, of systemic violence, and of the biomedical hegemony are all left unspoken.

Views From Somewhere

Many of the problems with cultural competence begin with its incomplete conception of culture. While the physicians I interviewed framed culture in many ways, a fundamental similarity in definition argued that the notion referred to one’s perceptions of what was acceptable or normal. Physicians suggested that culture was a generational worldview, one which enveloped individuals in a sense of affective comfort, explaining the intensity and resistance of cultural beliefs. In naming “cultures,” however, physicians borrowed a variety of characteristics and coded terminology to categorize patients. These insights into physicians’ reveals an important intersubjective dynamic in the equivalence between “cultures” and “others.” The salience of features attributed to culture is defined in terms of their *difference* or their *deviance*. For something to be different, of course, it must have a reference against which it must be compared. My argument has centered on this very reference to suggest that engagements with culture in the clinical encounter reinforces the hegemony of biomedicine and, furthermore, of whiteness. Cultural competence only compounds this issue.

Primarily, as I have shown, “the issue of cultural competency overlooks who exercises power to define meaning, perspective, and the ‘other’ and how meanings and perspectives relating to the ‘other’ are often caught up in discourses that uphold whiteness as the default standard” (Pon 2009, 60-61). “Cultures” are always defined *in relation to* something and that “something” is most commonly Western notions of whiteness and, in the clinical setting, biomedicine’s moralized adherent autonomy. Based on this reality of how “cultures” are conceived, a push for competence addresses individual biases but fails to acknowledge the ways in which commonly circulated cultural tropes are colored by the agenda to maintain power imbalances. Campaigns promoting competence may thereby reify culture as a static body of thoughts and actions, suffocating the individual for the sake of an imagined many, and conceal valuable discussions of structural violence.

Final Remarks

Addressing pseudocare requires an attention to deconstructing the performativity of competence in clinical education programs and moving towards abolitionist medicine. Cultural competence trainings should more consistently incorporate discussions of systemic imbalances. Excessively shifting focus to interpersonal bias and to identifying patient “cultures” forces an emphasis on resistance rather than on the *powers* that they oppose. Incorporating anthropological theory into these trainings will allow greater recognition of structural violence inside and outside the clinic. Particular stress should be placed on dissecting the factors which influence categorization of patients into “cultures.” While these are only elementary steps, they confront immediate problems and instigate necessary discussions about the imbalanced view of culture advanced by competence.

Appendix

1. How frequently do you discuss food with patients?
2. What are the biggest barriers to discussing food with patients more frequently?
3. In what contexts do you discuss food with patients? (food insecurity, dietary habits, etc.)
4. Throughout your education/training, how much emphasis was placed on discussing food with patients?
5. What does compliance mean?
6. What are the biggest barriers to patient “compliance” when it comes to the information you provide them about food?
7. How do you define culture?
8. How does a patient’s culture influence the conversations you have with them about food?
9. What does it mean to be culturally competent?
10. Do you believe cultural competency is important in a clinical setting?
11. Throughout your education/training, how much emphasis was placed on cultural competency?

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