Bhabha in the clinic
Hybridity, difference, and decolonizing health

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Abstract

Before professional diagnosis, the determination of whether one is 'ill' or 'well' rests within the patient. These moments, when sufferers (re)cognize their own bodily and phenomenological experience as abnormal or different, are critical to the positioning of healer and patient. So too are moments when diagnosed patients, struggling with a treatment regime, compromise and adjust to embrace, if only partially, disparate ideas of health. In this article, I apply Homi Bhabha's framework of hybridity and difference to think about the perception of illness, self-diagnosis, and power in healing relationships. I consider how sufferers enact hybrid positions between their bodily perceptions and their professional diagnoses. To illustrate the utility of Bhabha's colonial critique for health care, I examine narratives by patients with diabetes-related vision loss about: (1) first realizations that something was wrong, what Bhabha might call the 'intervention of difference'; (2) expressed differences between self-knowledge and biomedical knowledge, corresponding to Bhabha's 'partial embrace' of the colonial ideal; and (3) the self-colonizing epistemological work that compliant patients do as they re-orient their pre-diagnostic self to a post-diagnostic habitus of self-monitoring, timed medications, and other treatments. I conclude with a discussion of how Bhabha's colonial hybridity supports a more productively contentious medical anthropology that envisions and pursues decolonized health care.

Keywords

1. Portuguese Colonial Church of St. Francis of Assisi, Goa, India.

Introduction

In his lyrical and dense essay, 'Signs Taken for Wonders', Homi Bhabha reflects on the English book as a mimetic device for colonial authority, clarity, and virtue. Bhabha considers several texts and sets of events in 'battle for the *status* of the truth' (Bhabha 1994, 110, emphasis added), not purely in the cosmological sense but in a representational one. In that battle, the authority of a colonial text rests upon its 'rules of recognition – those social texts of epistemic, ethnocentric, nationalist intelligibility' (Bhabha 1994, 110), which by their assumed presence enact and effect colonial power (in this case, the power to name and identify God) and which accentuate the cultural difference of colonial subjects (i.e., Hindu Indians, Black Africans). As colonizer and colonized come together in numberless moments of culture clash, Bhabha saw not one outcome but a dynamic space (a third space) in which blends of culture were strategized, stumbled upon, and formed without notice. These were hybrids, and Bhabha's work on colonial hybridity helped deconstruct the colonizer:colonized binary into the strategic, multivalent, and 'unpredictable' forms of expression and identity on which postcolonial theory now relies.

Hybridity and Bhabha's third space have become iconic of postcolonial discourse. Complicating our view of colonial relations and representations, Bhabha has been applied to the 'confrontation of cultures' (Dehdari, Darabi, and Sepehrmanesh 2013, 135) not just in the

context of colonialism, but also in contexts of nationalism, culture, and – though minimally but certainly now – to medicine. Along with Edward Said and Gayatri Spivak, Bhabha's work has been drawn upon by scholars not only to evaluate post-independence national identities (Seed 1991; DiPaolo Loren 2015), but also to critique colonizing discourses in academia, ethics, and the arts (for example, Mignolo 1993; González-Ruibal 2009).

In this article, I use Bhabha's view of hybridity to think about diagnostic power and naming, and about the colonization of ideas in which patients and healers participate. I then consider narrative data from research among people living with complications of diabetes, whose perspectives reveal Bhabha's intervention of difference, a partial embrace of biomedical authority and the self-colonizing work of diabetes self-care. I will argue that although diagnostic encounters are neither as violent nor malevolent as were colonial engagements, the dynamics of power create similar reactions and responses in patients who variously attempt to co-opt, align themselves with, or resist that authoritative diagnosis. I conclude by considering the implications of hybridity across a variety of diagnoses for decolonizing health care.

Hybridity's space

Hybridity, a blend of things, attracts anyone muddled by a binary, unwilling or unable to theorize a third possibility. In colonial theory, this covers the blending of cultures and priorities of the colonizer into the behaviors, actions, and ideas of the colonized. Hybridity creates a 'third space' in which signs and cultures interact to create unique, new potentials for power distribution, colonial disruption, discrimination, ambivalence, and more (Bhabha 1994). In short, Bhabha's hybridity is a representational event that intervenes in cultural conflict, symbolizing not just a blend of authoritative and colonized, but a condition underlying and exceeding both of these from the first moment of recognition.

Hybridity allows colonial power to shift its 'forces and fixities' (Bhabha 1994, 34), ensuring that its discriminatory work is effective in whatever site it attempts to overtake. But the flexibility of this space also allows for ambivalence, and for 'strategies of subversion that turn the gaze of the discriminated back upon the eye of power' (Bhabha 1994, 112). Hybridity creates potential as a disruptor, 'disavowing' dominant ideas and structures not through outright resistance but by incomplete repetition, subverting domination through flawed mimicry, whether intentional or unintentional.

Hybridity simultaneously forms a cultural bridge, albeit a troubled one, between colonizer and colonized, but it is an 'unpredictable presence' whose essence is 'a (strategic) device in a specific colonial engagement (Bhabha 1994, 114–115). It is dangerous precisely because of the unbending and unforgiving nature of colonial authority, since this rigidity attempts to deny

the inevitable response to colonial power – one of resistance. Hybridity opens up a space where ambivalence might flourish:

> Hybridity is the sign of the productivity of colonial power, its shifting forces and fixities; it is the name for the strategic reversal of the process of domination through disavowal (that is the production of discriminatory identities that secure the 'pure' and original identity of authority). Hybridity is the revaluation of the assumption of colonial identity through the repetition of discriminatory identity effects. It displays the necessary deformation and displacement of all sites of discrimination and domination. It unsettles the mimetic or narcissistic demands of colonial power but reimplicates its identifications in strategies of subversion that turn the gaze of the discriminated back upon the eye of power. For the colonial hybrid is the articulation of the ambivalent space where the rite of power is enacted on the site of desire, making its objects at once disciplinary and disseminatory – or, in my mixed metaphor, a negative transparency. (Bhabha 1994, 112)

Yet Bhabha's theory of hybridity is relevant beyond the eighteenth and nineteenth century relations of geopolitical domination. To apply Bhabha's ideas to a contemporary view of healing and diagnosis, two adjustments must occur. First, one must carve away the historical and imperial dynamics that inspired Bhabha's work. Although the disciplining role and discriminatory harm of medicine in colonial processes is well established (Packard 2000; Anderson 2014; Frankenberg 1980; Turshen 1984; Manderson 1996), my explicit interest here is not in that history. Rather, my emphasis is on Bhabha's fundamental concern with *difference* in contexts of power, and how this difference is treated interpersonally and structurally. Secondly, while some medical encounters may be rigid, authoritative, and even discriminatory, I do not suggest that all diagnostic encounters are homologous with imperial domination. Instead, in this essay, I seek to conceptually map ideological perspectives in patient reactions to a diagnosis along lines drawn by 'the productivity of [colonial] power' (Bhabha 1994, 112). Since it is the privilege of the powerful to be able to name or attribute meaning to a text, it is also a privilege of power to diagnose, to call something a disease, or to withhold a diagnosis. Further, as colonial erasures and restrictions envision colonial subjects as only, ever, a partial copy of the colonizer, these other naming events erase and objectify their subjects.

The rules of recognition (Bhabha 1994, 110) in these encounters are set by the colonizer – the powerful – while the marginalized reel in response. An agility of identity to find and enact different possibilities is, therefore, the best and only possible asset of the colonized. A subaltern must rely on incomplete mimicry to ingratiate oneself to power brokers. Depending on the actor's understanding of a text's intended meaning, and on their ability to envision and enact a semiotically appropriate response, the colonized may co-opt some power or access certain limited resources. The patient's agenda in a healing encounter is parallel. Patients

struggle to be recognized, to understand and enact appropriate patient responses, and to advocate and obtain resources for themselves in astonishingly similar ways: through *tinkering* (Mol, Moser, and Pols 2015), *experimentation* (Mattingly 2014), and *controversy* (Smith-Morris 2015), to name a few.

An ethnographic application – narratives of diagnosis

To explore Bhabha's lessons on 'difference', the 'partial embrace' of colonial ideals, and 'hybridity', I turn now to narratives of patients with complex and multiple diagnoses. Data are drawn from a mixed method study of screening, treatment, and patient perceptions of vision-threatening diabetic retinopathy (VTDR) among patients and staff at three safety-net clinics in California. These clinics were chosen from among those that use EyePACS, a telemedicine-based screening program for diabetic retinopathy. All narrators are patients with diabetes and diagnosed with VTDR, the main cause of vision loss among working-age adults. Because vision loss from VTDR is only one of many late-stage complications of diabetes, VTDR often accompanies and complicates other chronic conditions; namely, vision loss from VTDR interferes with the management of diabetes and makes other aspects of self-care more difficult. The narratives below are largely from the home-interviews of that study, for which participants had been diagnosed with VTDR at least six months, and up to three-and-a-half years, before the start of the study. Interviews were conducted in Spanish or English, according to the participants' preferences (see Smith-Morris et al. 2018; Bouskill et al. 2018). As will be evident, these data mirror several other published works using diabetes narratives of illness identity, including in relation to discord with and adjustment to a doctor's diagnosis or treatment. In particular, diabetes is a diagnosis well known for its capacity to entangle all aspects of life, and to invoke other co-morbidities.

Organizing my discussion of these data are three events, formulated according to my adaptation of Bhabha's terms: feeling difference, partial embrace of a diagnosis, and the self-colonizing work of patients. These events mark parallels between colonial authoritative strategies and the incorporation of patients into a medicalized subjectivity.

Feeling difference

Sufferers feel difference in myriad ways. This difference of illness is comparable to a colonized difference insofar as the cultures/narratives/moral worlds of diagnosis may clash with the pre- or non-patient self-awareness. I point to three ways in which difference is felt: first, a difference between feeling 'normal' and feeling different or ill; second, a difference between oneself and others who are not ill, including family and friends; and third, a difference between oneself and one's diagnosing and treating professionals.

The first feeling of difference is often a bodily sensation contrasted with what a sufferer might consider normal. Such an experience is deeply informed by one's ethnomedical catalog of symptoms and bodily norms. That is, self-awareness that something is wrong spurs attempts to name the sensation or its cause, shifting an unknown experience into a personal nosology of meaning. But for clinicians (and for patients already indoctrinated into biomedical metrics of diabetes), the feeling of difference is often recognized through use of an external metric device. This monitoring activity shifts patients' attention 'away from their physical sensations [and] towards the numbers measured' (Mol 2002, 9), making them less dependent on professionals for information about their bodies but requiring them to self-colonize their bodily perceptions and to self-discipline their behaviors into ones that conform to a treatment plan.

Sufferers must be trained to recognize difference in this way because, without that colonizing influence, they may have no bodily feelings of disease. Indeed, they actually feel *better* when their blood sugar is 'too high'. In one patient's words:

> That melancholy feeling… I don't like to feel that way. So what would help not to feel that way is to eat, and keep my sugar a little bit elevated. I don't want to flatten out. I don't want it to drop tremendously. That's like the worst thing, because at that point you... can't really move at that point. Your thoughts aren't really clear, you maybe just are babbling… talking really bad. I do not like that part. That's like the one thing with the diabetes. I can take a high blood sugar – you're just like tired, you know, lethargic. That's a lot easier than just literally not being able to talk… I've noticed I've not felt that great and my blood sugar was great. It's been 120 [mg/dL]; I didn't feel good [but] it's been high and I felt great. (Dalila)

Dalila's narrative reveals the iterative and uncertain process of recognizing illness or, at least, that something is newly wrong. It can be a first recognition, or it can be one of many such self-assessments made through the course of an illness. How one's sense of difference from feeling 'healthy' or even 'normal' is recognized forms the moment of relevance to Bhabha. As a first and simplest point, this recognition of difference creates the potential for diagnostic colonization of ideas and experience.

The typically low-income patients of our VTDR study had already been recommended to see an optometrist and/or ophthalmologist for further evaluation and possible treatment. So their narratives do not capture a first-time exposure to the difference of a diagnosis, if such a moment can be identified in a technological world suffused with perpetual health messaging. Many of the people I have interviewed had no bodily cue of disorder, and had only diagnostic test results through which to perceive this new illness (Rhodes et al. 1999; Smith-Morris 2006). The process of clinical diagnosis can be iterative as well, but the goal of a definitive diagnostic

process is to be concrete and uniform. Receiving that diabetes diagnosis, especially when combined with the instruction to begin monitoring one's daily glucose, introduces patients to a new and authoritative version of health, one often informed by a machine or number, not by one's personal experience of suffering or (dis)comfort.

The second experience of difference is, therefore, in the separation sufferers may feel between themselves and others who are not ill. Raul, at the age of sixty-three, was typical in many ways of people struggling with this complicated chronic disease. He was retired from work in factory labor and in gardening, both of which he felt had exposed him to dangerous chemicals over a lifetime. Within the past year, he had been diagnosed with eye disease requiring surgery, but a heart attack had delayed the surgery. When we met him, Raul was not only on dialysis, but recovering from the heart attack and planning ahead for the rescheduled eye surgery. Even before the heart attack, he had made trips to the hospital for infections in his kidney, then his lungs. This lengthy cascade of issues was typical for our participants, whose VTDR diagnosis was often just one of several health problems that emerged after and due to diabetes.

Raul's struggle with the dietary changes prescribed for him, to control his blood sugar levels, is a constant reminder of his difference from those closest to him. Despite having support to help manage the medication and dietary regime, and with whom he could talk about this illness, it was a struggle to live *differently* from those around him:

> It's a very difficult diet because one is not set, you see the family eat other things and you want them, you want to eat something, but you can't.

Sabana, a fifty-five-year-old school aide, had similar feelings and gave a narrative full of tensions over choice and advice, friendship and jealousy:

> Like I said, [my friends] do give me advice, but it's my choice whether I want to take their advice, which sometimes I do, I will. But then I cheat again. And it's like, then, how am I helping myself if I'm not taking their advice, and then I will and then I will not. Like I said, it's hard. It's hard for me because, um, I don't know. I don't know if it's – what is it, jealousy or what? How come they're not sick and you are? I never felt this way, but lately I've been feeling it.

If an internal sense of difference were not isolating, self-care behaviors can certainly create difference and distance. Patients under treatment or monitoring for their diabetes are instructed to check their blood sugar daily, to change their diet, to add a daily medication regime, and to attend the medical appointments that legitimate one's access to valued information, pharmaceuticals, or other treatments. These physical and logistical activities are

also well known to accentuate a sufferer's sense of difference (de-Graft Aikins et al. 2015; Goldín et al. 2017; Naemiratch and Manderson 2008). Raul and Sabana narrate this difference not as an identity of diabetes, but of daily experiences – differences in what their family can eat, differences from their friends who are not sick. This difference is a colonizing isolation that transforms not simply one's medical practices, but all aspects of life, from food and mobility to one's sense of friendship and family participation (e.g., Kokanovic and Manderson 2006).

The third major category of difference is the difference sufferers recognize between themselves as naïve sufferers and the professional experts that they may consult. Sabana expressed the last of these categories most clearly. Hers was a feeling of communicative distance between herself and her doctors:

> [I] really want to know more. But, you know, in some simple words. Yeah, not medical speak, because it's very difficult. Because it's from one doctor to another. See, it's not most of the same doctor that I get, and they're always changing. So I have – they have to, like – I have to explain to them how I feel, they have to tell me, but they all, you know, they all use different words and it's hard for me to understand.

Even if patients feel they have good communication with their doctor, their doctor may be difficult to reach for logistical reasons. This was the case for Mark, one of our youngest participants at age forty-one:

> If you've had any kind of, you know, any issue, you're more or less going to be like, 'Oh, I'll just wait until, until I fall over and go to the ER first'… So I was even at that point this week, because of the allergies that I'm having. I was ready to go – I was going to go like two days ago, literally, to the ER. And that's basically my doctor, to be honest with you. My doctor is my doctor, I mean, if I have any issue. I don't call. I never even call the – call my physician and get an appointment. I'll just go to ER, and then, let them give me something, a medication for that moment, and then do a follow-up call and let those guys tell me. Because if you do it through the ER first, then… they'll give you an appointment probably within a week. If you call [the doctor] straight, you won't get the appointment.

The inability to access one's doctor, or to feel heard or helped by a doctor who is a poor communicator, illustrates the power difference both between physicians and patients and between institutions of health care and patients. Feelings of difference in their condition involve not only a process of acculturating oneself to the sick role (Parsons 1951), but also to a recognition that patienthood can be disempowering vis-à-vis the authority of biomedical practitioners and structures. Indeed, the difference from their practitioners and from family

and friends that patients may begin to feel, while isolating, also creates the need for therapeutic communities (Kokanovic and Manderson 2006; Smith-Morris et al. 2018). Such realizations of difference in the illness experience are hardly new for medical anthropology, but their parallels to Bhabha's hybridity in the colonial encounter seem clear.

Partial embrace

Once a professional diagnosis is sought, a sufferer has begun the approach and may come to embrace that authoritative assessment. Postcolonial theory has sufficiently complicated the colonial binary that we need not oversimplify this case application to diagnosis. For example, we recognize that sufferers take on the diagnostic identity only partially, and diagnosis can only partially satisfy the identity needs of the sufferer. According to John Gardner and colleagues, 'it is only by very carefully cutting, dicing, manipulating or exercising the body that diagnoses can be made' (Gardner et al. 2011, 844). And where Gardner and colleagues see variability in diagnostic practices being 'patched together' into a 'singular, coherent order of things' (ibid., 849), Jonathan Taee (2017) sees a 'patient multiple' with corresponding efforts to piece and weave together multiple bodily concerns, multiple diagnoses, multiple healers. Likewise, clinicians are neither homogenously authoritative nor do they represent a body of perfect knowledge.

After Bhabha's 'intervention of difference', sufferers are faced with countless decisions over whether and how to embrace a diagnosed role. As most ethnographies of diabetes relate, diabetes sufferers can often recite the ways in which they do *not* meet these enormous demands, ways in which they make only a partial embrace of what biomedical authority tells them they must do (Kreiner and Hunt 2014; Seligman et al. 2015). Diabetes diagnosis is famously complex and poorly understood by those undergoing it (Mendenhall 2016; Weller et al. 2012; Smith-Morris 2015). The past five years alone have also seen robust attention given to reframing diabetes as a biosocial and syndemic condition (Singer et al. 2017; Weaver and Mendenhall 2014), rather than as a singular, isolatable diagnostic category (Weaver, Barrett, and Nichter 2016). This complexity might productively be viewed in terms of domination.

Dalila was a sixty-five-year-old who had worked 'in the fields (and) packaging [in a] butcher shop' before she became disabled five years ago. Due to constant pain in her feet and legs, she can walk very little. Yet she cleans, cooks meals, and takes care of her grandson in a small apartment shared with her son and daughter-in-law. She expresses the difficulty of complying with her diabetes regimen, and her own annoyance with being only partially successful in her efforts:

> Then I really don't take care of myself, that I don't take my medication as I should [unclear]. Sometimes it's really difficult to do it all. It gets annoying. Very annoying.

She talked about how difficult it was to get to appointments, with her son and daughter working. She explained she would skip some of her regular check-ups because she 'already knew' when her sugars were low and when they were high. And she had so much pain – the pain that finger-pricks caused her, pain in her kidneys, sometimes she got a bladder infection. She also explained how her glucometer sometimes didn't work, but the last reading we saw on it registered 518 mg/dL. As we enjoyed this conversation in Dalila's crowded and dimly lit apartment, it was difficult to imagine how Dalila could safely function by herself. Her eyesight was so bad, she certainly could not read a glucometer or prescription bottle. And she was so unstable on her feet that walking, even with a walker and restricted to her own neighborhood block, posed a serious risk of falling. Dalila's partial embrace of her treatment and medication regime, under these circumstances, seemed like a substantial accomplishment.

Others who might be capable of doing so choose not to fully embrace a diagnosis and its corresponding treatment regime, and the reasons are many. Research on diabetes has enumerated various barriers to treatment adherence, from social and economic reasons to physical access, knowledge, trust in providers or health care settings, syndemic depression, safety, or even fatalism, just to name a few. For example, although we did not ask about citizenship status in the research that produced these narratives, we know that all were eligible for safety net health care, that eleven of fifteen home interview (sub-sample) participants were not born in the US, and that ten of those fifteen had an education of less than the tenth grade. These variables remind us that the social determinants of health are systematically left out of current diagnostic practice, leading to treatment paradigms entirely focused on behavioral and pharmaceutical intervention (see, e.g., Farmer and Ivers 2012).

Raul (the sixty-three-year-old retired laborer on dialysis and recovering from a heart attack) 'didn't believe that diabetes was that serious', so he did not make the changes he was told to. But as the symptoms and complications mounted over time, Raul's embrace of biomedicine's truth increased. He became a vocal coach to others about conforming to all the treatment recommendations:

> I had not said anything because I didn't believe that diabetes was that serious when they used to tell me that I had diabetes. Yes, there are other people with diabetes and they don't do anything, what's wrong with that. 'Don't eat this, don't eat that because it is bad for your diabetes'. What? This isn't bad for me. Diabetes who? But then, later, I would tell them that I began to feel that my face trembled, my lips trembled, they felt cold. Then, finally, my eyesight. I began to get blurry vision, blurrier. Then my feet, I began to feel the sensations from my legs all the way down, I felt fire. I could not wear

pants because it burned my skin… The only thing that I say is that you have to take care of yourself, you have to do your check-ups, to get your vision checked, get your blood sugar checked every year, to go to the doctor, don't develop diabetes like me.

Not everyone is annoyed or apologetic about having a partial embrace of a compliant identity. Mark, one of our youngest participants and perhaps somewhat like a younger Raul, simply explained to his specialist that he did not plan to comply with treatment instructions. 'It was pretty good because I was very honest – I told him that I'm not very disciplined with the food. I don't know, you know. I'm pretty young…'.

Bhabha's idea of the incomplete doubling of colonial mimicry parallels these patients' inability, or unwillingness, to be more compliant diagnostic subjects. Though one might wish to access its power or enjoy the privileges of membership in a dominant culture, it is very difficult to take on the cultural values of a dominant group without giving up something of one's own way of being, even temporarily (Singh 2009). Or, as Harris Solomon (2016) has written, the absorption not only of diabetes- and obesity-causing foods but also of particular substances and environments can 'shift definitional parameters', so that diagnosed patients understand themselves and the world in new ways.

This perception-colonizing process is not restricted to diabetes, but it is certainly well reflected in ethnographies of people with this diagnosis. For younger patients like Mark, giving up his freedom to eat as he chose was too great a sacrifice. But for Raul and Dalila, older and suffering under a tremendous cascade of problems, the value of compliance offered not simply the positive health effects but hope that excellent compliance might stop the cascade and prolong life.

Self-colonizing

This brings me to the third colonizing event, when hybridity emerges through some measure of self-colonization or self-erasure. According to Bhabha, this aspect of hybridity proves requisite for access to authoritative culture and its benefits. The authoritative ideal is for the colonized to take on responsibility for enacting new cultural values, to self-police and self-discipline so that the new moral authority need not be in constant control. In healing encounters, the concept of hybridity captures the process of framing the illness in a way that brings the sufferer closer to the resources, authority, and access available only through that healing system. But sufferers are expected to self-discipline under the authoritative directive of a treatment plan, through regimes of medicine, self-monitoring, and self-care.

The enactment of hybridity in diagnostic moments is dynamic, both for diagnosticians and patients. The diagnostician can, like the colonial authority of which Bhabha speaks, be 'terrorized' by the possibility of her own delegitimization.[1] When clinicians fail to acknowledge controversy over a diagnosis, or fail to name the suffering of the undiagnosable, they may lose their claim to legitimate authority. On the other hand, sufferers may claim to have a diagnosis that has not been bestowed by an authority but *self*-bestowed (Davis and Nichter 2015), or they may deny or avoid a diagnosis that is (racially, ethnically) assumed (Reverby 2010; Smith-Morris 2017). Hybridity is strategic in other ways, being 'somewhat more neutral – possibly a creative way of expressing cosmopolitanism or eclecticism' (Singh 2009), as well as more salient to contemporary anthropological notions of culture as it inhabits postcolonial settings, borderlands, and mobile and dynamic peoples (e.g., Castañeda 2010).

For diabetes, self-colonizing is seen through strategies of self-management or adherence to treatment. It is an indoctrination into the supervised, prescribed, and monitored authority of one's biomedical regime, as these typical examples illustrate:

> What is happening to give you examples, visiting the doctor does seem difficult, because when I have to go see the doctor, there are only certain days that the doctor can see me, but those days I already have dialysis scheduled and so it's a bit difficult. (Abril)

> Well, what I have to do is eat healthy. I eat more vegetables, less carbohydrates, less things with a lot of sugar… Don't drink any juices that have a lot of sugar or too many carbohydrates… I have to see in the graphs, how much sugar or how many carbohydrates each thing has, to know what is inside of my nutrition. (Fe)

> They told me that by putting on a plate the amount, you can only put one thing or another, just a little bit like that [motions a small portion]. Yes, to measure the food. (Agnese)

There is much for patients to learn in the realm and regimes of diabetes self-management. Although the end-goal of blood glucose control is set by professionals, sufferers bear final responsibility (and consequence) for conforming to those rules. They are not policed twenty-four hours per day, but routine testing reveals the degree to which they have taken on this new identity and responsibility for themselves – to self-police and self-colonize in ways that

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1   'The display of hybridity – its peculiar replication – terrorizes authority with the *ruse* of recognition, its mimicry, its mockery' (Bhabha 1994, 165).

conform to their diagnosed role. That is, an A1c test performed at a doctor's office reveals a patient's conformity over the past three months.[2] Other diagnoses, for which self-policing is not so necessary, are much simpler. Upon being asked, 'What is the most difficult? Your diabetes or your heart [problem]?', Veronica replies:

> Well, I say it's my diabetes. Because for my heart, they operated me, and I've been okay… [but] the diabetes is each day: diet, walk, yes walk to lower the sugar levels. Movement. Ah. I tell you [*Sighs*].

The greater burden for self-colonization posed by diabetes equates to a more persistent, chronic set of demands. Despite Parson's optimism that the sick would be excused from their normal obligations once their sickness was acknowledged and treatment begun, social and family role obligations do continue for many. Sufferers may have to accept the consequences for neglecting one role in favor of meeting another, as Mark experienced when he could not reach a private space in time for his insulin injections:

> A lot of days, when I used to have to pull that syringe out, I would be around people… And I didn't want to let anyone know that I had diabetes… So I would – I would never like to tell people that I had diabetes, and I told the doctor, sometimes I would like miss… taking my insulin because I didn't want to do that around people… And then I'd be like, oh man, my blood sugar would be extremely high later.

Mark's enacted hybridity is informed by his reluctance to take insulin shots 'around people' and by his lack of 'discipline' (quoted earlier) with a glucose-lowering diet. He openly acknowledged the role of his age and his sociability in that enactment. Meanwhile Raul, who is older and suffering a greater number of problematic symptoms and differences, adopts his diagnostic category and the regimes of behavior and ingestion as closely as he possibly can. Thus, hybridity involves certain agented choices, but also certain ways in which a sufferer can never fully embrace or 'double' (in Bhabha's term) an ideal diabetic patient.

Bhabha's theory of hybridity thus allows for an agented role in the creation of these blended states, and this is key to its utility for matters of health and diagnosis. Bhabha's ideas not only recognize that agented blending will occur, but that agency is tempered by knowledge and access. The flexibility and agented power in hybridity proves fairly important for people like Mark. But where Pierre Bourdieu (1990) and Bhabha were opaque, medical anthropologists

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2   An A1C test is a blood test that reflects your average blood glucose levels over the past three months.

have been more explicit about human agency. Sufferers estimate the benefits and responsibilities of the diagnosed role. They strategize whether, when, and how to embrace the diagnosed role (Warren and Manderson 2015; Koch 2015), and they will sense or react with different aspects of their body (or patienthood) multiple (Mol 2002; Taee 2017). Short of violently enforced treatment, sufferers explore and enact new ways of health with agency. To that degree, they colonize their own beliefs and values.

These three elements of Bhabha's colonial critique each offer unique views onto how a diagnosis might colonize a patient's consciousness, behaviors, and resources. And in these experiences of Raul, Sabana, Mark, and others across multiple elements of hybridity, the sense of systematic colonization becomes clearer.

Conclusion: What is gained by a decolonizing frame?

Bhabha's work has become central to theories of postcolonial mimesis and power, but its applications for the realms of healing and health care have not been adequately recognized. While medical anthropology has been successful in its many critiques of difference and inequality in clinical settings, it struggles to frame care relationships as ones of cultural domination. I have suggested that the roles of patients and healers in the negotiable aspects of care conform well to Bhabha's ideas of the intervention of difference, incomplete doubling, and hybridity. In particular, these ideas correspond respectively to: (1) the recognition that something is wrong in one's health; (2) the only-ever-partial embrace of a diagnostic identity; and (3) the active work of blending by patients of the diagnostic ideal and their experienced reality of self-care.

The value of this type of critique extends beyond diabetes, toward decolonizing health care encounters as well as health epistemologies that shore up certain structural inequities and norms. Bhabha's 'difference' refers not solely to economic or political inequity between patient and healer, but to the structural racisms and exploitations that define those roles in distinctive ways. The decolonizing framework, guided in part by Bhabha's concepts and language, can confront privilege in health care in a broad and historically informed sense.

With its analysis not simply of power dynamics but also of assumptions upholding patterns of disease over time, the decolonial frame is an important one to sustain in medical anthropology for at least two reasons. First, the postcolonial frame indicts the power dynamics of activities cloaked in moral garb. Few contemporary subjects are so morally infused as healing, medical and humanitarian aid, or even simply 'care'. Medical anthropology has been deeply interested in the morality and ethics of care over the past decade or more (Smith-Morris 2018). Given the impact of both capitalist and political processes on care globally, a postcolonial frame

examining those morally charged healing encounters keeps us watchful for medical trickery and collusion, biological justifications for inequity, and other repugnant repetitions of Western scientific history. This is part of what is intended by such contentious linguistic frames as 'structural violence' (Farmer 2004), 'the new slavery' (Bales 2004, 2012), 'settler-colonial logic' (Morgensen 2011; Wolfe 1999), or care as 'anonymous' (Stevenson 2014) or 'cold' (Morales 2018). The capitalist and statist agendas of many healthcare marketplaces, as well as hyper-individualist and progress orientations toward life and health, invite these frankly postcolonial critiques.

Second, medical anthropologists engaged in work alongside clinicians may prefer to avoid the contentious language of colonialism. But Bhabha's framework can promote a systemic and historically placed critique of healing without vilifying local works of care. For example, my criticism has not been leveled at the nosological function of diabetes diagnosis at the bedside, but at the power dynamics during periods of diagnostic incorporation – the transformation of experience into authoritative knowledge through its positioning or placement (Bhabha's *einstellung*). Yet biomedical authority can be hegemonically powerful and, due in part to its embeddedness in for-profit pharmaceutical and technological markets, gains power through coupling with other sources of power. Recent arguments that decouple diagnosis from biomedical authority throw this problem into relief. For example, the manner and target of diagnosing can shift power to pharmaceutical markets (Dumit 2012; Petryna, Lakoff, and Kleinman 2006; Street 2014), to healers working on symptoms rather than root causes (McDowell and Pai 2016; Das and Das 2006), to corporate interests (Moynihan et al. 2013), or through various forms of self-diagnosis to persons in social contexts (Ebeling 2014; Prior 2014). Furthermore, the hyper-individualistic and medico-legal systems which typically attend biomedical hospital systems are empowered to ignore or overrun local systems of meaning, authority, and support (Smith-Morris and Epstein 2014; Street 2014). The harm of unexamined assumptions in this realm clearly warrants contentious language and radical openness to alternatives.

I conclude by suggesting how these three ideas – feeling difference, partial embrace, and the self-colonizing work of the patient – might be applied in productive and liberating ways across at least two levels of healing. At the level of clinical interaction, healers and patients recognize illness in different ways, not least because diagnostic technology assures that professionals and laypeople have vastly different data sets of signs and symptoms. Acknowledgement of *this* difference, and of the motivational conflicts it inspires, is an early step in decolonized care. Already, there exist power-leveling 'empowerment' models (Funnell and Anderson 2004; Hunt 2000) and 'motivational' approaches (Foley et al. 2005; Chen et al. 2012) in health care, though they are difficult to implement and sustain. As the sick become dependent on others, they are increasingly vulnerable to the moral actions of others (Gilligan 1982). Remembering the

relational obligations of the healing professions is part of 'person-centered care' (Barry and Edgman-Levitan 2012; Funnell and Anderson 2004). Models that promote flexibility, innovation, and workarounds in clinical settings (Timmermans and Freidin 2007; Berg and Timmermans 2000; Bouskill et al. 2018), and which complement the critical review of care processes for diabetes (Rock 2005; Mull, Nguyen, and Mull 2001; Hinder and Greenhalgh 2012) are positive ones. However, these models also run the risk of *distributing* knowledge and responsibility without necessarily *sharing* power and access to resources (Browne and Fiske 2001; Joseph-Williams, Elwyn, and Edwards 2014). Decolonized clinical interactions therefore require power sharing through invested relationships that emphasize relational and cooperative treatment priorities *over* unrealistic medical, metric, or logistical goals. Power sharing is, of course, relevant for a broad range of diagnoses (Hardon 2015; Myers 2015; Rohden 2015). Decolonized approaches will give greater value to consensus in treatment planning, and to both social and material capital (Smith-Morris 2008; Kawachi, Subramanian, and Kim 2008), thereby ensuring that patient change is less self-colonizing and more self-determining.

At a societal and structural level, colonizing health care ignores the social determinants of disease and all cascading (Manderson and Warren 2016) and syndemic (Mendenhall 2016) complexities of illness. While this diagnostic and treatment myopia may have its purposes, an important role of medical anthropology has been to broaden and particularize the healing gaze. For example, there is no diagnosis for two etiological factors in the suffering of those quoted above: their educationally influenced poverty and their dependence on others for transportation and mobility. Likewise, there is no diagnostic code, or corresponding investment in treatment, for the clearly narrated pressures to perform one's social and family roles, to manage multiple illnesses or a job, and to avoid becoming a burden on loved ones (Choudhury et al. 2014; Smith-Morris 2019; Weaver 2018).

About these latter pieces of knowledge, and their relevance to health care relationships, biomedicine can be a strategic and imperious colonizer (consider Stewart-Harawira 2005), not just for diabetes (e.g., Yates-Doerr 2015; Manian 2017). What have been known for decades as the 'social determinants of health' might be reconceptualized in decolonized medicine as the social features of health: elements of health and illness squarely *within* the responsibility of healing relationships. This shift will require fairly radical decolonization of current health structures and priorities.

Finally, medical anthropologists are well positioned to question the frames into which illness is diagnostically re-oriented. That is, there are epistemological and interventional assumptions at play in the diagnostic codes available, and in biomedicine's decision to assert a diagnosis before treatment. For example, consider Andrew McDowell and Madhukar Pai's (2016) work among Bengali doctors who, in contexts with limited basic medical care, attend to patients'

symptoms without feeling the need to make a diagnosis. Their research shows the connection of bodily symptoms 'to political economies, individual experience, and localized biomedicine' (McDowell and Pai 2016, 332). Likewise, there will always be aspects of illness that resist a diagnostic framework, reflecting the partial embrace of biotechnological frame, as for asthma sufferers who find themselves 'moving in and out of asthma' (Trnka 2018). Biomedical diagnosis, then, must be scrutinized for whatever pharmaceutical, technological, or simply capitalist agendas it helps sustain. Correspondingly, biomedicine's embrace of any patient's lifeworld can only ever be partial.[3] Decolonizing medicine will mean constant challenges to the unquestioned domination of a variety of ideas: of individualized autonomy and responsibility over communal self-determination in health; of Western, patriarchal, racist, gendered, or other structures that uphold health inequities; or of funding and organizational structures that create barriers to relational care (consider variously: Fanon 1994; Comaroff 1993; Nundy and Gulhati 2005; Hanchey 2016; Seth 2009; Greene et al. 2013; Hollenberg and Muzzin 2010; Smith-Morris 2019).

To acknowledge a third space of hybridity between the diagnostician and the patient, as Bhabha has done for the colonizer and colonized, is an underutilized tool for critical medical anthropology. The fierce convictions of V. S. Naipaul, whom Bhabha sees translating Joseph Conrad 'from Africa to the Caribbean' convinced of the value and integrity of the English word, autonomous from its own colonial history, are comparable to the fervor of the healer. The nosological claiming of territory, the demarcation of an actionable healing space and target – these acts are discursive proclamations that situate a sufferer into their colonial difference, neither original in their enactment of the diagnosis nor identical to the textbook version of that diagnosis. In colonial terms, diagnosis becomes an act of governance and control, if not also biocitizenship, capitalist relationality, or settler nation subject. Hybridity meanwhile provides a space in which to resist or only-partially submit, where disease stigma, unequal access, and the injustice of market-based medicine can be taken into account. Bhabha is neither an applied scientist nor a medical anthropologist, but were contemporary lessons for clinical care to be learned under the shade of the trees just outside Delhi, they would invoke the revolutionary language of decolonization.

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3   For Bhabha, from the moment at which difference is recognized or acknowledged ('after the intervention of difference'), a number of events unfold that contribute to hybrid possibilities including of race, religion, and gender. Bhabha's hybridity thereby differs from the more singular hybrid state of the individual in colonial alterity of Mauss, Dumont, and Said, or even of Derrida's Other. This attitude toward hybridity is what makes it more useful to studies of the patient experience than some of these other theories of personhood and ethnicity.

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About the author

Carolyn Smith-Morris is a medical anthropologist and associate professor at Southern Methodist University. Her research documents the experience of chronic disease and disability, particularly diabetes, through mixed methodologies. She has conducted research among the Gila River (Akimel O'odham) Indian Community of Southern Arizona, Mexicans and Mexican immigrants to the USA, and veterans with spinal cord injuries. Her most recent work questions the inadequacies of disease-specific health care systems; that is, the systems of multiple medical appointments, overlapping medication regimes, and competing professional explanations that patients suffering from multiple chronic conditions must endure, understand, and manage.

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