Health care as a means of social control: An argument against galvanizing through education

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Opinion Editorial
Published November 30, 2018

The operating assumptions that underlie conscious and subconscious frameworks are shaped by group norms and socialization from the various cultures and communities in which we engage. As such, the frameworks inherent in Western, and more specifically American, individuals tend toward individualistic dispositions. This results from the culture of capitalistic consumerism and human rights violations that remain largely unquestioned. Those that do question this socialization often come from backgrounds in formal ethnographic or philosophical settings that reinforce labor and intellectual hierarchies without calling for equity. As such, the frameworks that elites work within, though commonly labeled as progressive, contribute to the rise of theoretical dispositions composed of elitism and intellectualism. This disposition delegitimizes narrative and lived experience to favor theoretical interpretation that prioritizes merit based on socially acceptable methods of education. This not only disempowers the voices of people experiencing marginalization, but also dehumanizes and objectifies their right to space, voice, and power in a society that continues to benefit from their extortion. This is exemplified in the United States health care system through the organization of, and interactions between, health care administrators, practitioners, and patients.

Intersectionality argues that truth is polyvocal and that there is no single narrative. Furthermore, the dominant narrative is one that, while holding truth, is often violent. This violence does not stem from content, but rather context in that the prioritization of some truths over others is objectifying and depersonalizing. Meaning is relational in its experience and interpretation. Interpretation is far from infallible in that the interpretation of something, meaning the manner in which interactions are categorized and transformed to equivocate meaning from one to another, necessitates projection. This process becomes violent when one lacks the will and ability to be reflexive. By engaging in a reflexive framework, the self becomes increasingly aware of how its own presentation impacts their interactions with others. This process also facilitates a better understanding of meaning as a result of socialization and interpretive reality, recognizing the incomplete nature of assumptions in all things. In medicine, this is best observed in the role of providers in the monetization of wellness and bodily norms.

The concept of the sick role and cultural competence lack a major component necessary to providing just, equitable, and humane health care interactions: compassion. Compassion is (or ought to be) the basis for health care. Health as a human right is a belief that any health care worker should possess as motivation; however, with labor-based oppression, this is often not the case as wage labor criminalizes poverty. Capitalistic systems enforce career standards that make the health care field a likely place to find dispossessed people who are overworked, underpaid, and underappreciated. This combination feeds on emotional energy and mental stamina, creating a toxic environment focused on medicalizing bodies and hegemonic interpretation of illness. The sick role attempts not only to instill this process, but justify it through the process of socializing patients and medical providers into worsening the power imbalance in clinical settings. This is disguised as an explanation for patient-doctor interactions when, in reality, it operates as a tool of hegemonic enterprise by corrupting natural reciprocal altruism evident in humans.

Centering compassion as a means to provide basis for theory prioritizes humanity over false efficiency. I say false efficiency under the assumption that the ultimate goal of the health care system is healthy communities and the ultimate goal of health providers is healthy individuals; however, this is not necessarily the case. Our profit-based health care system prioritizes monetary achievements and fiscal health over the benefice of communities. As such, the system favors interactions that yield high profits with little time expenditure. Simply put, our health care system engages in a cost-benefit analysis to determine morality and justice. Being composed of

capitalists, our government endorses this mindset with lax profit regulations on insurance companies, medical technology and pharmaceutical companies, and clinical regulations. Until our disposition on an institutional level centers compassion and the right to wellness, dignity, and health for all people as a problem of access and environment, the systematic indoctrination of physicians and wellness institutions to prioritize wealth over humanity will continue.

The concepts behind the sick role and cultural competence focus on individual interpersonal interactions that stigmatize illness and non-hegemonic identities as deviant and "fixable." Generalizing about all people through a medicalized mindset dehumanize bodies and devalue narratives. It places the responsibility for care on the shoulders of those whose experiences and existences differ from that of the practitioners. The reductionist views in the sick role and cultural competence generalize based on stigma and objectification while valuing distinct identity groups based on assigned, rather than self-identified, labels. This pretends that identity is immutable, unaffected by context or personal experience.

Overall, the sick role and cultural competence is yet another form of bodily control through subjective legitimacy and false dualities. The sick role, for example, fails to problematize mental illness and disability as a cultural and social creation. Sociocultural barriers to communication, logocentrism, and appropriation regarding self-designation and the conceptualization of knowledge in biomedicine further engrains the proximal goal of medical interactions as resocialization of deviance for the "good of society." The failure to address interpretive positionality and favor for detachment as an alternative to reflexivity has evolved from neoliberal ideology and threatens to disengage humanity from the medical process altogether.

Addressing these inequalities inherent in society and health care, many propose educational reform. To start with education during medical training is to see the problem of the physiological embodiments of discrimination and social determinants of health as insignificant in addressing health disparities based on identity. Instead, we should be addressing systemic and institutional barriers to health equity through policy reformation. Limits to contextual understanding and awareness hinder reflexivity, especially when individuals do not actively seek to challenge their assumptions. In addition to these limiting factors, our sociocultural values prioritize the "stability" of capitalist hierarchy and often support the belief in self-made success evident in the cult of the individual. So long as people hope for a better life and believe in the existence of social mobility to validate their existences, institutional capitalism will continue to abuse our population.

Rejecting methods and theory-based paradigms would require a disruption in the prevalent belief that merit must be proven through institutional mechanisms, rather than inherent legitimacy. As such, elites hold the power to control understanding and approach based on "expert" arguments and hegemonic narratives. Furthermore, marginalized people are forced to subject themselves to physical, emotional, and mental damage in interactions, even when they are not attempting to engage hegemony.

We, as a society, must learn to value all voices, without having them restrained and filtered through elite mechanisms or pandering for social respectability. Reframing and reconstructing the values of human stories requires an in-depth reflection on our history as well as our present. If we begin by re-educating, we continue to contribute to current oppression through an inadequate understanding of past violence. This method also fails to achieve the goal of reducing violence, because the majority of the violence is maintained by systematic and institutional forces that govern human behavior. This is not to suggest that individuals lack agency to act justly, but rather that benefice is limited in its significance and accessibility without movements to address systematic oppression. Working within reductionist realities contribute to the theoretical and positivist approach without addressing critical realism or operational reciprocity. We must continue to fight for order without hierarchy and reject the social norms that contribute to hegemony through elitism and intellectualism.

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