Narrative Intersectionality in Caring for Marginalized or Disadvantaged Patients: Thinking Beyond Categories in Medical Education and Care

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Abstract

Categories are essential to doctors' thinking and reasoning about their patients. Much of the clinical categorization learned in medical school serves useful purposes, but an extensive literature exists on students' reliance on broad systems of *social* categorization. In this article, the authors challenge some of the orthodoxies of categorization by combining narrative approaches to medical practice with the theoretical term "intersectionality" to draw students' attention to the important intersecting, but often overlooked, identities of their patients. Although intersectionality applies for all patients, the focus here is on its importance in understanding and caring for marginalized or disadvantaged persons.

Intersectionality posits that understanding individual lives requires looking beyond categories of identity in isolation and instead considering them at their intersection, where interrelated systems of power and oppression, advantage and discrimination are at play and determine access to social and material necessities of life. Combined with narrative approaches that emphasize the singularity of a person's story, narrative intersectionality can enable a more robust understanding of how injustice and inequality interrelate multidimensionally to produce social disadvantage.

The authors apply this framework to two films that present characters whose lives are made up of numerous and often-contradictory identities to highlight what physicians may be overlooking in the care of patients. If the education of physicians encourages synthesis and categorization aimed at the critically useful process of making clinical "assessments" and "plans," then there must also be emphasis in their education on what might be missing from that process.

> Social life is considered too irreducibly complex … to make fixed categories anything but simplifying social fictions.
>
> —McCall, 2005[1]

Medical education depends on categories. From the first day of medical school, students are trained to see, hear, and think in categories. In the preclinical curriculum, a great deal of this thinking is binary: healthy versus diseased, normal versus abnormal, typical versus atypical. In the clinical environment, much of this thinking involves "preset algorithms and practice guidelines in the form of decision trees."[2] Does it look normal/feel normal/sound normal, or not? Do the numbers/counts/values fall within a range called "normal," or outside that range? Such categories, then, are essential to doctors' thinking and reasoning about their patients' health and illnesses. Indeed, much of the clinical categorization that is learned serves useful purposes. For instance, identifying a person within one of the body-mass-index-based categories of obesity (underweight, normal weight, overweight, overweight obesity I, overweight obesity II, overweight obesity III) offers the benefits of understanding differences in risk factors, responsiveness to treatments, and prognosis.

The categorizing work of medicine isn't, however, limited to the purely clinical. Even though the *social* categorization of patients is generally not part of the formal curriculum, such categorization is unequivocally taught or modeled, or both, explicitly and implicitly throughout students' clinical education. A wide literature exists on the *social* categorization of patients, beginning over a half century ago with Howard Becker and colleagues'[3] classic study of medical education, *Boys in White*. This study found that students engage in continuous categorizing of patients into two major systems of social classification—the interesting/uninteresting patient as relates to his or her illness, and the ideal/despised patient marked by their personal characteristics and social status outside of the hospital. Such sorting patients into groups or types was elaborated further a quarter century later in Terry Mizrah's[4] *Getting Rid of Patients*, and 20 years later by several of us in "Making Fun of Patients,"[5] both of which detailed the often-subtle and complex categorization of patients. Importantly, all of this categorization—whether clinical or social—is purposeful, meant to frame how physicians might approach those so categorized in their efforts to "help them."

Here we attempt to challenge the orthodoxies of categorization using an educational approach we call narrative intersectionality. This approach draws from narrative medicine and the concept of intersectionality, which holds that we are all made up of many different, intersecting identities. In what follows, we introduce intersectionality and then link it to narrative approaches within

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medicine. From there, we demonstrate how we use two films to explore the insights about social categories that narrative intersectionality makes available to learners. By linking narrative to the concept of intersectionality, we make a case for blending the two orientations as a means of offering future physicians a richer, and thus more beneficial, understanding of the patients for whom they will provide care. And although the concept of intersectionality can be applied to all patients, albeit differently depending on their intersecting traits and the interplay of advantage and disadvantage, we focus specifically on how the approach we outline here can lead to a greater understanding of disadvantaged people, and greater appreciation of the complexities of health disparities.

Intersectionality

Intersectionality is a concept and methodology used widely in many academic disciplines outside of medicine. It is most often traced to scholar Kimberlé Crenshaw,[6] who works in the field of law, and who describes intersectionality as "an analytic sensibility, a way of thinking about identity and its relationship to power." At its core is the belief that individual lives cannot be fully understood by attending simply to narrow bands or categories of identity—gender, race, age, class, sexual identity, disability, immigration status, and so forth—in isolation. Rather, individuals must be considered at the intersection of their identity categories, where interrelated systems of oppression and discrimination, advantage and disadvantage are at play and determine access to the social and material necessities of life. Thus, intersectionality offers a framework that "captures the complexity of lived experiences and concomitant, interacting factors of social inequity, which in turn are key to understanding health inequities."[7] Here such a framework can enable a more robust understanding of how injustice and inequality occur on a multidimensional basis, and in fact interrelate, producing a "complex synergy" of social disadvantage, "the parts interacting to form a complex whole that cannot be disentangled into any single phenomenon."[8] Using an intersectionality framework, one begins to pay attention, for example, to how

> different types of discrimination intersect to oppress people in multiple and simultaneous ways, contributing to social inequality and systemic injustice. For example, knowing that a woman lives in a sexist society is not enough to understand her experience of that sexism: one must also know her race, sexuality, age, and class [among other factors] to begin to understand her unique experience of discrimination.[9]

In other words, "a real life person is not, for example, a woman on Monday, a member of the working class on Tuesday, and a woman of African descent on Wednesday."[10] She is already and always all of these identities. It is equally important to dispel the notion that these identities are hierarchically situated, or that singly each has an equivalent effect on her life; these identifications are continually overlapping and intersecting in *this* particular person. Thus, when seeking to understand the life experiences of any one person, any stand-alone category of identity falls short of broadening such understanding when treated as a discrete entity.[11]

Although the concept of intersectionality is seldom discussed in the actual practice of health care, it often informs the literature of medical education,[12–14] medical sociology, and public health,[15,16] as well as any number of disciplines focusing on women's health.[1,8,10] Because it focuses on power, privilege, and discriminating social practices,

> Intersectionality embraces rather than avoids the complexities that are essential to understanding social inequities, which in turn manifest in health inequities. It therefore has the potential to create more accurate and inclusive knowledge of human lives and health needs.[7]

In addition, the concept of intersectionality lends itself to narrative traditions involving case studies, which we discuss below.

Narrative Intersectionality

Narrative medicine, as Rita Charon[17] contends, is an approach that recognizes that the "care of the sick unfolds in stories" and that "the effective practice of health care requires the ability to recognize, absorb, interpret, and act on the stories and plights of others." The kind of knowledge one gains from stories of all kinds—novels, poems, film, newspaper and magazine articles—provides a "rich, resonant comprehension of a singular person's situation as it unfolds in time."[17] This *singularity* is key to the link between narrative and intersectionality, for this link emphasizes the singular person who, in her singularity, may embody many categories of identity. It highlights her uniqueness, her particularity, as she presents to the health care provider in the variegated aspects of her life that are present in no one else's. Intersectionality, then, "can be considered an intellectual descendent of narrative studies."[1]

Sayantani DasGupta[18] has written eloquently about narrative medicine, adding the critical element of humility to this inquiry. Doctors and other caregivers do not ever fully "get" their patients' lived experiences, and the efforts of medical educators and evaluators to move medical students and residents toward "competency" in such understanding are, at best, mythical thinking. Rather, she contends, they must enter such relationships with humility about their ability to understand, acknowledging that when patients walk into health care settings, there is a

> parallel sociopolitical narrative that enable[s] the telling of certain sorts of stories and silence[s] other stories. Narrative humility allows clinicians to recognise that each story we hear holds elements that are unfamiliar—be they cultural, socioeconomic, sexual, religious, or idiosyncratically personal. Assuming that our reading of any patient's story is the definitive interpretation of that story is to risk closing ourselves off to its most valuable nuances and particularities.[18]

Such is the link between narrative and intersectionality for clinicians, bringing together two analytic sensibilities that rest on the "multiple, intersecting, and complex social relations"[1] always present in patients' lives and the stories they bring to health care settings. In the next section, we offer examples of how to illustrate this link for students in discussions of two films.

Narrative Intersectionality in Two Films

In what follows, we examine two films, *Precious*[19] and *Dirty Pretty Things*,[20] that present characters whose lives comprise numerous and often-contradictory identities. The objective of this exercise

is not to deny the power and influence of categories—either on individuals thus labeled, or by viewers who apply those same labels—but, rather, to invite interpretations that acknowledge the limitations of such efforts to categorize. As Leslie McCall[1] argues, categories are often inescapable, but developing a critical stance toward their application is a worthwhile endeavor that fosters a greater appreciation of the complexities of intersecting identities.

Precious

Precious depicts the story of Claireece Precious Jones, a 16-year-old African American woman living in Harlem during the late 1980s. When the film begins, she is pregnant with her second child, who, like her first, is a product of incest perpetrated by her father, Carl. Precious lives in squalid public housing with her mother, Mary, who is verbally, physically, and sexually abusive. Precious's first child, Mongo, a daughter born with Down syndrome, lives with Precious's grandmother.

Precious is a difficult film to watch and can be seen as trafficking in stereotypes—what has been called "poverty porn" by more than one reviewer[21,22]—but perhaps the film's problematic aspects make it especially useful for discussions of narrative intersectionality. Just as a reliance on single categories in the practice of medicine may lead to an oversimplification of patients' lives, so too does a focus on the character Precious as only female, only illiterate, or only poor reduce the complexities engendered when those identities intersect in a single individual. Narrative intersectionality recognizes that more is going on than any single category or identity can explain. With such recognition comes the possibility for greater appreciation of patients' complex and particular lived experiences beyond the exam room.

One particular scene in *Precious*, titled "For the Social Worker," offers medical educators a rich depiction of how these complexities play out. In this scene, Precious and her mother are at home, where Precious's grandmother has arrived with Precious's daughter Mongo for a staged "performance" for the social worker, who believes Mongo belongs to Mary, not her teenage daughter, Precious. Once the social worker arrives, Precious assists in her mother's performance, clearly understanding how to play her part in her mother's deception. Only once during the social worker's visit does Precious speak; she answers "I'm doing good" when asked about her own well-being. Staring coolly at the social worker, Precious inhabits intersecting identities: a teenage mother, victimized by incestuous rape and an abusive mother; a young woman living in poverty; an illiterate high school student wronged by dysfunctional public schools; and a morbidly obese teenager force-fed by her mother.

To further explore the powerful nature of these intersecting identities, we suggest introducing into the discussion the following description of Precious by Sapphire, the author of the novel on which the film is based, who writes: "I wanted to show that this girl is locked out through literacy. She's locked out by her physical appearance. She's locked out by her class, and she's locked out by her color."[23] We would add that she is also locked out by her limited education, and as a victim of abuse. As Sapphire makes clear, no single factor or characteristic explains Precious's situation. To simply focus on one of them is to oversimplify the complexities of her lived experience.

While the social worker in the scene never recognizes these complexities, and seems to function as an example of the institutions that fail to assist Precious, the film offers examples of individuals within those same institutions who do not fail her: Ms. Rain, a teacher at an alternative school Precious ultimately attends; and Ms. Weiss, another social worker, who works with Precious directly. In both instances, these individuals invite Precious to tell her story, a strategy that assists her efforts to speak authoritatively about herself as she is able to name and ultimately resist the forces that have formed her.

Just as *Precious* is a difficult film to watch, discussions of it can be equally tough, especially given the complexities of Precious's intersecting identities. Asking students to imagine a patient like Precious seeking their care offers them an opportunity to focus their attention on those complexities, rather than on a single category such as obesity, and then to describe how her obesity intersects with sexual abuse, illiteracy, and poverty. Through this exercise, students begin to realize that to focus entirely on Precious's obesity in a health care setting dooms the care she receives.

Dirty Pretty Things

Dirty Pretty Things offers a darkly layered, disturbing portrait of characters whose lives are lived on the margins of British society, all who find themselves for one reason or another at West London's Baltic Hotel. Okwe was a doctor in his native Nigeria but is now a political exile who works by day as a cab driver, by night as a desk attendant at the Baltic Hotel. He rents a couch at the apartment of Senay, who fled Turkey and is now working as a maid at the hotel—illegal work because of her immigration status. One evening when Okwe is managing the front desk, he is called upstairs to check a clogged toilet, and the first thread of the plot begins: A human heart is the source of the blockage. When he reports this to the hotel night manager Juan, himself an immigrant, he is told to mind his own business, but ultimately uncovers the cruel activity taking place there. In makeshift surgical suites, desperate people—here, undocumented persons—are having their kidneys extracted in exchange for fake passports, the flushed heart resulting from a procedure gone awry.

In the meantime, Senay is having her own problems with immigration officials who are on to her illegal employment at the Baltic. Forced to take a job at a sweatshop, she and dozens of women, most of them undocumented, work under a similar threat of being discovered. The following scene at the sweatshop illuminates the intersectionality Senay embodies, which goes to the heart of this film about the human lives found in the hidden world of undocumented workers. The manager of the sweatshop preys on their vulnerability and targets Senay with demands for sexual acts. Claiming that he wants to be "respectful" of the religious code of chastity for Muslim women, he forces her to engage in oral sex as payment for his silence to immigration authorities. Her humiliation is immense, and ongoing, until she can no longer yield to his demands and, quite simply, "bites" and flees the sweatshop. At the close of this scene, Senay's plight becomes more desperate as she lives her life as a woman,

a Muslim, an undocumented immigrant without employment and family support, and now a person without a place to live. The remainder of the film's action links back to the earlier scene involving organ trafficking which increasingly involves Senay and Okwe as they work to avoid deportation and build lives with some semblance of hope.

Discussion of this scene is fraught with complexity. Where, one might ask learners, would a health care provider even *begin* when Senay appears in the exam room, disclosing, perhaps, sleeplessness and anxiety? As Zowie Davy[24] points out, immigrant women are usually in lower-paid, "part-time, precariously safeguarded work, often a great distance away from friendship and kin networks; this, joined with racism and poor housing, results in unfavorable social conditions, all of which can add associated bodily stresses that may exacerbate ill health." Senay's story is variegated with issues that are folded together, intersecting, not layered one on top of the other in discrete categories of identity. Moreover, choosing to focus on only one identity obscures the others, and to prevent that, a caregiver would have to begin at the beginning to address who she is, how she arrived in London, what her life has been like, and what she currently faces. Attempting to understand the intersections that define who and where Senay is, is thus a move toward patient-centered care.

Narrative Intersectionality, Film, and Medical Education

Given how often time constraints and curricular demands limit the space available for humanities courses in medical education, we find that using film provides educators with a means of introducing humanities concepts and tools for analyzing complex narratives with students in an efficient but valuable manner. If possible, we recommend requiring students to watch a film in advance, so class time can be devoted to discussing specific scenes that can be watched and rewatched collectively.

Rewatching a scene is especially valuable for introducing students to a concept such as narrative intersectionality because it offers them opportunities to practice its application. The following is a description of how the scene from *Precious*, where the social worker visits Precious's home, can be used in the classroom for this purpose. Begin by providing students with a brief setup for the first viewing of it as a class. After watching the scene, ask students to identify what they see as most important about it. The point here is to encourage open dialogue, while taking notice of what students do and do not discuss. Before the second viewing, introduce the concept of narrative intersectionality and ask students to name Precious's various identities, prompting them when necessary to think beyond obese or pregnant to include others that are less obvious medical concerns. Then return to the scene and ask students to look for instances where these identities become apparent and when and how they intersect. The objective for the discussion following the second viewing is to guide students toward a recognition of factors, such as illiteracy and poverty, that influence health outcomes of patients. Although this overview focuses on *Precious*, the approach can also be applied to the scene from *Dirty Pretty Things* discussed previously, as well as to other films.

Insights and Implications

We have drawn attention to the commonalities between narrative and intersectionality. The development of Precious into a literate and self-possessed person, along with her eventual decision to care for her two children and distance herself from her family, comes as a result of her learning to tell her story, and meeting a teacher and a social worker who have the skills necessary to recognize the many intersecting identities that constitute it. Similarly, our understanding of Senay does not rest on any one aspect of the multiple identities that converge into her particular life story. Such understandings involve what Charon[17] calls narrative competence—that is, the ability to "absorb, interpret, and respond to stories." Such competence is, however, not to be mistaken for mastery of another's story,[25] a process that can lead to a reliance on the same systems of categorization we have cautioned against. As a strategy for the practice of medicine, narrative intersectionality recognizes that any given patient's life comprises many different identities, the telling of which may never occur completely in the health care setting. Herein lies the importance of DasGupta's[18] concept of narrative humility, which acknowledges that "patients' stories are not objects that we can comprehend or master, but rather dynamic entities that we can approach and engage with, while simultaneously remaining open to their ambiguity and contradiction."

If the nature of the clinical education of physicians moves them toward synthesis and categorization aimed at the critically useful process of making clinical "assessments" and "plans," then there must also be emphasis in that education on what might be missing to inform such assessments and plans. Students are taught to gather a detailed history and conduct a thorough examination, all the while progressively focusing more and more on the disease dimensions of that history and exam, and then to synthesize all the gathered data into a cogent unifying summarization—an aim Robert Coles[26] describes as getting "to the concise, penetrating heart of things." Coles, reflecting on his own training, refers to this process as learning to construct a concise but all-encompassing "theory," an abstraction that results from "how we shape what we have heard into our own version of someone's troubles."[26] Describing his own "acquiring facility with abstractions," Coles goes on to confess that despite being chided by a mentor for "more stories, less theory," he often remained "in pursuit of *le mot juste*,"[26] a way of turning all of a particular patient's experiences and identities into a single, often one-sentence characterization: a 58-year-old black male who presents with chest pain likely cardiac in origin. Coles discovers, with the help of his more narratively focused mentor, the cautionary flag that needs to be waved here, that "in our self-consciousness as … theorists, we lose sight of human particularity."[26]

Traditional efforts to move clinicians toward tying all of what is known about a suffering person into a tidy little bow risk enforcing a system of categorization that ignores elements of such a person's multiple and complex life experiences, identities, and life worlds. Clinical scenarios unfold each day in which physicians encounter patients at the intersection of their complex and varied identities, and in which physicians overlook important identities and oppressive experiences in ways that lead to substandard care, and even to

patient harm. Consider a patient who presents, for example, to a local free clinic—a place where many assumptions are made about patients, where "single story thinking"[27] is prevalent, and where patients often have multiple overlapping identities and life circumstances, many of which they may seek to hide from their caregivers. In the initial interview, the patient ultimately discloses that she is a retired college professor who has fallen on hard times financially since her university employer terminated her pension benefits. Such a person must be approached with every attempt to understand her lived experiences as having been shaped in the contexts of the identities not only of an older person, a woman, an African American, a patient at a free clinic, and a person of limited financial means but also a highly educated scholar and professor. Absent a fuller understanding, the disconnects that can develop between such a patient and her physician can only be overcome by greater self-knowledge on the part of the physician, a fuller understanding of the person standing before them, and a greater humility regarding physicians' always-incomplete knowledge of others. A narrative intersectionality framework for relationships with patients offers some hope that medical education can do better.

Over a century ago, William James wrote that "we carve out order by leaving the disorderly parts out."[28] At the heart of any one person's "intersectional self" is disorder—the disorder of multiple, interweaving identities that converge uniquely in the story of a solitary life. In the training of physicians and other health care professionals who are invited into just such a solitary life to engage with a particular person possessing many intersected identities, it is clearly not enough to simply strive toward checking all of the competency boxes in their "learned" understanding of such others. As medical education has begun to move away from learning pedagogies aimed solely at achieving *competency* toward more complex assessments aimed at *mastery*, a focus on intersectionality offers students a broader appreciation of the always-incomplete understanding of others. In all such efforts, health care professionals and health professions educators are better served to surface the discomfort, the disorder, the complexity, and the oppression that reside within the intersectionality of each particular patient's lived experiences. Only then can we offer hope that patients whom we always thought we would come to understand fully might be invited into humble and healing relationships with those whose care they seek.

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