Problematized Patients

– Intersectional Perspectives on Gender, Ethnicity, Class and Biomedicine

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Equality in access is a cornerstone of the Danish public health system. Therefore it can be seen as particularly important to neutralize differences related to gender, ethnicity and class in order to provide equal access for all. This article[1] argues that gender, ethnicity, and class cannot be neutralized, and that these categories play a constitutive role in subjectifying patients. The article presents an empirical analysis of the constitutional processes of becoming a patient in a Danish hospital setting by focusing on the intersections between biomedicine, gender, ethnicity, and class.

This article demonstrates how the categories of gender, ethnicity, and class are brought into play, silenced and/or merged and mixed differently in each case. In addition, we show how biomedicine is produced as neutral in negotiations with gender, ethnicity, age, and class, and how this intertwining play a constitutive role in the way patients are constructed as problematic within the clinic.

Three 'problematized' patients will be analysed: Tanja, a dissatisfied patient with an unclear diagnosis; Ali, a patient with terminal cancer who wants to secure his wife's housing situation; and lastly Kamal, who has been critically ill, but is now recovering, though still complaining about pain and weakness.[2]

Intersectionality and health

Research produced from the perspective of intersectionality is rare within health and medicine. Hardly any such study has been

carried out in Denmark. It seems that gender, ethnicity, and class are still controversial and marginalized research topics (Hølge-Hazelton et al. 2009). The male, white, middle-class subject still constitutes the norm (Hovelius et al. 2004, Malterud 2006). This, together with the conventional view of biomedicine as neutral, may explain why identity categories are dealt with separately and why intersectional approaches within this field are rare.

Within medical anthropology and sociology, studies of patients with an ethnic minority background are more frequent. Often the focus is also on gender in the sense of, for example, a focus on migrant women (e.g. Nielsen 2005). However, in general the focus is neither on the construction of ethnicity or gender nor on the intersection between them.

Schulz and Mullings (2006) present intersectional studies of health, primarily in the United States. They argue that intersectional approaches are useful when it comes to understanding health disparities. They propose a macro view of how factors such as politics, culture, society and knowledge structure and effect inequalities on the basis of race, class, and gender, combined with a micro view of how race, class, gender, and health are produced in specific social contexts.

Theoretical and methological remarks

Appreciating that intersectionality does not present an unified theoretical concept (e.g. Jensen 2006), the work presented here draws on two different positions within intersectionality studies: a Danish, post-structural approach rooted in social psychology (e.g. Staunæs 2003, 2004, Søndergaard 2005), and a US structural approach grounded in Critical Race Studies (Crenshaw 1995). Whereas the former position emphasizes the ways in which categories like gender, ethnicity, and class are interpersonally negotiated and thus given meaning by subjects in interpersonal doings and sayings, the latter focuses on the effects that these categories have on processes of structural and political marginalization. Christensen and Siim (2006) argue that there is a need to develop an intersectionality position that links the level of social structures and discourse to that of acting subjects. In this article we build upon these approaches. Following Schulz et al. (2006), the article applies the notion of intersectionality in such a way that it emphasizes institutional concepts and how they shape knowledge, how inequalities are intersectional and contextual, and how the positioning of patients and thus access to health care are differentiated by race, class, and gender. The potentials of this approach will be discussed at the end of the article.

The work presented here represents a process of subjectification, but it also relates a particular welfare institution, the hospital. The view of institutions put forward here is that they are not free-floating or disconnected from the societies in which they exist, but profoundly social and specific at the same time, constituted by culture and history as well as everyday practices (Rasmussen 2009). Placing the daily practices of the institution at the core of the analysis enables the actual conditions of subjectification to be explored. In line with Foucault, we understand practices as "places where what is said and what is done, rules imposed and reasons given, the planned and the taken for granted meet and interconnect" (Foucault 2003: 248). In other words, we conceive realities as constituted in and through practice.

The empirical material presented here is based upon ethnographic fieldwork undertaken in two wards in two Danish hospitals for a total of two months during 2008-2009 (Holen in preparation). The method used for data production consisted of observation of daily practices in the ward and of interactions between patients and profes-

sionals, as well as among professionals and among patients separately (e.g. ward rounds, conferences and informal conversations). Comprehensive notes were taken on basis of the field observations, focusing on the doings and saying of the actors.

The three cases have been selected and linked together as they are all problematized patients: indeed, they are, in different ways, being rendered problematic by the institution itself. Analyzing problematized patients permits the ideals of the normal patient to be analysed. Processes of normalization often pose a blind spot in both daily life and research, since the normal is invisible. Therefore, examining the arguments of professionals when discussing difficult patients can function as a mirror to what is considered normal (Søndergaard 2002) within the hospital.

We draw on analytical tools from the Foucauldian/poststructuralist approach within socio-psychology (Søndergaard 2002) as well as sociology (Rose 1998, 2009). The analysis explores the concerns in relation to which the problematization occurs and the systems of judgement used in doing so (Rose 1998: 25). This implies that we focus primarily on those actors that surround the patients, in most cases the health professionals, but also fellow patients. We analyse the doings and sayings around the given patient, exploring the elements and processes of othering (Lehn-Christiansen in preparation) and asking whether they are connected to gender, ethnicity and/or class, and if so how. Analytically we look for enactments (Mol 2002) of gender, ethnicity, and class by all the actors concerned. In some cases the patients are being explicitly gendered (as is true of Kamal), while in other cases gender surfaces as a result of the analysis (as is true of Tanja). In these cases we display the analytical chain of reasoning that makes the arguments plausible.

Gender, ethnicity, and class are analytical as well as empirical categories. We conceive these categories as emerging from relational, unstable and contextual negotiations, as well as structural, biological and material circumstances.[3] We consider biomedicine to be highly influential within the clinic (Bentsen 2000). Biomedicine and psychology are viewed here from within the Foucauldian tradition, which means conceiving them as certain ''styles of thought' (Rose 2007: 12). Biomedicine is based upon the idea of the clean and objective clinical gaze (Rose 2007, Foucault 1993), psychology on the idea of an inner, true self (Rose 1998).

'It is not easy being a young man from Pakistan'

Kamal was released from intensive care a few days ago. Now his temperature varies excessively and he needs a blood transfusion. While his medical condition is far from stable, the nurses nevertheless say he is improving. They describe Kamal as an exacting person who is forever ringing the bell, asking for assistance. At the morning meeting, they agree that the time has come when Kamal should do more by himself. Later, Kamal asks for help to shave. Pia, his nurse, agrees to hand Kamal his shaving gear, but refuses to help him shave. Kamal also asks Pia to call his mother and ask her to bring him some soft drinks, but she refuses, encouraging Kamal to make the call himself. In the office the nurses talk about how Kamal orders them about, and they support Pia in her efforts to make Kamal understand that 'he has to do more by himself to recover'.

Kamal is also said to disturb the other patients. One of them, Lars, has complained to his nurse, Mie, that Kamal asks some of the other patients in the ward to help him with various things during the night. Mie and Pia agree that this is not acceptable, and Mie says: "You just can't change it. I've tried it before. It is something cultural. They have difficulties under-

standing that they need to do something themselves to recover." In this discussion, it is ethnicity, not the biomedical condition that becomes the explanation for Kamal's behaviour. The arguments are based on the concept that Kamal's own experiences and expressions of his illness are not to be trusted due to his minority background. Thus, ethnic minority background implies 'being unable to understand', and if you do not understand you cannot take responsibility for your own condition.

"It is not easy to be a young man from Pakistan", the nurses say when they discuss Kamal. The statement seems to refer to a sense of logic whereby young men enact being a patient differently than young women. At the same time, ethnicity comes very much into play in the problematization of Kamal. The nurses agree that the problem is a combination of the 'cultural' (being Pakistani), age (being young) and gender (being male). When discussing Kamal, all nurses agree that Kamal is problematic. No one questions the idea that this is linked to his 'culture'. Certainly not all ethnic minority patients are problematized, but nonetheless problematic enactments among ethnic minority patients tend to be explained in terms of ethnicity.

'It is something cultural; He has to provide for his wife'

Ali, a man in his fifties originally from Iraq, is being discussed at the weekly nurses' conference. It is not his biomedical condition that is the issue. At this advanced stage of Ali's cancer disease, the aim of treatment is to improve his 'quality of life'. It is not Ali's way of being a patient in the ward that makes him a problematic patient; Ali is not complaining or asking for much help.

Nonetheless, Ali causes problems. The municipality has offered him a handicap-friendly apartment. They have now learnt that Ali has only a short time left to live, and they are considering retracting their offer. They are asking the health professionals to confirm that Ali is not in need of the flat anymore. The discussion is whether the municipality should be involved in Ali's medical condition: some nurses think that, as long as Ali is still alive, he should be offered the apartment. Also, Ali and his family are saying that they would like to move in before he dies, otherwise his wife will lose the right to stay in the flat. The doctors estimate that Ali will die within the fourteen days it will take the municipality to make the flat ready for occupancy.

When discussing Ali's case, the professionals describe Ali's wife as passive. It is pointed out that "she doesn't speak Danish", "she would always be at home" and "she's on welfare". Some think "it's a bit too tactical" of Ali and his family to try and secure the wife a better home before Ali's death, and they argue that the ward should tell the municipality that Ali's needs for housing have changed. The notion of excessive 'tactics' is linked to Ali's ethnic minority background, in effect to a particular understanding of 'culture'. What is being problematized is not Ali and his wife's economic situation, but their 'culturality'. More precisely, the chain of reasoning appears to be that Ali and his wife's current social and economic situation is a consequence of their ethnic minority background. Using this logic, one could argue that, if Ali and his wife were 'integrated' into Danish society, they would also become better off economically. In this understanding, Denmark remains classless: in other words, there is no socioeconomic disparity. In the case of Ali, it seems that the category of class is indeed very present, but at the same time it has no explanatory potential.

As in Kamal's case, it is ethnicity and gender that holds the key to explaining attitudes amongst the care-givers. "It is something cultural; he has to provide for his wife…", one of the nurses says. This statement, which is supported by many of those present and not questioned by any-

one in the conference, is based on the presumption that this would never happen in a 'Danish' family. Men maintaining women and men ruling women are constituted as something 'not Danish' and as the core of the problem surrounding Ali.

In discussing Ali's case, the nurses do not agree on what to do. But the idea that Ali's behaviour is linked to 'his culture' is, as in the case of Kamal, never discussed. This does not mean that there are no other perceptions in the ward or the hospital.

Nonetheless, in the case of Kamal and Ali, 'culture' is deployed as an explanation for patient enactments. Culture, or more specifically an ethnic minority background, makes gender tangible at the same time as class becomes veiled. In the next section we consider Tanja, a white Danish patient.

Can she be trusted?

Tanja is a 44-year-old woman who has been diagnosed with Crohn's disease, a chronic disease. This is the information on the blackboard in the conference room, where the nurses meet to discuss her. Tanja is waiting for an ERCP[4] to remove some gallstones. Tanja has asked for a full anaesthetic during the ERCP, which is not standard procedure. The doctors discuss whether she might have an infection. However, nothing in her condition is alarming. It is the language of biomedicine, which is the starting point for the health professional's construction of Tanja as a patient. But it is not Tanja's unresolved medical status that makes her a problematic patient.

The reason why Tanja has been chosen as subject for the weekly conference is that she is considered to be problematic because 'communication is difficult'. Tanja has left the ward in anger because she got into an argument with the leading doctor. She is now considering transferring to another hospital, as well as handing in a formal complaint. The nurses find this unreasonable and exaggerated. The question discussed is therefore not whether this behaviour is fair or not, but how to handle Tanja.

It is the interaction with Tanja that is viewed as problematic, a dimension that is explicitly put into words when one of the nurses suggests that they discuss the psychological aspect of her treatment. The suggestion activates a different knowledge paradigm from the biomedical one, namely the knowledge paradigm of psychology, which enables Tanja to be constructed as more than a diagnosis or a malfunctioning organism. Using psychological language, Tanja is now constructed as a patient who 'wants attention', and who is trying to 'manipulate' the professionals in order to gain 'secondary reward'. Thus, Tanja's request for a full anaesthetic could be seen as a call for more attention. It is this construction of Tanja that makes it sensible to discuss whether the nurses need to be 'firmer' or whether Tanja should have the ERCP 'as quickly as possible' in order to speed up her eventual discharge. It becomes a question of Tanja's personal characteristics, and the major issue is whether Tanja is trustworthy or not. There is no final biomedical proof of her condition available at present, and the evaluation of Tanja's personality makes the professionals question her right to a position as patient, which admission to the hospital formally entitles her to.

The nurses are not sure whether Tanja is really as sick as she claims to be. She reports diarrhoea and vomiting, but no one has actually seen them. Furthermore, the nurses are not sure whether Tanja is telling the truth when she says that she is not eating due to heavy nausea. They try to convince Tanja to eat by telling her that her body needs nutrition, but Tanja does not seem to listen. One nurse argues that some food would perhaps help Tanja to be a better mother to her two children. Tanja's medical test results do not give cause for concern, but on the other hand it is not possible to determine the level of pain or discomfort Tanja might feel.

Where Kamal's and Ali's unintelligible enactments are explained as 'culture', Tanja's ethnicity is not mentioned. Her majority ethnicity appears neutral. Her gender appears on the blackboard, but it is not problematized as such. It seems to be obvious what it means to be a woman, especially when one nurse links Tanja's eating habits to her role as the mother of her children. Unlike in Ali's case, gender is not linked to Tanja's ethnicity. Nobody says: 'It must be something cultural', or 'it is always women who are single parents'. Instead, it is said as if it is evident that women have the responsibility for their children, even if they are ill.

Mixing categories

The analyses of Ali, Kamal and Tanja shows how patients are subjectified in a hospital setting. We suggest that our analysis shows how the categories of gender, ethnicity, and class are put into play, silenced, and/or merged and mixed differently in each case (Lykke 2008).

The article discusses the cases of two ethnic minority patients and one patient who is positioned within the ethnic majority. It is only the minority positions that are articulated, the majority position being left unmarked. Ethnicity changes from being an 'invisible' category when it 'changes colour'. Tanja's ethnicity is invisible to the professionals, while Ali and Kamal come to be defined through their minority positions.

The category of ethnicity is used as a means of explaining individual behaviour: the professionals add meaning to the actions of Kamal and Ali by drawing on a discursive repertoire grounded in 'culture'. Here, 'culture' (as minority ethnicity) is constructed as an individualized and naturalized category that is completely open to interpersonal explanations.

What happens, though, when a 'minority ethnicity' intersects with 'gender'? The analysis shows that gender is used within the hospital setting as a naturalized and common-sense category. Gender is primarily addressed indirectly, intertwining with the ways in which patient enactments are evaluated. Thus, women are more likely to be understood as 'mentally deviant' (see Hovelius et al. 2004), while male patients are more likely to be positioned as 'whining' if they express fear or pain. In addition the analysis shows that the category of gender changes from being a naturalized category when combined with ethnic majority positioning to a 'visible' and de-naturalized category when combined with ethnic minority positioning: while Tanja's caring responsibilities in relation to her children are mentioned without any problematization, Ali's urge to care for his family is problematized. The latter is also true of the relationship between Kamal and his mother: her way of caring for her son is constructed as one that needs to change. In Kamal's case, it seems that it is the intertwining of the male-young-ethnic minority categories that activate and thus reproduce a certain kind of repertoire of problems about how young men with ethnic minority backgrounds behave and how, ideally, they *should* behave. The biomedical process of recovering is thus intertwined with gender and ethnicity, giving a certain meaning to the process of disciplining Kamal as a patient. Biomedicine delivers the argumentation to the professionals, making it obvious that it is Kamal who is mal-performing when he insists so determinedly on assistance.

Within the hospital, gender is viewed as a biological and psychological category. It is most often constituted as 'merely biological, a body-sign (Søndergaard 1996) that determines whether a patient should be admitted to the women's or the men's ward, whether they should be handed one type of patient clothing or another, etc. Gender is a statistical variable utilized in the production of epidemiological knowledge about gender differences in health (e.g. Minister for

Gender Equality 2004). But above all, gender is 'naturalized'.

The knowledge regimes of biomedicine and psychology allow for the production of knowledge about the mal-functioning male or female body, knowledge about gender-specific patient behaviour (Madsen 2007), or the 'culturally different patient' (Board of Health 2007). This knowledge (re)produces the norms of intelligible patient performance, but it does not allow for reflections of gender or ethnicity as enacted or produced within the hospital setting. Consequently, gender as well as ethnicity is constructed as an individual explanatory category, but excluding the present practices of the hospital.

But what kind of conclusion can be drawn in relation to the category of class, especially as this is not articulated in any of the three cases? Tanja and Ali are both on welfare and could therefore be categorized as socially or economically 'lower class'. Thus, the cases of Ali and Tanja have aspects pointing towards a clash of classes, and the analysis also indicates that class is dealt with very differently depending on its intersection with minority or majority ethnicity respectively. In Ali's case, the ethnic minority positioning seems to transform the category of class into a problematized one, leaving it open for ongoing negotiations Here, the professionals are positioned (by Ali and by the system) as playing an active role in Ali's economic situation. They discuss and take a stance in the discussion. In Tanja's case, class is silenced and her economic hardship is never open for discussion. In both cases, intersections between class and disease, or class as inherent in the hospital setting, are missing.

Conclusion

In this article, we have shown how patients are subjectified by two of the hegemonic knowledge regimes of the hospital: biomedicine and psychology. The article has shown how gender, ethnicity, age, and class are intertwined with hegemonic knowledge regimes, thus playing a constitutive role in the way patients are constructed as problematic within the clinic. Problematized patients are not to be accounted for through biomedical complexities, but through 'problematic' patient enactments. At the same time, patient enactments seem to have implications for the professional's understanding of the biomedical condition.

Existing research has already shown that biomedicine is not in any way neutral (Foucault 1993). But what our research adds to the existing body of knowledge is how biomedicine is reproduced as neutral within the clinic. By excluding problematic patient enactments from the knowledge regime of biomedicine and placing it within psychology or culture, a dichotomy between problematic patient enactment and biomedicine is reproduced.

We suggest this is possible because biomedicine is intertwined with another hegemonic knowledge regime within the welfare state, that of neo-liberalism.[5] Both regimes build upon individualization.

The analysis has also shown how professionals discuss their patients in ways in which gender, ethnicity, and class function to some extent as discursive resources providing explanations of patient's mal-performances. But as already mentioned, the explanations remain on the individual level.[6] While Kamal's and Ali's enactments are evaluated as culturally strange, Tanja's are evaluated as mentally deviant. Even though the discussions about Ali, Kamal and Tanja differ, they therefore also have something in common: the 'problem' is never the hospital, nor the relationship between the hospital and the patients. The problem is individualized: it is Tanja, Kamal and Ali who are the problems. As such, the challenge is that of handling problematic patients. There is thus no focus on how gender, ethnicity and/or class are profoundly structuring Danish society or the respective distrib-

ution of health and ill-health, and there is no reflection on the role of the hospital or the professionals in the negotiation of acceptable patient behaviour. In this way, biomedicine remains 'unmarked'.

One implication of this institutional individualization is that it renders meaningless discussions of how the hospital reproduces inequality. Another implication is that the professionals themselves are individualized, although it is obvious that, for example, the nurses' room for manoeuvre is limited by rationales that are profound rooted in the Danish hospital, such as neoliberalism, biomedicine and care-rationales (Holen and Lehn-Christiansen 2009).

Revisiting the concept of intersectionality

We argue that intersectionality is powerful as an analytic tool. Following Christensen and Siim (2006), the concept of intersectionality is understood and developed in close connection with the empirical field.

As pointed out earlier, intersectionality needs to be addressed not in relation to neither a subject- or inter-subjective micro-level, nor a structural-macro-level. Like Staunæs' use (2003), the concept of intersectionality used in this article actually brings together the concepts of intersectionality and subjectification. The process of becoming a patient is one of subjectification, a process of submission and resistance made visible in human interaction and speech acts. The analysis shows that categories may pre-exist as cultural reservoirs, but their articulation and particular meaning are matters of negotiation. But in addition to this 'micro-perspective', we insist on a perspective that stretches beyond the focus on inter-personal relations. By including the hospital as an institutional setting and knowledge regimes in the core of our analysis, we point to the conclusion that processes of subjectification are not only *embedded* in an institutional setting but in fact *constituted* by knowledge regimes and, specifically, by knowledge-doings in the institution.

By insisting on this 'double focus', we argue that it is possible within the same empirical analysis to grasp the processes of how identity categories are negotiated interpersonally, and how they are intertwined and transformed with and by knowledge regimes and knowledge doings embedded in both institutions and society. In other words, this position takes seriously the structuring effect that gender, ethnicity, and class have on the social reproduction of both health and marginalization, without treating the meanings of categories as inherent.

Notes

1. We wish to thank associate professor, RU, Stephen Carney, and scientific employee, DPU, Mette Lykke Nielsen, for their useful comments to this article.
2. This project is approved by the Danish Data Protection Agency. Patients and hospitals are anonymised.
3. This article does not have room for a discussion of how the categories differ in terms of their socio-cultural and material dimensions, nor the fact that they function according to different logics. See Jensen 2006 for a discussion of this problem.
4. ERCP is used to diagnose and treat conditions in, e.g., the gallbladder.
5. See Dean (1999) for an analysis of neo-liberalism in a Foucauldian perspective.
6. See Rose (1998) for a genealogical exploration of the contribution of psychology to the project of individualization.

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SUMMARY

Problematized patients – Intersectional perspectives on gender, ethnicity, class and biomedicine.

This article presents an empirical analysis of the constitutional processes of becoming a patient in a Danish hospital setting by focusing on the intersections between biomedicine, gender, ethnicity, and class.

The article uses the concept of intersectionality to emphasize institutional practices and how they shape knowledge, how inequalities are intersectional and contextual, and how the positioning of patients and thereby access

to health care is differentiated by race, class, and gender. Three 'problematized' patients are analysed, showing how patients are subjectified by the hegemonic knowledge regimes of the hospital. This illustrates that gender, ethnicity, age and class play a constitutive role in the way patients are constructed as problematic within the clinic, thus supporting existing research in biomedicine as not neutral but negotiable. In addition, the article shows how the categories of gender, ethnicity, and class are put into play, silenced, and/or merged and mixed differently in each case.

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