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Lateral Solidarity

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It was the afternoon of December 31st. Dinner had been served in the bedrooms of the rehabilitation clinic, but Ms. Dats decided that hers could wait: She had been in Guadeloupe for a month already, but hadn't sat outside much. That night, she'd rather watch the sky and chat for a bit. At home, she used an electric wheelchair and could easily move about, but in the rehabilitation clinic where I met her, she was constrained by an old manual wheelchair, too cumbersome and heavy for her to navigate. She noticed I had time and seized the occasion to be wheeled outside of her usual circuit in the clinic. We settled atop the hill overlooking Pointe-a-Pître, the main town of Guadeloupe where the clinic was situated, in a former colonial medical center first run by militaries and nuns nearly a century ago. We watched health workers leave for the night, wishing us a happy New Year as the last day of 2015 waned. Well installed in the twenty-first century, we were still sitting in the remnants of colonial history.

Housed in an outdated and structurally inaccessible building, in a hospital plagued by financial woes and thus unable to deliver consistent pharmacy, food and laundry services, the rehabilitation clinic was also situated in a major teaching and research hospital of Guadeloupe. Opened by a Guadeloupean doctor who wanted to bring post-stroke treatment to the Guadeloupean population, it was the main site of access to physical medicine and readaptation for Afro-descendant Guadeloupeans of all socio-economic backgrounds, as well as for people from nearby islands. In contrast, white Guadeloupeans tended to turn to private clinics on the island, or even fly to Paris or Bordeaux for treatment.

In this French-Caribbean archipelago first developed as a sugar plantation under the direct authority of Louis XIV and still non-sovereign today (Bonilla 2015), my research is broadly concerned with "postcolonial repair," or the strategies people develop to address and respond to historical and contemporary inequities that weigh on their everyday life. I understand repair as always ongoing rather than a one-time event, enacted through everyday movements. In the clinic where I met Ms. Dats, I observed repair through the increased presence of Guadeloupean health providers. This has opened the possibility of what I call "lateral solidarity:" the counteracting of medical hierarchies by intersectional solidarity

between Afro-descendant patients and health workers, in the midst of a French medical institution, in a society still organized along color lines. For this short essay, I focus on the possibilities opened up by lateral solidarity between Ms. Dats and her doctor, whose difference of position in the hospital was mitigated by their shared positions as Afro-descendant Caribbean women.

Traversing old colonial routes, Ms. Dats—a dark-skinned Afro-descendant woman in her forties—flew from Sint Marteen to Guadeloupe. She left behind her electric wheelchair, her primary care-taker and the ability to communicate in her primary language (English) in order to access rehabilitation treatment. Just before our outing, I acted as translator in Ms. Dats' exchange with her doctor, Dr. Begrand, a light-skinned Afro-descendant Guadeloupean woman in her thirties. Despite their recourse to me as a translator, they had a friendly and collaborative relationship. Dr. Begrand was known to be attentive. Her appointments with patients often turned into conversations. She didn't interrupt them, or insist on the prominence of her medical knowledge over patients' experience. Instead, her goal, as she later explained to me, was "to do everything so that things move forward according to the patient."

What forms of solidarity become possible when a doctor and a patient can see each other as inhabiting relatable social positions? Let's look at their interaction: When Dr. Begrand launched into an explanation of her symptoms and their framing under a diagnosis, Ms. Dats pushed back: "The tests are still inconclusive. I'd rather not be told how the story might end if it's still not sure." Dr. Begrand backtracked immediately: "You're right, what matters is what we do right now to treat your symptoms." That evening, when we sat outside, Ms. Dats explained to me why refusing this diagnostic was important: "I'd rather have no diagnosis. I don't want them to say it's over and done when I see I make progress." She had willingly taken a series of diagnostic tests, but was cautious to not let ambiguous results turn into a fixed diagnosis. Following Ms. Dats' wish, I am not naming the diagnosis uttered by Dr. Begrand. I believe that sharing it would frame the reader's understanding, even as Ms. Dats contests it. What matters here is that she refused to be subsumed by it, and was able to express her reservations in her conversation with her doctor. Through this refusal, she worked to ground herself in the present she experienced, and hoped to avoid a future already delineated for her. She wasn't sure that she would still be given access to the treatments she wanted under the diagnosis of a degenerative disease. Dr. Begrand was able to hear her concerns, follow her lead and pivot to focus on addressing Ms. Dats' symptoms and demands.

In addition to refusing a diagnosis, Ms. Dats opted out of a surgical intervention and new medication her doctor suggested. She defended the

integrity of her body, and instead continued to focus on treatment via physical therapy: “I only have one vessel, this body,” she explained. “I don’t want the side effects that come with all of this. I’d rather keep on trying option one before jumping to surgery.” Ms. Dats was wary of any procedure that could harm her body and inscribe it as chronically and irremediably under treatment. Instead, she hoped that through physical therapy, she could regain enough mobility to free herself from medical intervention. There again, Dr. Begrand didn’t insist: the intervention she suggested was an option to consider, not a requirement. She agreed to continue the therapeutic program underway and focused for the rest of the conversation on discussing Ms. Dats’ goals and her desire to return home with a plan for physical therapy.

Instead of reading in this interaction the opposition between the medical model, which locates expertise and authority in the realm of medicine, and the valuation of the lived experience of disability, I am interested in the collaborative elements it holds. Ms. Dats did not refuse treatment as a whole, and Dr. Begrand did not experience her push back as an attack on her authority. Ms. Dats asserted her right to shape the treatment plan according to her goals rather than following medical prescription. She was able to do so because her doctor could hear her wishes and engage in a dialogue with her. Rather than positioning herself as the bearer of an ultimate authority, Doctor Begrand readily accepted Ms. Dats’ demands and worked with her on a treatment plan. The goal was for Ms. Dats to define the therapeutic plan and set the objectives that worked best for her, not a top-down approach in which the doctor defined and controlled interactions and their outcome. In this, Dr. Begrand followed the patient-centered approach of the head doctor and founder of the clinic.

Rather than being primarily structured by coercive power, this interaction and many others struck me as marked by lateral solidarity. Even if they spoke different languages and inhabited different occupational positions, Ms. Dats and Dr. Begrand were both Afro-descendant Caribbean women, who lived in societies with majority Black populations, historically and structurally tied to European governance. In a context where access to healthcare remained structured by racialized health inequalities, in the wake/shadow/inflection of slavery and colonial governance, this doctor and patient who were both Afro-descendant women shared structurally-determined positions of inequity relative to the hierarchies of the French hospital system. Amongst many possible configurations of their relationships, they had the option to form an alliance based on this shared position. Their alliance facilitated health care access for Ms. Dats. More broadly, this movement of lateral solidarity can be understood as one of many strategies to mitigate health inequity and enact postcolonial repair.

Following Kimberlé Crenshaw’s call to account for the “multiple grounds

of identity when considering how the social world is constructed,” I analyzed their exchange in terms of “structural intersectionality,” to understand how their location in terms of race and gender shaped their relationship (Crenshaw 1991: 1945). I also follow the methods of Disability Critical Race Theory (DisCrit, see Annamma, Connor, and Ferry 2013) to bring into the frame concerns about questions of health equity and structural conditions of access for disabled Black people, but I pull DisCrit outside of the US context. I call for a renewed attention to the experience of those who face barriers in accessing healthcare services due to their positions as racialized subjects in marginalized geographies. As Liat Ben-Moshe and Sandy Magaña argue, we need to continue to defend the existence of disability outside of medicalization and diagnostic categories, but this shouldn’t be done at the cost of overlooking health disparities and the barriers that people who want to access medical services face because of racialized social determinants (Ben-Moshe and Magaña, 2014: 106).

People who find themselves at the intersection of disability worlds and racialized structural health inequities navigate relationships with their health providers with heightened stakes. We can notice the difference made by lateral solidarity, when people of structurally-underrepresented populations become healthcare providers. This is not to say that disabled Black women in postcolonial societies face no social, environmental, or medical barriers. Rather, I argue that within spaces where these barriers are prominent, we can also decipher movements of resistance, solidarity and repair, and imagine new strategies to counter structural inequities.

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