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Integrating Intersectionality in Bioethics Education: Cinemeducation Guidelines for Teaching Shared Decision-Making

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ABSTRACT

Bioethics education is increasingly recognised as essential for preparing future medical doctors. As contemporary bioethical challenges are often deeply entwined with social and economic disparities, medical students must understand fundamental ethical aspects related to their professional practice and clinical frameworks, such as shared decision-making. An intersectional approach, which addresses axes of inequality such as age, disability or functional diversity, ethnicity, migration, sex and gender, sexual orientation and gender identity, religion, and social class, can provide a more nuanced and comprehensive understanding of patient care. The consideration of multiple aspects of a patient's identity and circumstances is related to core bioethical principles such as autonomy and justice. One way to reach such an objective is through cinemeducation, which utilises popular movies and television medical dramas as tools for medical education. This approach aims to provide a common framework to teach doctor-patient relationship and shared decision-making taking into account the intersectionality approach. We propose selecting specific clips of contemporary medical dramas to integrate bioethics and each axis of inequality into the learning objectives. The proposed guidelines outline the stages of the sessions, delineate the learning objectives, and provide targeted questions and theoretical references to guide debates with medical students. By defining the use of cinemeducation alongside an intersectional perspective, these guidelines offer a promising approach for enhancing bioethics education in medical training, fostering the development of skills essential for future medical practitioners.

Keywords: *Medical education, Cinemeducation, Medical drama, Intersectionality, Shared decision-making*

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INTRODUCTION

Teaching bioethics plays a key role in integrating clinical competence, critical thinking, professionalism and moral values into medical education (1). However, there is ongoing debate regarding the content and teaching methods that best prepare future medical professionals to confront bioethical dilemmas in clinical practice (2).

Empirical evidence indicates that health inequities and poor outcomes among historically marginalised populations result from structural inequities, including unequal resource allocation and treatment based on race, ethnicity or socioeconomic status (3, 4). Understanding the interaction between structural factors and individual influences, such as the social determinants of health (5), it is crucial for identifying the roots of these disparities (6). These disparities can also affect ethical deliberations and health policy, from which historically marginalised groups have often been excluded (7, 8).

The medical literature shows that the ways that physicians treat and interact with patients significantly determine patients' understanding and compliance, which affect patient outcomes. At the same time, physicians' interactions with patients are strongly influenced by their perceptions of their patients (9, 10). Therefore, communication training should be an integral part of medical education to equip physicians with skills to identify and address patients' needs, perceptions, and expectations (11).

Shared decision-making (SDM) seeks to balance patients' autonomy with healthcare practitioners' duty to ensure patient safety (12), emphasising the importance of understanding what matters most to the patient within the clinical relationship. This collaborative approach ensures that treatment decisions align with patients' values and preferences, while promoting clear and effective communication between doctor and patient (13). The core objective of SDM is to guide patients in understanding the benefits and risks of their options, enabling informed choices aligned with their goals and values. By integrating clinical practice with bioethical principles, particularly autonomy, SDM actively involves patients and their families in care decisions (14–16).

Although SDM aims to facilitate patient engagement in healthcare decisions regardless of cultural differences or barriers to health literacy (17), its implementation can be hindered by several factors, including a lack of knowledge of this concept and the power imbalance between patient and physician (18). Therefore, it is necessary to improve the understanding of patient and clinician identities and to acknowledge how multifaceted differences and structural inequities influence the doctor–patient relationship (19).

Applying an intersectional approach in medical education can enhance the understanding of professional and personal identities, improve doctor–patient relationships, and promote health justice, equity, and inclusion. Intersectionality offers valuable insights into the intricate interplay of identities such as race, gender, and socioeconomic status (20), and it shapes how individual identity and interpersonal dynamics can affect SDM (19). This approach emphasises the holistic understanding of personal experiences within specific social groups and warns against viewing identities as separate categories without considering their interconnections (21).

Intersectionality serves as both a method and an analytical tool for examining how social identities intertwine and generate power dynamics. Individuals, based on their social group affiliations, may have varying access to resources such as wealth, networks or information (19). Inequalities are not limited to race, gender, and class but also include factors such as sexuality, ability, and age (22). It is crucial to acknowledge that these factors are not exhaustive and are not hierarchical; the axes intersect and operate concurrently.

The contribution of an understanding of intersectionality to the clinical environment can be understood as a "conceptual shift" that highlights how intersecting social identities, along with their interaction with sociopolitical structures, influence clinical outcomes. This includes issues such as limited access to healthcare and delayed treatment (19).

At the core of medical education is the incorporation of rational knowledge and technical skills through scientific study, observation, and clinical practice. However, medical curricula should equally foster humanistic aspects of professional identity formation (23). Bioethics is a multifaceted and transversal discipline that encompasses such aspects within a diversity of topics, reflecting the complexity and breadth of ethical issues that arise in the evolving nature of clinical practice. Since the establishment of the importance of the social determinants of health in the early 2000s (5), the field of bioethics has addressed many new questions about the social, ethical, and legal aspects of health (24). Hence, the intersectional approach can be used to teach trainee physicians how to establish ethical and meaningful dialogues with patients that encourage them to become involved in their own treatment, thus allowing trainee physicians to gain a new perspective (8).

As medical dilemmas evolve, innovative educational methods are needed. Audiovisual fictions, such as movies and TV series, offer valuable tools for considering biomedical and ethical issues (25–29), as well as for addressing power relations through an intersectional approach (30–33). These narratives can be used as clinical cases, offering engaging scenarios that simulate real-world medical dilemmas (34), and provide a dynamic platform for exploring complex ethical and clinical issues that evoke emotional responses and enhance learning experiences for medical students (35, 36). These materials can also help uncover students' preconceptions and foster the development of critical thinking and a scientific mindset (37).

The teaching approach that uses these materials is known as cinemeducation. It involves the use of entire films or excerpts from films or episodes of TV series for specific purposes within medical education (34, 38, 39). This approach consists of guided viewings with specific educational goals, followed by group discussions and analyses of the content and emotional impact of the audiovisual material (35). It has proven beneficial for teaching medical professionalism, medical ethics, doctor–patient communication, empathy, and cultural competency (40, 41). However, limited empirical research has investigated the use of this teaching method in diverse contexts. Our proposed study aims to explore whether cinemeducation may be a feasible methodology for integrating intersectional perspectives into bioethics education.

This article offers guidelines for cinemeducation activities and provides a framework for using cinemeducation to incorporate an intersectional perspective into the bioethics education of medical students. Specifically, it emphasises the exploration of the doctor–patient relationship and SDM within the context of human diversity and health inequities.

First Steps for Designing a Cinemeducation Session

The first step is to identify the learning objectives and the corpus of audiovisual materials to be used in the cinemeducation sessions. The sessions should aim to help students achieve some of the learning outcomes listed in Table 1. Tutors should adapt these objectives to the specific context of their medical curriculum, considering the timing of the session within the programme and students' prior knowledge. This flexibility ensures that learning objectives align with the evolving needs and competencies of medical students.

Table 1: Expected learning outcomes from the cinemeducation session

Expected learning outcomes from the cinemeducation session
To identify ethical conflicts in clinical cases.
To recognise the importance of considering patients' needs, perceptions, and expectations in shared decision-making.
To analyse how different axes of inequality may impact the doctor-patient relationship.
To reflect on their own social categories and their influence within the doctor-patient dynamics.
To discuss the bioethical implications of an intersectional approach in clinical practice.
To apply critical thinking to evaluate healthcare professionals' actions and decisions, considering ethical, cultural, and contextual factors.
To understand the ethical implications of health in a global context of change.
To maintain a critical and creative perspective in professional practice.

The process of selecting audiovisual materials involves searching movie databases, streaming platforms, and academic articles to curate episodes that effectively portray doctor–patient relationships within the context of intersectionality and bioethics. The focus should be on classroom relevance rather than the exhaustive use of a TV series or a movie.

A qualitative content analysis of potential medical drama scenes should be conducted to identify situations where an axis of inequality significantly influences the doctor–patient relationship and SDM. This analysis should follow a systematic and rigorous approach to integrate, interpret and synthesise qualitative insights (42, 43). After reviewing the scenes, clips relevant to the identified learning objectives should be selected based on their pertinence to healthcare scenarios and their depiction of inequalities affecting SDM. The clips can include one scene or several scenes in a sequence. Selected clips should meet the following criteria: inclusion of a patient's story involving an inequality-related issue, relevance to an ethical dilemma, and a suggested duration of 3 to 10 minutes (37, 44).

The categorisation of the audiovisual materials follows the axes of inequality established by Coll-Planas and Solà-Morales (45) (see Table 2).

Table 2: Axes of inequality

Axes of inequality	Description
Age or life cycle	Disparities or discrimination related to age, such as ageism.
Disability or functional diversity	Discrimination or inequality experienced by individuals with disabilities or functional differences.
Ethnicity or racialisation	Systemic biases, discrimination, or marginalisation based on racial or ethnic identity.
Origin or migration	Discrimination or inequality faced by individuals due to their national or cultural origins, including xenophobia.
Sex and gender	Gender-based discrimination, stereotypes, and inequalities.
Sexual orientation, gender identity, LGBTQ+	Discrimination or inequality experienced by individuals based on their sexual orientation or gender identity.
Religion or beliefs	Discrimination or bias based on religious affiliation.
Social class	Disparities, discrimination, or marginalisation related to socioeconomic status poverty.

Staging and Planning a Cinemeducation Session

Table 3 summarises the stages of a cinemeducation session focusing on the doctor–patient relationship and SDM from an intersectional perspective, specifying the objectives and the time allotted for each stage. Its implementation is intended for a session of 120 minutes.

Table 3: Stages of the sessions with the time and objectives for each stage

Stage content	Duration (min)	Objectives and development
Introduction	10	To frame the session's learning objectives, outline the structure and flow of the activities, and provide students with context of the selected TV series they will be working with. This includes explaining the main plot of the TV series and contextualising the selected clip, as well as introducing the key characters featured in the clip. Including images during this introduction can be useful to enhance student engagement and understanding.
Pre-intervention asessment	10	To assess students' prior knowledge on the topic, to measure the effectiveness of cinemeducation methodology and the impact of this session on the acquired concepts and notions. It consists of a 10-question multiple-choice test addressing the following key aspects: • Normative framework: international regulations on bioethics, biomedicine, and human rights, local legislation. • Intersectional approach and axes of inequality. • Doctor-patient relationship and SDM. Students are required to do the work individually, without prior access to information or explanations from the tutor. This ensures an unbiased assessment of their previous understanding of the topics covered in the session.
Viewing of the TV series selected clip	10–15	To critically view the audiovisual fragment, focusing on the learning objectives. Before starting the viewing of the clip, students may be encouraged to take notes on issues they believe are related to the session's previously announced objectives, with the understanding that these topics will be addressed later.
Debate/ deliberation	40–45	The tutor actively guides the conversation to assist students in the interpretation and analysis of the doctor-patient relationship and the axes of inequality introduced in the audiovisual fragment. This discussion provides an opportunity for students to reflect on their own moral values, beliefs, and personal implications about the ethical issues presented in the clip. The tutor facilitates a supportive and inclusive environment for sharing diverse viewpoints. It is important that the tutor does not reveal the relevant topics and bioethical issues in advance. The objective is for the students themselves to begin analysing the material. In this phase, it may be useful to prepare guiding questions to enhance the discussion.
Concept clarification	10–15	To clarify and/or explain the main topics and concepts that arose in the previous debate. At this stage, the tutor should review the discussion held by the students, highlighting the right points and addressing any mistakes. Additionally, the fundamental theory related to the topics discussed should be explained.

(*Continued on next page*)

Table 3 (*Continued*)

Stage content	Duration (min)	Objectives and development
Post-intervention assessment	10	To assess students' knowledge through a 10-question multiple-choice test (the same one used in the pre-intervention assessment). Students are required to respond to the test individually.
Qualitative questionnaire	10	To understand how students apply the contents to the situation presented in the audiovisual fragment. Two to three questions can be oriented towards the following topics: • Describe how the doctor-patient relationship interacts with SDM in the clip. • Identify the axes of inequality that interfere in the clinical case of the audiovisual fragment. • Consider the articulation between the axes of inequality and the doctor-patient relationship. • Analyse the doctor-patient relationship and propose alternative ways for the medical role to ensure SDM. Students are required to respond to the questionnaire individually.
Satisfaction survey	5	To gather feedback from participants regarding their overall satisfaction and engagement with the program, a survey asks them about different aspects of the session, such as the dynamics of the debate, the teacher's knowledge, and its usefulness for their professional future. Students are required to respond to the survey individually, and a "Likert" scale is used to assess their responses effectively.
Closure	5	To provide closing remarks and a farewell. It may be helpful to briefly recap the main points discussed during the session, emphasising key insights related to the learning objectives and acknowledging significant contributions from the students. The tutor can also suggest additional resources or lectures for further exploration of the topics covered in the session.

For the cinemeducation sessions on bioethics and intersectionality, we propose using specific episodes from top-ranked primetime network medical dramas broadcast in the United States during 2023, such as *Grey's Anatomy* (Rhimes, 2005–present [ongoing]), *The Good Doctor* (Shore, 2017–2024), *The Resident* (Holden Jones, 2018–2023) and *New Amsterdam* (Schulner, 2018–2023). The selected audiovisual materials along with their corresponding learning objectives related to the axes of inequality, questions and suggested references for the discussion stage of the cinemeducation session, are outlined in the supplementary material.

It is important to note that while the distinction between different axes of inequality serves pedagogical purposes, reality is often more complex. Multiple axes may coexist within a patient, and a separate consideration of each is not always feasible. To illustrate the proposed methodology, among the various axes of inequality that might be addressed in the session, we propose an example that addresses the axis of ethnicity and racialisation using an eight-minute clip from *New Amsterdam* (Season 3, Episode 8). In this episode, Evelyn Davis, a prominent African American lawyer, is admitted to New Amsterdam Hospital to give birth. Evelyn explicitly requests that the medical team adhere to her birth plan, which includes a vaginal birth after her previous caesarean delivery (VBAC). She shares her dissatisfaction with her prior caesarean experience, highlighting the lack of explanation provided for the medical procedures performed. In response, the medical team initially focuses on assessing

the risks associated with VBAC using a standardised calculation. However, the hospital's medical director grows concerned that the calculation process may embed implicit biases that affect Black women in particular and could lead to decisions that might differ if Evelyn were white.

This case allows students to critically engage with several key themes. First, they can examine the role of racial bias and disparities in healthcare, including how these biases can influence medical research. Additionally, students' attention can be directed to the case's depiction of the ways in which race and gender intersect in shaping SDM motherhood-related processes. Students can also consider the importance of cultural competence and patient-centred care in clinical practice. The discussion can be guided by questions that encourage reflection on whether Evelyn's request for VBAC should be respected. Another focal point may involve the examination of the ethical responsibility of healthcare professionals to acknowledge and address implicit biases in SDM, particularly when caring for racialised patients such as Evelyn. Implicit biases, when unexamined, can undermine SDM by disregarding the patient's voice and perpetuating inequities in care. The discussion can explore how the lack of research on historically excluded populations influences the quality of medical care and the reliability of statistical models. Finally, the need for culturally competent and patient-centred approaches in clinical practice should be emphasised.

This case exemplifies how SDM operates as a bridge between clinical practice and bioethical principles, particularly autonomy. Evelyn's request underscores the importance of integrating her individual values and preferences into the decision-making process, especially given her past experience and desire for a more empowered birth. While the medical team initially relies on standardised risk calculations to evaluate the feasibility of VBAC, the hospital's medical director raises critical concerns about the potential for implicit racial biases embedded in these calculations, which may unfairly influence healthcare decisions.

DISCUSSION

These guidelines build on the established feasibility and effectiveness of using cinemeducation methodology to teach bioethics to medical students (46–48). The proposed sessions focus on developing essential competencies—such as critical thinking, empathy, and cultural competence—through the use of audiovisual media (40, 49).

The integration of the concept of intersectionality in medical education is essential for fostering a comprehensive understanding of the diverse experiences and needs of patients and for preventing bias and ensuring equitable access to medical resources (50–52). However, its exploration within the clinical medicine context has been limited as medical education tends to emphasise the care of specific demographic groups rather than seeking broader relevance and applicability (19).

Evidence has shown that cinemeducation enhances students' understanding and fosters emotional engagement with patients, their families and the clinical team (35). By analysing medical dramas, students are prompted to reflect on their values, beliefs, and attitudes and to explore the intersecting factors that impact doctors' decisions as well as patient experiences and health outcomes. This approach provides a nuanced perspective on complex medical scenarios, offering insights that might be challenging to convey through other teaching methods (34).

The proposed stages and duration of each stage in these guidelines should be adapted to fit the specific needs of each group, considering factors such as time constraints, the teacher's expertise and students' current knowledge attainment, both within the subject and in terms of their academic level. It is important to note that learning objectives must consider whether students are in their clinical or preclinical years. Preclinical students, who lack experience with direct patient contact, may perceive patient issues as more standardised or less complex. Engaging with patient characters in scenes from medical dramas allows them to explore and challenge these perceptions, fostering a deeper understanding of the complexities of patient care and critically analysing the patient–doctor relationship before entering clinical rotations.

Regarding the selection of audiovisual materials, while it is possible to use full episodes of a TV series (typically around 40 minutes in duration), the inclusion of subplots often detracts from student engagement and draws their attention to topics that are unrelated to the learning objectives (53). Thus, we recommend curating shorter excerpts that include scenes directly relevant to the learning objectives and that last no more than 10 minutes (37, 44). As observed by Blasco and Moreto (54), we live in a dynamic and fast-paced environment of rapid information acquisition and high emotional impact, and thus, it makes sense to use short clips because of their brevity, rapidity, and emotional intensity.

Selecting the appropriate drama series and episodes can pose significant challenges, underscoring the importance of preliminary discussions with teaching or research teams to identify the most suitable material for each specific teaching objective. We recommend utilising medical series from the past five years as representations of ethical dilemmas, medical professionalism, and the characteristics of healthcare professionals have evolved over time (55). In addition, considerable changes have taken place over the years in regard to the portrayal in audiovisual media of people from particular social classes, ethnic, racial, gender, and disability groups, some of which have been historically underrepresented (32).

Since most medical dramas are made and set in the United States, it is advisable to also incorporate locally produced content if available. This allows students exposure to a closer representation of their own healthcare system. Differences between the US healthcare system and those of other countries (e.g., Canada or Western Europe) should be addressed during the session to help students understand potential variations in healthcare and cultural issues.

A critical aspect of the cinemeducation sessions is the role of trained tutors in facilitating discussion among students. Tutors should focus on encouraging self-reflection and challenging biases rather than imposing moral directives or leading discussions in a theoretical or moralistic manner (56). To enhance student engagement and learning, small-group sessions are recommended as they improve knowledge retention, self-directed learning, communication skills, and teamwork (57, 58). If small-group sessions are not feasible, larger groups can be subdivided into small discussion groups, with insights shared with the whole group by designated representatives from each small group.

The discussion stage of the session provides a crucial opportunity for students to critically examine the ethical dimensions of SDM, particularly the intersection of patient autonomy and justice principles. Addressing these concepts in depth allows students to engage with the complexities of real-world scenarios in which structural inequities and implicit biases influence healthcare outcomes. By ensuring that patients' values, preferences, and lived experiences are central to medical decisions, SDM offers a pathway to mitigate disparities and promote fairness in care. Furthermore, its emphasis on individualised, patient-centred

communication reinforces the ethical responsibility of healthcare practitioners to bridge gaps in access and representation, particularly for marginalised populations. As such, SDM emerges as a critical framework for aligning bioethical principles with the realities of diverse and complex clinical environments.

Although the evaluation of students' knowledge and clinical skills is beyond the scope of this article, the evaluation of the effectiveness of cinemeducation requires strict consideration and meticulous planning. Empirical educational research that aims to implement cinemeducation sessions should consider that control groups can be included in the study design to establish the pedagogical value of the activities (59). Additionally, a post-evaluation conducted three or six months after the activity could be incorporated to assess the long-term retention of knowledge. In assessing the application of transversal skills or cross-cutting competencies, it could be advantageous to complement traditional evaluation methods with experiential activities, such as role-playing or simulations (60, 61). These interactive techniques offer a dynamic platform for learners to demonstrate their proficiency in skills such as communication, teamwork, problem-solving, and adaptability within simulated real-world scenarios.

CONCLUSION

The proposed guidelines provide a structured framework for implementing cinemeducation in medical training. By offering clear criteria for selecting audiovisual materials, well-defined lesson stages, specific pedagogical objectives, and engaging discussion prompts, they can help ensure the effectiveness of the sessions. Challenges may arise in selecting appropriate content or integrating intersectional perspectives into the lesson plans. Therefore, broader applications of these guidelines could be explored in future research using social media or AI-generated videos as pedagogical resources.

By encouraging critical thinking and ethical reasoning regarding the societal responsibilities of health professionals, cinemeducation offers a promising approach to the integration of intersectionality in medical education. Ultimately, it fosters the development of compassionate and ethically grounded practitioners, promoting relationship-based and patient-centred care.

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