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# Broadening the Conversation About Intersectionality in Clinical Medicine

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We found the commentaries for our recent article, “Intersectionality in Clinical Medicine: The Need for a Conceptual Framework” (Wilson et al. 2019) helpful in providing opportunities for us to clarify our position on some issues, expand our analysis in some areas, and defend what we understand to be the significant contributions of intersectionality in clinical medicine. The commentaries as we understood them raised four major issues that we address here: intersectionality’s social justice requirements, intersectionality in medicine “versus” scientific realism, the role of the clinician in an intersectional framework, and intersectionality’s space for further analysis.

## INTERSECTIONALITY AND THE REQUIREMENTS OF SOCIAL JUSTICE

Barned, Lajoie, and Racine (2019) applaud our attention to social structure and our emphasis that clinical encounters do not occur in a vacuum, while they and Grzanka and Brian (2019) worry that our focus on the dyadic interactions between patients and clinicians somehow diminishes our commitment to challenging the unjust social institutions and practices that form the central concern of intersectionality. Barned, Lajoie, and Racine rightfully point out that commitment to intersectionality requires broader commitment to institutional change, which can be difficult to bring about, given the intransigence of institutional policies and practices (Barned, Lajoie, and Racine 2019). They offer institutionally mandated clinician time constraints with patients as an excellent example of an institutional barrier to the kind of intersectionality-minded encounter we propose. In other words, even the most well-intentioned clinician who is

deeply committed to implementing an intersectional framework in the clinical encounter will often run into difficulty not of his or her own making. Barned, Lajoie, and Racine suggest broadening our analysis in order to account for how, in practice, the clinician can either change or circumvent these kinds of institutional barriers to change that perpetuate injustice (2019). While we state in our article that “oppressed social status is not merely the product of individual perceptions, attitudes, and behaviors. Rather, our social identities are also wrapped up in complex structural/systemic inequality” (2019, 11), their suggestion that we think concretely about how to address these realities in the clinical encounter is a helpful one. Additionally, we agree with Muntaner and Augustinavicius, who suggest that one helpful intervention would be requiring institutions to recruit doctors “from the class, gender, and race of the communities they serve.” However, while Muntaner and Augustinavicius assert that a “systemic approach ... is missing from the intersectional framework, which is concerned with identities, categories, and subjectivities,” we would argue that intersectionality is the very framework that highlights the need for systemic change like diverse physician recruitment (Muntaner and Augustinavicius 2019).

Perhaps the most pointed critique on the matter of intersectionality’s social justice requirement comes from Grzanka and Brian. They write:

Wilson and colleagues notably do not attend to social justice in their paper; indeed, they do not use the term. While an intersectionality-like approach to clinical interactions, including diagnosis and treatment, may better attend to the lived experiences of systemic oppression and privilege that produce unequal health outcomes, we are

skeptical of the extent to which clinical interactions *in and of themselves* [emphasis ours] are capable of engendering the social transformation that exemplifies what Collins (2015) characterized as intersectionality's critical edge. (Grzanka and Brian 2019, 23)

Nothing in this article or our earlier papers that Grzanka and Brian cite (Danis, Wilson, and White 2016; Wilson, Danis, and White 2016) commits us to the view that clinical interactions "in and of themselves" transform society at large. However, we are very clear that, following Hankivsky and colleagues (2012), intersectionality is concerned with macro-, meso-, and micro-level interactions. Our focus in this article on the patient-clinician interaction came about as three of the four authors are, in fact, clinicians (obstetrics and gynecology, allergy and immunology, and internal medicine) who have had the conversation among themselves and their colleagues about what issues arise in the room and how to address them. This article is a contribution to that very narrow, very specific question. While Grzanka and Brian are right to point out that there is an abundance of psychology literature that focuses on intersectionality and interpersonal interactions (much of which we cite), we are interested in how attention to intersectionality might work in the context of clinical medicine.

Narrow focus on the microlevel interaction does not absolve clinicians of the responsibility to engage in other practices and behaviors that would bring about further institutional change or broader societal change. In this article we explicitly discuss the role of "broader institutions and policies" in affecting microlevel interactions in order to show why they matter or should matter to clinicians committed to intersectionality (2019). According to Grzanka and Brian, a properly intersectional bioethics is "unequivocally" committed to social justice "as a primary (not supplementary) goal" (Grzanka and Brian 2019, 23). They get no argument from us on this point. In one of our 2016 papers that Grzanka and Brian cite, we make the case for why bioethicists should address racism, even beyond the hospital or clinic walls. In making the argument, we state that "concern for justice has been one of the core commitments of bioethics" (Danis, Wilson, and White 2016, 5).

Although Grzanka and Brian claim that there is no "one-size-fits-all model" to "implement social change," in their quest to emphasize the importance of moving beyond "the traditional locus of clinical activity" (Grzanka and Brian 2019, 24), they overlook the reality that small-scale social change can also begin within clinic walls. While the nature of these efforts may differ inside versus outside the health care setting, interventions are necessary in both environments (Danis, Wilson, and White 2016, 5). Our position is and had been that it is squarely in the realm of what bioethicists should be doing to address all of the complex factors that shape health, health outcomes, and health care (Wilson, Danis, and White 2016, W1). Grzanka and Brian highlight social

justice commitments to ending discrimination, income and wealth inequality, mass incarceration, precarious housing, food insecurity, and poverty as the kind of work that will fall largely outside of the clinical encounter but that bioethicists have obligations to pursue (Grzanka and Brian 2019). These suggestions are consistent with the kinds of interventions falling outside of the clinical setting that we have previously highlighted as important spaces for bioethicists to contribute in, including addressing police violence, rejecting the practice of segregating hospital floors by ability to pay, persistent wealth gaps persisting even after attaining higher education, and racially biased jury selection practices (Danis, Wilson, and White 2016, 3–8 *en passant*).

### SCIENTIFIC REALISM

Muntaner and Augustinavicius see intersectionality as potentially providing "qualitative descriptions of the mechanisms through which class, gender, and race work simultaneously to generate ill health" (2019, 40). However, the criticisms of intersectionality that they offer seem to make intersectionality incommensurate with their scientific realist project. These criticisms turn on a fundamental misunderstanding both of intersectionality and of the argument we make in the article. Muntaner and Augustinavicius offer the following criticism:

In brief, the intersectionality framework is limited in its ability to help reverse race, gender, and class inequalities in health due to its idealist ontology (priority of ideas, lack of system and levels), antirealist epistemology (subjectivism and lack of scientific method), and relativist ethics (idiosyncratic axiology and morals). (Muntaner and Augustinavicius 2019, 39)

While this sentence reads like nails on a chalkboard to the philosopher, we take the broad worry to be one about what methodology provides the best information. Muntaner and Augustinavicius claim that intersectionality carries with it an "exclusive concern about the subjective" that "clashes with the realist (objectivist) ontology in science" (Muntaner and Augustinavicius 2019, 40). Muntaner and Augustinavicius's contention that intersectionality is focused on the subjective is in direct contradiction to our position that intersectionality is "not primarily concerned with superficial notions of difference, identity, or categories" (Wilson et al. 2019, 11).

They further claim that intersectionality's "idealist ontology" leads to "moral relativism." While we understand that intersectionality requires one to consider how "one's social identity contributes to one's experience of the world" (Wilson et al. 2019, 11), this consideration is not the equivalent of moral relativism nor does it necessarily lead to moral relativism. Indeed, the commitment to paying attention to the ways that oppression and

privilege intersect requires a fundamental understanding of the ways that social identity and social/political institutions contribute to oppression—which is not synonymous with the view that different ways of being in the world are beyond evaluation. To the contrary, it is precisely the kinds of oppression that intersectionality highlights that must be ameliorated in order to live up to the broader values of fairness, equality, and justice. Muntaner and Augustinavicius’s claims reflect a misunderstanding of the broad project of intersectionality.

As a specific critique of our article, Muntaner and Augustinavicius characterize our argument as advocating “awareness” alone in order to produce change in clinicians’ behavior (Muntaner and Augustinavicius 2019). We do not hold this view and we do not express this view anywhere in our article. Of course mere awareness is insufficient to motivate behavioral change, and we certainly appreciate the importance of epidemiologic information and scientific data. For example, in our article we highlight that data that show that black women with the highest socioeconomic status have equivalent or worse maternal–fetal health outcomes than white women with the lowest socioeconomic status, a fact that has earned tremendous media attention in the past year. Given the expectation that health outcomes improve with socioeconomic status, this is a surprising finding—even though black women of high socioeconomic status do have better maternal–fetal health outcomes than black women of low socioeconomic status. While improving access to health care and addressing other social determinants of health for black women have been proposed as critical areas for intervention (Gadson, Akpovi, and Mehta 2017), these factors do not fully explain why health disparities persist in maternal–fetal outcomes (Howell 2018, 390). Answering this question will require an ongoing commitment to gathering clinical and public health data and conducting rigorous scientific analysis. Yet identifying the root of the problem in order to propose specific solutions also requires understanding how class and race intersect for black women in ways that a single-axis analysis of either class or race would not capture. This illustrates the synchronicity between intersectionality and science.

While good science is crucial, we contend that to focus exclusively or even primarily on traditional scientific data misses the mark. The measurements available to scientists may not capture everything that is important. Scientists tend to measure what they know or what they know how to measure. An intersectional framework can challenge scientists to be more explicit in “why [they] choose particular intersections rather than simply that [they] do” (Warner 2008, 456). An approach like intersectionality can show what to measure that scientists may otherwise miss.

Intersectionality neither conflicts with nor muddies the scientific waters.

## THE CLINICIAN’S PERSPECTIVE

A worry presented in some of the critiques is that focus on intersectionality from the clinician’s perspective may actually harm, rather than help, patients. Macer frames this worry as a worry about potential “labeling” of patients (Macer 2019). Meanwhile, Cho frames this worry as a worry about potential unconscious bias, and Lanphier and Anani worry about stigmatizing or “othering” patients (Cho 2019; Lanphier and Anani 2019). Lanphier and Anani notably offer a narrative ethics framework to supplement intersectionality. Because the intersectional framework alone does not tell the clinician what matters most to a patient, narrative ethics allows the physician to solicit a patient’s story in order to learn this information (Lanphier and Anani 2019). Narrative ethics further guards against trying to fit patients into the clinician’s assumptions and invites conversation, understanding, and trust between clinician and patient (Lanphier and Anani 2019).

Lanphier and Anani argue that as we have presented it, intersectionality becomes “a tool for *clinicians* [emphasis ours] to analyze the intersecting structural features that impact their patients’ health” (Lanphier and Anani 2019, 30). As such, intersectionality in the clinical environment can reinforce, rather than ameliorate, oppression. Although we state in the article that a physician failing to consider an intersectional framework may cause physicians to miss opportunities for therapeutic intervention, we appreciate Lanphier and Anani’s reading of our article and think that the narrative ethics framework they propose might indeed foster (and sustain) more meaningful communication between patient and clinician. The institutional impediments, such as clinician time constraints, that Bamed, Lajoie, and Racine raised in response to our initial proposal for intersectionality in clinical medicine likely also hinder incorporating narrative ethics into the intersectional framework.

However, we think narrative ethics is potentially a worthy intervention that would help to even further clarify the themes that emerged in our article: (1) that clinicians must confront their own biases and (2) that it is important to challenge assumptions and develop avenues to clarify misunderstanding.

Clavel-Vazquez and Palacios-Gonzalez and Muntaner and Augustinavicius argue that the framework we propose should include other healthcare professionals, such as nurses and allied health personnel, as they often have as much or more contact with patients (Clavel-Vazquez and Palacios-Gonzalez 2019; Muntaner and Augustinavicius 2019). Although we focused on clinicians in this article, we absolutely believe that all health care personnel enrich the intersectional framework. That our discussion was about clinicians in the conceptual framework of intersectionality in no way means that we think only clinicians have a role. However, we were attempting to contribute a solution to

a very specific problem that the clinician-authors of this article have encountered and continue to encounter.

Ray argues that our approach to intersectionality focuses too narrowly on patients in the patient–clinician encounter, which may lead to assumptions that the clinician “always has a privileged social identity with respect to the patient” (Ray 2019, 25). Ray claims that we risk undermining intersectionality in that the experience of the “prototypical” white male clinician does not “encompass everything we need to know about the experience of clinicians in a clinical setting” (Ray 2019, 26), specifically referencing the experience of clinicians of color. We agree with Ray’s observation. Two of the authors are clinicians of color and have personally experienced the power differences in clinical encounters compared to our white colleagues. We do not intend to argue that an intersectional framework should not also focus on clinicians. In fact, an “intersectional shift” requires that both clinicians and patients “understand how one’s positions of privilege and/or oppression operate within an interpersonal context” (Wilson et al. 2019, 11). We appreciate the opportunity to clarify our position regarding the role of clinicians in our approach to implementing intersectionality.

#### INTERSECTIONALITY: FURTHER ANALYSIS

Byeon and colleagues agree with us that intersectionality’s ambiguity is not a weakness. Rather, the ambiguity allows for openness and creativity in considering the connections between patients’ social position and health (Byeon et al. 2019). In that vein, they encourage us to consider “the embodied features of lived experience” (Barned, Lajoie, and Racine 2019, 28). That is, we should think about the ways that patients’ bodies are themselves subjected to scrutiny, prejudice, and stereotype. Eilenberger and colleagues highlight the importance of age in an intersectional analysis, using a phenomenological–existential perspective to argue that age and the process of aging continually transform patients’ attitudes about health, illness, and death in ways that clinicians must be sensitive to in order to get a full picture of patients’ desires and treatment goals (Eilenberger et al. 2019). Clavel-Vazquez and Palacios-Gonzalez show that arguments for intersectionality also hold in the international context and can prevent aid workers from replicating the oppression that they seek to overcome (Clavel-Vazquez and Palacios-Gonzalez 2019). Byeon and colleagues argue that intersectionality can challenge “an uncritical use of race to foster a more expansive consideration of social identities in clinical decision making” (Byeon et al. 2019, 20). Finally, Cho shows that intersectionality can potentially lead to correct diagnoses that may be otherwise overlooked due to symptom minimization and diagnostic overshadowing that multiply marginalized patients disproportionately experience (Cho 2019).

All of these suggestions and interventions are consistent with the conceptual framework that we propose. Furthermore, we believe that the analysis can and should be expanded in the ways that these authors propose.

#### DISCLAIMER

The views expressed here are those of the authors and do not necessarily reflect the policies of the institutions where they work. ■

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