Intersectionality in Clinical Medicine: The Need for a Conceptual Framework

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Intersectionality has become a significant intellectual concept for those thinking about the ways that race, gender, and other social identities converge in order to create unique forms of oppression. Although the initial work on intersectionality addressed the unique position of black women relative to both black men and white women, the concept has since been expanded to address a range of social identities. The underlying idea of intersectionality is that heretofore traditional, “single-axis” analyses of race and gender have focused on the most privileged members of the group in strategizing how to ameliorate oppression, thereby “undermin[ing] efforts to broaden feminist and antiracist analyses” (Crenshaw 1989, 139–40). That is, efforts by African Americans to combat racial oppression have prioritized the experiences of black men, while efforts to combat gender oppression have prioritized the experiences of middle-class white women. Although legal theorist Kimberlé Crenshaw coined the term “intersectionality” in her work in anti-discrimination law, she was not the first to theorize that black women in particular are disadvantaged because of both race and gender and that race and gender are not mutually exclusive categories (Crenshaw 1989, 139–40). The conceptual framework of intersectionality has spawned much discussion in the humanities, social sciences, and some aspects of health care (van Mens-Verhulst and Lorraine Radtke 2006; Viruell-Fuentes et al. 2012; Weber and Fore 2007). While there has been work in health policy, particularly in health disparities research, and social and clinical psychology, consideration of the application of intersectionality specifically to the clinical medicine setting has predominantly focused on particular groups of individuals rather than its broad applicability (Baig et al. 2016; Ng 2016; Tan et al. 2016). We argue that an intersectional conceptual framework can offer important insight to the clinical medicine context. While we by no means think that intersectionality is the only useful framework to make the clinical medicine environment more appropriately attentive to the complex identities of patients and clinicians and the ways

1. Crenshaw herself acknowledges this in the opening lines of her article when she highlights the 1982 volume edited by Gloria T. Hull et al., *All the Women Are White, All the Blacks Are Men, But Some of Us Are Brave.*

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that structural practices shape those identities, we do think that intersectionality provides a useful starting point to address some of the challenges that arise in clinical contexts as a result of these differences.

Rather than pretending that differences do not exist, or minimizing their potential impact on the patient—clinician relationship, intersectionality acknowledges how multifaceted differences shape the patient–clinician interaction and forces a reframing that can lead to improved outcomes. An intersectional conceptual framework also requires an exploration of how institutional practices within the clinical environment, even those that seem neutral, unfairly advantage some and disadvantage others. We begin with a discussion of intersectionality and how, despite its challenges, it might be useful in a clinical context. We then discuss two clinical scenarios that highlight how consideration of intersectionality could lead to more successful patient–clinician interactions. Finally, we extrapolate general strategies for applying intersectionality to the clinical medicine context before considering objections and replies.

THE CONCEPT OF INTERSECTIONALITY

In response to traditional antiracism and antisexism strategies, proponents of intersectionality have argued that the experiences of the most privileged members of the group could not represent the entire group’s experiences. Thus, the experiences of middle-class white women cannot exemplify the experiences of all women, nor can the experiences of black men exemplify the experiences of all African Americans. Similarly, clinicians and researchers have come to understand that the experiences of the “prototypical” white male patient do not encompass everything we need to know about health, disease, and the experience of illness. Intersectionality requires that we explicitly think about the ways that categories like race, gender, sexuality, and class interact with one another and shape our sense of self and how we interact in the world (van Mens-Verhulst and Radtke 2006, 4). Moreover, intersectionality attends to the ideological structures that shape both problems and solutions (Cho et al. 2013, 791).

Far from operating as a simple analysis of identity and experience, intersectionality as a conceptual framework shines a light on existing social structures of power and exclusion that make some more vulnerable by shaping the life chances and choices of those who are marginalized by race, gender, and class. In so doing, intersectionality challenges “the logic of how processes of racial, gender, class, and sexuality disparities are produced and remedied” (Cho et al. 2013, 797; Hancock 2013, 260). In other words, intersectionality turns on its head simple patient labels like “difficult” or “noncompliant” and instead requires a more complex assessment. An intersectional framework necessarily requires thinking about the ways in which categories are fluid, dynamic, and shaped and created by their relations to power (Cho et al. 2013, 795). Thus, we understand intersectionality to be protean in nature.

Attention to intersectionality makes it possible to raise interesting questions as the kinds of identities drawing on an intersectional framework have expanded. Nash observes that the initial emphasis on black women’s experiences “has obscured the question of whether all identities are intersectional or whether only multiply marginalized subjects have an intersectional identity” (Nash 2008, 9). She goes on to note that while some feminist theorists conceptualize intersectionality as a way to understand how different aspects of one’s identity intersect, most theorists limit intersectional analyses to the experiences of those who are “multiply marginalized” (Nash 2008, 10). Although it is the case that intersectionality’s central subjects are “nonprototype groups,” that is, “black women” instead of “black men” (race prototype) or “white women” (gender prototype), the conceptual framework of intersectionality does not rule out the possibility of understanding the ways in which marginalization and advantage, or even advantage and disadvantage, intersect (Moradi 2017, 111). Our position will be that if we take seriously the role that intersectionality plays in clinical contexts, it is important to recognize how all aspects of one’s identity—not just areas of marginalization—intersect and manifest themselves in and impact clinical interactions even while paying careful attention to the ways that intersectional identities sometimes beget disadvantage.²

INTERSECTIONALITY AND ITS RELEVANCE TO HEALTH

Intersectionality shows that paying particular attention to the ways that axes of identity and structural inequality converge can yield unexpected results. For example, it is typically understood that those who are middle-class generally experience better health and health outcomes than those who are poor. However, Jackson and Williams have shown that “at the intersection of race, class, and gender, new experiences emerge that undermine the benefits of being a member of the black middle class” (Jackson and Williams 2006, 139). They found that, among other things, “The highest SES [socioeconomic status] group of African American women has equivalent or higher rates of infant mortality, low birth weight, hypertension, and excess weight than the lowest SES group of white women” (Jackson and Williams 2006, 142).³ Additionally, they found that “Middle-class status

² We take this view because individuals’ lives are rarely simply characterized and exclusively marginalized. As individual mature and age, and as their circumstances change, they may vary in the way and the degree to which they are marginalized.
³ Since the initial review of this article, there has been increased media attention given to the dramatic disparities in black women’s maternal health outcomes, including the story of the life-threatening postpartum crisis of tennis star Serena
does not provide African American men with the normally expected reductions for at least some health risks” (Jackson and Williams 2006, 146). A single axis analysis solely of class or of race would obscure the way that race and class operate to affect the health and welfare of African Americans: While there is certainly some improvement in health status relative to poorer African Americans, the black–white gap in health status actually widens with increasing SES, in, for example, infant mortality rates (Jackson and Williams 2006, 142).

Although middle-class African Americans may experience some advantage along the axis of class, they experience disadvantage due to racism. The amount of advantage and/or disadvantage one experiences may be context dependent. For example, one cannot assume that in every context an African American lesbian will be more disadvantaged than a heterosexual African American man (Bowleg 2008, 313–4). In some environments one’s class status may be more salient, whereas in others it might not be. Additionally, an essential principle of intersectionality is that axes of disadvantage cannot simply be added together, but that axes of disadvantage coalesce to create their own unique forms of disadvantage. An additive approach assumes that identities can be “ranked” (Bowleg 2008, 314). For example, black women may place equal importance on their single-axis race and gender identities, but conceive of their specific identity as a “black woman” differently from either (Settles 2006, 597).

Accordingly, intersectionality must address the reality that axes of advantage and disadvantage also intersect in unique ways, as the health outcomes of the black middle-class studied by Jackson and Williams illustrate.

Rather than having full access to the significantly improved health outcomes one would expect to find among an undifferentiated middle class, middle-class African Americans have improved health status with respect to poor African Americans but worsened health status when compared with middle-class whites. Thus, African Americans are not able to fully leverage their middle-class status to create significantly better health outcomes for themselves. An intersectional approach enables us to conceptualize both race and class differently in thinking about how to address health disparities because centering nonprototypic groups yields different information about those groups that cannot simply be extrapolated by studying prototypic groups (McGibbon and McPhearson 2011, 61; Moradi 2017, 111). In confronting health disparities, much work has focused on incorporating cultural competence and cultural humility into clinical practice as a means of addressing patient needs related to race, class, ethnicity, and other social categories. What an intersectional framework adds to these already existing approaches may not be immediately apparent. Traditional approaches to multicultural training often focus on “cultural competence,” a framework for promoting clinician awareness of social and cultural influences that affect a patient’s health beliefs, behaviors, and outcomes (Bentacourt et al. 2003, 297; Ben-Ari and Strier 2010, 3; Horevitz et al. 2013, 137). Cultural competence has been criticized for failing to adequately account for broader structural and institutional forces that perpetuate inequality and shape health outcomes (Fisher-Bourne et al. 2015, 171, Hester 2012, 286; Danso 2016, 8).

More recently, “cultural humility” is an approach that emphasizes the clinician’s commitment to self-reflection, self-critique, and attention to power imbalances in the physician–patient relationship (Danso 2016, 12; Fisher-Bourne et al. 2015, 172). While both cultural competence and cultural humility can be useful concepts, both have a tendency to focus on the efforts of the individual clinician. Yet attention to the intersection of race, gender, class, and other dimensions of a patient’s identity highlights the need to focus on more broadly institutional and structural forces that create patterns of oppression, marginalization, and health disparities. By adding a lens through which to consider the multidimensional axes of a patient’s identity and thereby understand a patient’s background, perspectives, areas of vulnerability, and needs more fully, an intersectional framework serves to supplement cultural competence and humility. It draws attention to structural and institutional forces that lead to the patient’s experience of marginalization on account of these intersecting identities. In this way, intersectionality goes well beyond cultural competence and humility. We revisit the distinction between intersectionality and cultural competence in the objections section.

APPLICATION TO CLINICAL PRACTICE

In explaining how an intersectional approach could work in a health research environment, Hankivsky notes that the goal of intersectionality is to bring about a conceptual shift in how researchers understand social categories, their relationships, and interactions and then to have this different understanding transform how researchers interrogate processes and mechanisms of power that shape health inequities. An ‘intersectionality shift’ encourages researchers to reflect on the complexity of their own social locations, how their values, experiences, and interests shape the type of research they engage with, including the problems they choose to study, and how they view problems and affected populations. (Hankivsky 2012, 1715)
Hankivsky’s work on intersectionality in health research can be instructive for the clinical environment. We show in the following sections that intersectionality’s contribution in the clinical environment is precisely the kind of “conceptual shift” about which Hankivsky writes. Recognition of intersectionality informs the way in which both intersecting social identities and the interaction of these identities with sociopolitical structures affects clinical outcomes. Another virtue of an intersectional approach is the recognition 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 (Weber and Fore 2007, 205). Still, as van Mens-Verhulst and Radtke acknowledge, intersectionality does not offer a “how-to manual” for clinicians or researchers (van Mens-Verhulst and Radtke 2006, 10). Rather than attempting to provide such a manual, we intend to generate insight about how thinking from an intersectional framework might enrich patient–clinician encounters, increase patient centeredness, and help navigate better clinical experiences.

Case One: History of Trauma

Dr. Jones is an African American female obstetrician who sees a new African American female patient, Ms. Lawrence, for a prenatal visit. The physician and patient are of different social classes. While taking the medical history, Dr. Jones asks about and Ms. Lawrence discloses that she is experiencing physical and sexual abuse in her relationship. Ms. Lawrence then expresses that due to their different social backgrounds and because she assumes Dr. Jones has not personally experienced such violence, there is no way for Dr. Jones to understand her experiences.

Upon initial consideration, this case might seem to highlight the shortcomings of an intersectional analysis. There is concordance along race and gender. Yet the patient still insists that the clinician cannot understand her. She and her doctor may both be African American women, but Ms. Lawrence assumes that Dr. Jones lacks the same history of trauma, and because of this, cannot completely comprehend and therefore cannot entirely effectively care for Ms. Lawrence. Two related issues come into stark relief through this example. The first issue is that, taken to what appears to be its logical conclusion, full attention to the implications of intersectionality would require concordance along every possible axis of difference. That is, an African American woman from a socioeconomically disadvantaged background who has had a history of sexual trauma would require a doctor with precisely the same characteristics to be a satisfactory health care provider. Yet we know that this is not feasible, and even if it were feasible, it may not be desirable for reasons that we discuss later. Second, as Nash highlights, the focus on black women as a singular, analytic category obscures differences between black women—including differences in class and sexuality (Nash 2008, 9).

The first issue, that concordance along every axis is preferred, relies on a mistaken interpretation of intersectionality. Attention to intersectionality does not necessarily demand finer and finer grained distinctions in order to create new analytic categories of similarity. Nor is intersectionality primarily concerned with superficial notions of difference, identity, or categories. The idea is not to simply add more variables (MacKinnon 2013, 1020). Rather, intersectionality requires a shift in thinking from dominant frameworks to frameworks that are mindful of how one’s social identity contributes to one’s experience of the world. While it may not be necessary to have an exact one-to-one match between people in order to foster understanding, it will be necessary to understand how one’s positions of privilege and/or oppression operate within an interpersonal context.

Even if attention to intersectionality required one-to-one concordance, it would not be feasible to meet such a requirement within clinical environments. There is not enough diversity within the medical field to bring this about even if it were a desirable state of affairs. If this were the standard that intersectionality required, then the project would be doomed from the beginning. However, it is morally objectionable to even attempt to bring about such a level of concordance. Segregated medical care is not a worthy goal. One should not think, for example, that only black women physicians are suited to care for black women patients. Frankly, as we see in the aforementioned case, there are instances when race and gender concordance is not sufficient to gain patient trust.

This brings us to the second issue. Nash presents this as a “so what” question remaining for intersectional theorists to explain:

While intersectionality purports to describe multiple marginalizations and multiple privileges, it neglects to describe the ways in which privilege and oppression intersect, informing each subject’s experiences. In painting black women, for example, as wholly oppressed and marginalized, intersectional theory can not [sic] attend to variations within black women’s experiences that afford some black women greater privilege, autonomy, and freedom. (Nash 2008, 12)

When Ms. Lawrence claims that Dr. Jones does not understand her despite the fact that they are both black women, the patient sees their differences in social class status and other presumed differences in life experience as insurmountable obstacles. Nash sees this outcome both as predictable and as a shortcoming of

5. We grant that if one is doing research with a large data set, one might be advised to add class and other factors to the analysis in order to understand the data fully.
intersectionality theory. However, Crenshaw herself never intended race and gender to be the exhaustive categories of analysis. Although Crenshaw highlighted the specific special status of black women, she acknowledges that experiences of black women cannot be understood solely through the lens of race and gender but that an intersectional analysis “can and should be expanded by factoring in issues such as class, sexual orientation, age, and color” (Crenshaw 1991, 1244fn9). While categories necessarily “obfuscate individual differences,” theorists of intersectionality understand that they can be a useful way to address “differences among groups” (Kelly 2009, E46).

Far from attempting to create a false sense of “sisterhood” among black women—thereby recreating the kind of false narrative that middle-class, white women feminists have long been accused of doing—intersectionality by its structure encourages the exploration of those differences. It offers the “possibility of connection between social identities and acknowledgment of differing power dynamics with each identity” (van Mens-Verhulst and Radtke 2006, 5). In the clinical environment, this means that rather than becoming defensive or dismissing the patient’s concerns, the physician can understand the ways that she occupies a position of privilege relative to the patient: as the physician in the physician–patient dynamic, as someone of higher SES, and as someone whom the patient assumes has had no direct experience with domestic violence (regardless of whether this is actually the case).

In such circumstances, attention to intersectionality will lead the clinician to acknowledge their lack of full understanding and awareness, to listen and learn from the patient about the impact of her traumatic experience, and to work collaboratively to find ways to address this impact. Despite the fact that in this instance both Dr. Jones and Ms. Lawrence are black women, Dr. Jones should also resist the urge to insist on their similarity on the basis of shared race and gender identity. In so doing, the interaction can move beyond the discomfort, validate and acknowledge some apparent differences, and provide an opportunity for more therapeutic interaction. Furthermore, in thinking through an intersectional framework, Dr. Jones may ask herself which dimensions of intersectionality she is attending to, which ones she may be overlooking, and what assumptions follow from each (Moradi 2017, 112). She may further ask herself how her own attention to intersectionality fits with her patient’s experiences (Moradi 2017, 120).

It might be appropriate for Dr. Jones to discreetly offer to refer Ms. Lawrence to a domestic violence intervention program, while also understanding the race, gender, and class structural dynamics that may limit Ms. Lawrence’s access to such a program or prompt her refusal. For example, because some black women may feel obligated to prioritize racial loyalty, Ms. Jones may view the suggestion to attend a domestic violence intervention program as a betrayal of her partner (Jones 2014; http://time.com/3313343/ray-rice-black-women-domestic-violence). If Dr. Jones stops at Ms. Lawrence’s refusal without thinking about further intersectional implications, she may miss an important opportunity for an effective therapeutic intervention. With careful attention to the “overlapping structures of subordination,” Dr. Jones can see the ways in which a mere referral might be an inadequate interaction (Cho et al. 2013, 797).

A peer support group, such as exemplified by the Centering Pregnancy Institute, may be more appealing to Ms. Lawrence, given that it is not specifically a domestic violence intervention.6

Case One clarifies that applying an intersectional framework to clinical practice does not call for simple concordance of physician–patient race and gender. This would be both a misapplication and an oversimplification of the theory. Rather, an intersectional framework calls for the physician’s acknowledgment of the power dynamic in the patient–physician relationship and the possible ways that the patient’s intersecting social identities could lead to social disadvantage and marginalization. To be clear, the patient’s social identity is not the problem (MacKinnon 2013, 1028). Rather, the problem is the ways in which patients experience marginalization as a result of discriminatory social and structural practices. Inattention to the patient’s intersecting social identities and the ways in which social structures reinforce disadvantage could lead to further marginalization in the clinical encounter.

Case Two: Chronic Pain

Mr. Fuentes is a 36-year-old construction worker from Central America with chronic lower back pain. He has gone to numerous urgent care centers seeking pain relief in the setting of back spasms and now presents to a primary care clinic that accepts walk-ins.7 The doctor who

6. Centering Pregnancy is a well-established model of group prenatal care. Providing care in this way allows the patients and providers to relax and get to know one another on a deeper and more meaningful level. Members of the group form lasting friendships and are connected in ways not possible in traditional care. The program brings women who may have differing backgrounds and experiences together to share the common experience of pregnancy. See details about the Centering Pregnancy Institute available at: https://www.centeringhealthcare.org/what-we-do/centering-pregnancy

7. One may wonder why we have decided to include a case involving a male patient in an article where we advocate using the tools of intersectionality, an explicitly feminist theory, in the clinical environment. As we discuss earlier in the article, there is disagreement within the intersectionality literature regarding how to conceptualize intersectional identity. (Recall, for example, Nash [2008, 10].) We think that intersectionality offers the appropriate vocabulary to discuss how axes of identity shape and are shaped by the social structures that one navigates. Mr. Fuentes is a male patient, not because we have chosen to center maleness (which would defeat the fundamental project of intersectionality), but in order to show the connection
examines him, Dr. Roberts prescribes a muscle relaxant. When Mr. Fuentes remarks, “Can you give me anything stronger? I’ve already used this medication and it makes me sleepy but doesn’t help the pain,” Dr. Roberts worries that Mr. Fuentes may be seeking narcotics. Hesitant to prescribe opioids, Dr. Roberts suggests that physical therapy may be a more appropriate intervention and sends a referral. Mr. Fuentes leaves the encounter disappointed, wondering how he is going to get through his next day on the job without worsening pain.

Intersectionality can provide a lens that brings into clearer focus the converging issues of structural disadvantage and ethnicity that Mr. Fuentes and other patients may carry into the clinical encounter. Racial/ethnic minority members like Mr. Fuentes are disproportionately employed as maintenance workers, cleaners, housekeepers, construction workers, and many other so-called blue-collar jobs that are a common source of injury and chronic pain due to their physically demanding nature. Furthermore, these types of jobs typically pay less and provide insufficient (if any) insurance, which in turn limits access to ongoing clinical care and appropriate pain-relieving medications, including opioids (Tait and Chibnall 2014, 137). Mr. Fuentes’ work not only is the source of his injury, but also contributes to the structural barriers that prevent him from accessing consistent care.

Additionally, Dr. Roberts is skeptical of Mr. Fuentes’s request for opioids. Given the seriousness of the opioid crisis, physicians are encouraged to prescribe opioids more cautiously. However, African Americans and Latinos are more scrutinized for drug seeking compared with whites, despite having drug use rates similar to those of whites (Tait and Chibnall 2014, 133). Because Mr. Fuentes faces the aforementioned structural challenges and does not receive consistent care from a clinician who can vouch for and manage Mr. Fuentes’s chronic pain, and because Latino patients are more likely than white patients to be perceived as drug seeking, Mr. Fuentes’s request for opioids leads Dr. Roberts to offer a referral instead of adequate pain medication (Blair et al. 2013, 94).9

Finally, it is important to note that the same structural barriers that precluded Mr. Fuentes from receiving adequate care in the first place may also interfere with his ability to make use of the referral. As a construction worker, Mr. Fuentes may have a less flexible work schedule that is not conducive to physical therapy. Additionally, physical therapy may not be covered by Mr. Fuentes’s insurance plan (if he has one) and is likely to be too expensive to pay for out of pocket. While a white-collar patient with sufficient insurance or income may benefit from physical therapy and ergonomic adjustments to deal with chronic wrist pain from typing, a day laborer at a construction site is likely to need a different set of recommendations. Differences between individuals at the level of social class, education, and so on highlight structural issues that cannot be directly changed in the clinical encounter, but attention to the social determinants of health that intersectionality foregrounds can assist clinicians in providing to patients needed resources (e.g., referral to social work and vocational training) that may improve health-related outcomes.

COMMON INTERSECTIONALITY THEMES EMERGING FROM THE CASES

Two themes emerge from the cases we have considered: (1) An intersectional lens requires the clinician to confront his or her own biases, whether the presumptions are of commonality or of difference between the clinician and the patient. (2) Understanding clinician–patient interaction through an intersectional lens complicates the picture, challenges assumptions (sometimes yielding surprising information), and potentially clarifies issues that arise between the patient and the clinician.

Intersectionality is concerned with the ways that multiple social identities intersect with one another at the macro- (national and international), meso- (regional institutions and policies), and micro- (community, grassroots, and individual) levels (Hankivsky et al. 2012, 35;

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8. The increased scrutiny is the result of the stereotype that African Americans and Latinos are more likely to be drug abusers/seekers.
9. Dr. Roberts need not hold any explicit racial/ethnic animus toward Mr. Fuentes. However, implicit bias research (based on Implicit Association Test, or IAT, results) shows that clinicians hold bias against Latinos compared to whites. These biases (explicit or implicit) are often stereotype consistent, for example, “Latinos are drug abusers.” The facts that Mr. Fuentes has (a) sought help at a walk-in clinic instead of through a primary care physician and (b) explicitly asks for “stronger” medications were probably already red flags for Dr. Roberts. In this instance Mr. Fuentes’s Latino identity was the (possibly unconscious) tipping point for Dr. Roberts that resulted in issuing a referral for physical therapy, rather than a prescription for opioids. Similarly, an interesting study with African American subjects showed that even when African Americans have access to regular physicians who are aware of their patients’ chronic pain, African American patients were still more likely than white patients to be subjected to opioid abuse risk reduction strategies such as urine drug tests, more frequently scheduled office visits, and restricted early refills. See Becker and colleagues (2011).
Bowleg 2012; 1269). While the clinician-patient interaction is a micro-level interaction, the interaction does not occur in a vacuum. Rather, social categories interact with and reinforce one another (Hankivsky et al. 2012, 35). With this in mind, it is important to consider the ways in which broader institutions and policies influence and are influenced by our social identities, which in turn, shapes interpersonal interactions.

The first case highlights that even with concordance along race and gender lines, the patient may have a different sense of commonality (or lack thereof) between patient and clinician than outward appearances might suggest. Although there is some evidence that race concordance leads to greater patient satisfaction, understanding racial concordance through a lens of intersectionality shows that other axes of the patient’s identity may converge in a way that highlights the insufficiency of race concordance alone (Cooper et al. 2003, 907). Meanwhile, the second case highlights the need for the clinician to more carefully consider the structural conditions that shape a patient’s options and preferences. The intersection of Mr. Fuentes’s ethnicity and socioeconomic status created barriers in both how he sought care and the treatment options he was offered. In addition, the lack of intersectional framework meant that Dr. Roberts did not consider whether the physical therapy referral best addressed Mr. Fuentes’s needs.

As Crenshaw conceived of it, intersectionality provided new insights into the ways that law might fail to address discrimination against individuals whose identities differ from prevalent groups. The application of the concept of intersectionality in medical practice has a similar value while being used somewhat differently. The medical context is one that is intended to be nonadversarial. While the medical ethics literature has addressed worries about a power differential in the patient-clinician interaction, the current medical ethics literature about the patient-clinician relationship endorses a patient-clinician partnership and shared decision making that reduces the power differential. Any discussion of the application of intersectionality to the medical context needs to recognize these features of patient-clinician interactions.

Furthermore, intersectionality can help the clinician to understand the less-than-straightforward ways in which various characteristics of a patient and the social structures patients must navigate interplay to yield her response to illness and her preferences regarding a therapeutic response. The application of intersectionality in clinical practice allows clinicians to be as informed about the sociodemographic characteristics of their patients as they are about the pathobiology of a patient’s symptoms and illness. Clinicians can engage in more complex differential diagnoses when, for example, an African American, middle-class patient has persistent hypertension. This is because clinicians can be as knowledgeable about the impact of social policies on their patients as they are about the impact of the renin-angiotensin system on a patient’s blood pressure. We do not mean that clinicians should merely stereotype their patients in more thorough ways. Rather, we are saying that clinicians must recognize that to fully understand their patient, they must expand their preparation and know about a larger set of influences that may affect a patient’s response to illness and the possible ways to treat it. As clinicians bring this information to the clinical encounter, it can be useful both in their understanding of patients’ circumstances and in sharing understanding with the patient as they collaborate in addressing the clinical problem.

OBJECTIONS AND REPLIES

We now consider three kinds of objections with regard to intersectionality theory and its use in the clinical environment. The first kind of objection we consider is friendly to intersectionality as a conceptual framework, but raises the possibility that intersectionality does not offer anything new or radical to guide physicians—that what intersectionality calls for is merely cultural competence. Indeed, this objection might be understood as less of an objection and more of a helpful way of framing intersectionality in the clinical environment. That is, this objection is actually an attempt to show how the medical community is already poised to honor the commitments of intersectionality. The second kind of objection we consider is an objection to the usefulness of intersectionality itself. Finally, the third kind of objection we consider is sympathetic to the idea of intersectionality as a theory, but calls for clarity—particularly around methodology.

Objection that Intersectionality is Merely Cultural Competence

Eckstrand and colleagues offer what could be considered less an objection and more of a friendly amendment that offers an opportunity to incorporate intersectionality into the clinical context. They argue that the tenets [of intersectionality] build on concepts already addressed in academic medicine. The Association of American Medical Colleges’ (AAMC) Diversity 3.0 framework emphasizes that all aspects of human difference represent diversity, and calls for institutional culture and climate to demonstrate “inclusiveness, mutual respect, and multiple perspectives.” (Eckstrand et al. 2016, 904)

A benefit of their view is that it does not require clinicians to engage in a radical reframing of how to be inclusive. Because of this, it might prove easier to get clinician “buy-in.”

However, we do not think that framing intersectionality in this way actually does justice to intersectionality. Intersectionality has been since its inception an attempt
to radically reconceptualize difference by being deliber-
ate about the ways that aspects of identity and social
structures converge in ways that empower some and dis-
advantage others. As such, intersectionality requires
knowledge of the “sociohistorical realities of historically
oppressed groups” (Bowleg 2008, 318). Cultural compe-
tence focuses on a clinical skill—the ability to interact
with those who are different—without necessarily being
aware of, or finding the importance of, the intersections
of different identities, the ways in which those identities
intersect with social structures, and the outcomes related
to health and health care. Metzl and Roberts understand
the shortcomings thusly:

Locating medical approaches to racial diversity solely in the
bodies, backgrounds, or attitudes of patients and doctors,
therefore, leaves practitioners unprepared to address the
biological, socioeconomic, and racial impacts of upstream
decisions on structural factors such as expanding health
and wealth disparities. (Metzl and Roberts 2014, 674)

They advocate structural competency as a means to
remedy the shortcomings of cultural competence.
Structural competency, as defined by Metzl and Roberts,
is the ability to recognize the policies that have down-
stream effects on an individual’s health. It has been
used, in many ways, to push the boundaries of cultural
competence. While cultural competence focuses on
approaches to patient–clinician encounters that take into
account cross-cultural differences, structural competency
seeks to address the structural and institutional forces at
play that may affect population health outcomes. Both
cultural competence and structural competency are
important tools in addressing health inequities.

Intersectionality seeks to promote many tenets of
both tools, but more specifically provides a framework
that allows clinicians to take into account structural
forces, cultural forces, multiple forms of oppression
and/or privilege, and the unique social identities that
are derived from these interlocking factors. Cultural
competence may be too simplistic, while structural compe-
tency’s focus is above the level of the individual
patient encounter. Intersectionality can strengthen both.

Thus, while we acknowledge that recognition of
intersectionality aims to achieve some of the same goals
as cultural competence and structural competency, inter-
sectionality both complements and challenges these other
intellectual approaches. As an analytical method, inter-
sectionality adds scholarship and analysis that can
inform cultural competence. For example, as we showed
earlier, epidemiologic research that is attentive to inter-
sectionality shows that black middle-class women do not
experience the same health outcomes as white middle-
class women.10 We also argue that intersectionality can

10. Another clear example is epidemiologic data demonstrating
the differential effects of rural life on individuals of different
ethnic backgrounds (James et al. 2017).

help clinicians appreciate the fluidity and contextual
nature of identity and power. It enhances understanding
that individuals’ lives may evolve so that a particular
axis may be a source of advantage at one point in a per-
son’s life and disadvantage in another. Intersectionality
offers a framework for clinicians to understand the ways
that “multiple intersecting social identities” reflect
“multiple interlocking structural-level inequality at the
macro levels of society” (Bowleg 2012, 1267). While cul-
tural competence fosters sympathetic understanding,
intersectional analysis demands precise knowledge and
expertise that allows a clinician to dissect the particular
situation of her patient.

Objection to Intersectionality Itself

In her provocatively titled chapter “Beyond
Intersectionality,” Naomi Zack argues that intersectional-
ity leads to fragmentation and that women in particular
should instead opt for what she calls a relational model.
She understands the impulse of intersectionality as a cri-
tique of universalism. Zack clarifies that universalism is
not necessarily pernicious, “but only that overgenerali-
zation from the circumstances of those privileged does not
further the liberation of those not privileged” (Zack
2005, 10). She continues that at most, the kinds of cri-
tiques launched by intersectionality show that universal-
ism is “too hastily drawn from insufficient experience of
human difference” (Zack 2005, 10). She concludes that as
a response to universalism, intersectionality is neither
practical or moral (Zack 2005, 17).

Zack rejects an intersectional model and instead pro-
poses a relational model. Within a relational model,

Women are those human beings who are related to this
historical category of individuals who are designated
female from birth or biological mothers or primary sexual
choice of men … This shared essential relation does not
entail that all who are women are mothers or male sexual
choices, or that they have been designated female from
birth. Neither does it entail that female birth designation,
heterosexuality, or motherhood are feminist values (or
virtues). They are, rather, the historical conditions and facts
that have made feminism necessary in a dual-gender
system of men and women. (Zack 2005, 8)

However, Zack’s relational model does not address
the practical difficulties that intersectionality attempts to
rectify. Her description of the relational model appears
to merely add several characteristics together that have
historically been associated with being a woman. That
these characteristics would be a sufficient tie to bind
women in a fight against oppression is precisely what
intersectionality rejects.

Furthermore, Zack does not offer any strong reason
why her relational model is preferable. She merely
asserts that the recognition of differences between
women will result in such strong investment in “separate
domains of assistance and cooperation” that it forecloses on any possibilities of helping one another (Zack 2005, 18). Yet as May notes, “gender is already differentiated” because despite the conception of womanhood that accompanies Zack’s relational model, additional social and political factors shape gender identity (May 2015, 127). Intersectionality does not cause the fragmentation that Zack predicts will occur as a result of paying careful attention to difference. Rather, the social and political structures within which women exist create the problems that intersectionality attempts to rectify (Hancock 2013, 281). As a conceptual framework, intersectionality understands the important ways that identity categories such as race, ethnicity, sexual orientation, gender, and class shape one another.

Additionally, van Mens-Verhulst and Radtke argue for the importance of intersectional considerations in the clinical environment. They anticipate the objection, contra Zack, that intersectionality does not go far enough in its recognition of difference:

On the one hand, one might argue that this variety [in theory and method of thinking about intersectionality] may be an advantage in that, regardless of theoretical orientation, researchers and clinicians can take up intersectionality in their work ... On the other hand, all this plurality could lead to obfuscation of the primary concern that Intersectionality Theory was developed to address, i.e., inequities sustained by failure to explore the lives of people located at the intersection of multiple dimensions of difference. (van Mens-Verhulst and Radtke 2006, 10)

We contend that the worry raised by van Mens-Verhulst and Radtke is a recurring one that may be difficult to resolve, but that the practice of clinical medicine, informed by an intersectional analysis, can be up to the task. Clinicians who spend much of their training understanding differential diagnosis can expand their diagnostic set to incorporate an understanding of different sources of disadvantage.

**Objection Calling for Clarity**

Connected to the objection that van Mens-Verhulst and Radtke anticipate, McCaff and Nash raise specific methodological objections. McCaff’s objection is what she calls the “defining characteristic of research in this area” (McCaff 2005, 1772). That is, it is difficult to develop a methodology for intersectionality when “the subject of analysis expands to include multiple dimensions of social life and categories of analysis” (McCaff 2005, 1772). Nash raises two related worries about intersectionality in addition to the worry about the lack of clear methodology. The first is that there is “ambiguity inherent to the definition of intersectionality,” and the second is that there is a lack of “coherence between intersectionality and lived experiences of multiple identities” (Nash 2008, 4). Both Nash and McCaff think of intersectionality as important and potentially fruitful, but they each see these objections as important to resolve in order for intersectionality to continue to evolve as a conceptual framework for increasingly sophisticated analysis.

Our response to this kind of objection is twofold. First, McCaff’s worry about the difficulty of developing a clear methodology given the ever-expanding categories of identity and analysis seems unfounded when we recognize the extent to which careful epidemiologic research can inform the clinician’s awareness of the many complex variables that can pose disadvantages in patients’ lives. Furthermore, McCaff’s worry mislocates intersectionality’s center of analysis. McCaff herself answers this objection in a later paper coauthored with Cho and Crenshaw. They argue that intersectionality “emphasizes political and structural inequalities” over a preoccupation with “categories, identities, and subjectivities” (Cho et al. 2013, 797). In other words, while identities and categories matter, a properly intersectional framework does not merely require fixation with establishing finer and finer grained categories. As a matter of fact, intersectionality highlights the role that differential power relations within social and political structures play in the use and creation of categories (Cho et al. 2013, 797).

Second, it is important to distinguish between the theoretical foundations of intersectionality and the application of intersectionality in the clinical environment. Intersectionality facilitates a broadening of thought that forces clinicians to rethink the ways that axes of identity shape both interpersonal and institutional interactions. The aims of the clinical environment are different from the aims of the theorist trying to make use of intersectionality. Because intersectionality takes seriously the standpoint of those who are multiply marginalized, intersectionality can also help clinicians devise more productively tailored clinical interventions for various patients (Bowleg 2012, 1272). Nevertheless, even as a strictly theoretical account, intersectionality’s ambiguities may not be a weakness. Kathy Davis suggests that it is precisely the ambiguities of intersectionality that provide opportunities for its improvement (Davis 2008, 76). That is, the continued attempts to resolve the puzzles of intersectionality are precisely what animates it.

**CONCLUSION**

We have shown how one might apply an intersectional framework in the clinical environment. We understand that adopting an intersectional approach will require rethinking some strategies and assumptions (Crenshaw 1991, 1264). Grzanka, Brian, and Shim noted, in response to a paper by Danis, Wilson, and White, that,

Actually implementing an intersectionality-informed bioethics means first recognizing the important ongoing
work at the nexus of health, science, technology, and society already being done by antiracist scholars and activists, many of whom are women of color. (Danis et al. 2016; Grzanka et al. 2016, 28)

This general observation with regard to bioethics can also inform the clinical environment. We have shown how this can happen practically.

Contra Zack, we have argued that difference and the recognition of difference are not inherently bad. Intersectionality is an important contribution because it undermines the synthesis of difference plus the power to shape institutions and clinical priorities (Crenshaw 1991, 1265). Highlighting the ways in which priorities have been shaped according to the most privileged members of a group has allowed us to think about how to reframe and broaden those priorities.

However, even within an intersectional conceptual framework, there may be times when one or two features are more salient than others. Yet the issue of which identities are salient and under what circumstances remains. We understand the objection and we understand the worry. Kelly notes this as a worry for biomedical scientists in general, where increasing levels of specificity lead to homogeneity in groups, which is preferred, but limits generalization of findings to other groups. The process of deciding which categories to use for descriptive or analytic purposes involves gain and loss from each perspective (Kelly 2009, E47).

While it may be useful to emphasize some aspects of one’s identity over others in some circumstances, it is important to note that certainly in group circumstances, but also in individual cases, there will be fluidity of categories over time. Individual life trajectories change throughout the life cycle. Categories like social class and disability status may change several times in one’s life, and any intersectional analysis must be prepared to handle this reality. Beyond this, insightful clinicians recognize that the care of each patient involves engagement and collaboration with that person with appreciation of her unique circumstances.

**DISCLAIMER**

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

11. Wilson, Danis, and White have written elsewhere in response to concerns raised by Grzanka and colleagues that how one experiences of racism (for example) will vary by gender, sexual orientation, and educational attainment. However, sometimes it may be important to delineate the experience of racism from other forms of discrimination (Wilson, Danis, and White 2016, W2).

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