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CAN INTERSECTIONALITY HELP LEAD TO MORE ACCURATE DIAGNOSIS?

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With their intersectional conceptual framework, Wilson and colleagues create a constructive platform through which physicians and other healthcare providers can discuss the multidisciplinary nature of patient care (Wilson et al. 2018). Their framework emphasizes how physicians should recognize the ways in which their patients' identities may impact their medical care, focusing on the patients' attitudes towards their providers and the efficacy of their treatment plans.

Although this is an important aspect of using an intersectional framework in clinical medicine, I believe intersectionality also calls for physicians to recognize the ways in which they themselves are affected by their patients' identities. More specifically, I argue that physicians must pay special attention to the ways in which they or their field may be unconsciously biased towards or lack information about certain identity groups. This slight shift in directionality is especially important in tackling systematic errors and delays in diagnosis.

Wilson and colleagues do briefly mention that intersectionality may aid diagnosis during their case presentation of Mr. Fuentes, but they do not provide concrete details on how this may be done (Wilson et al. 2018, 20). I propose that an intersectional framework that considers how patients' multiple identities affect both their own attitudes towards their physicians and their physicians' attitudes towards them may help improve diagnostic accuracy

Missed diagnoses and misdiagnoses

Despite improvements in diagnostic technologies, errors and delays in diagnosis continue to pose serious physical and psychological harm to patients, as well as financial harm to the healthcare system (Khullar et al. 2015). Systematic biases that disproportionately affect historically marginalized groups underlie some of these misdiagnoses (Chen et al. 2008; Schopen 2017; Hoffman et al. 2016; Jones et al. 2008; Knaack et al. 2017).

A quintessential example of this bias is the minimization of pain and other symptoms reported by women. Studies, news reports, and patient narratives all suggest that compared to men, women are less likely to receive and wait longer for pain medication, feel dismissed

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as “hysterical” or “hypochondriacal” when they describe their symptoms, and receive wrong and delayed diagnoses as a result (Chen et al. 2008; Schopen 2017; Dusenbery 2018). People of color, particularly African Americans, face similar issues of symptom minimization, which some studies suggest may be due to the false perception that African Americans biologically feel less pain than other races (Hoffman et al. 2016).

Another example is diagnostic overshadowing, or the attribution of symptoms to an existing diagnosis rather than a potential co-morbid condition. The concept of diagnostic overshadowing came about in the 1980s to give a label to what was affecting people with cognitive disabilities or mental health conditions (Jones et al. 2008). This overshadowing continues to affect these same groups today, who already perceive significant discrimination from their healthcare providers (Knaack et al. 2017). Notably, diagnostic overshadowing calls for consideration of not just the patient’s disease, but also the clinician’s “years of experience, [and] cognitive complexity” and how this may impact the ways in which they see the patient (Jones et al. 2008, 169).

Using intersectionality to help improve the accuracy of diagnosis

To illustrate how intersectionality may guide diagnosis, I describe the process by which a physician may apply an intersectional framework to three hypothetical patients that reflect real clinical situations frequently resulting in misdiagnosis.

1. Case One

Carla is 26-year-old, African American female who comes to the emergency department with a chief complaint of severe pelvic pain. Unbeknownst to Carla, she has endometriosis; and for many patients in Carla’s situation, receiving a correct diagnosis may take seven to eight years (Schopen 2017).

Using an intersectional lens that considers Carla’s identity as a woman of color may help Carla’s physician during her diagnosis. First, Carla’s physician could take into account Carla’s identity as a woman of color and consider how this may impact Carla’s attitude towards her providers. As a woman, Carla may have experienced dismissal of her symptoms from past providers; moreover, as a woman of color, she may also be less likely to trust her provider enough to open up about her symptoms given the historical treatment of African Americans in Tuskegee and other areas of medicine.

Beyond this, Carla’s physician (who may be female or male, African American or another race) could also think about how she herself might be impacted by Carla’s identities. Is she feeling skeptical of Carla’s description of her symptoms? Is she considering other possibilities beyond pelvic inflammatory disorder, which is a common misdiagnosis for African American women with endometriosis (Shade et al. 2012)? By recognizing the potential biases that the medical field may project onto each of Carla’s identities and the additive nature of these biases, Carla’s physician may preemptively consider the possibility that she is dismissing Carla’s symptoms due to Carla’s identity as a woman and/or as a person of color. Finally, the physician again may use an intersectional lens to consider how

differences in presentation of endometriosis between African American and Caucasian women may impact Carla's diagnosis (Shade et al.

2012).

2. Case Two

Tina is a 42-year-old woman with anxiety disorder who is at her primary care physician's office due to fatigue, abdominal cramping, and low appetite. Utilizing an intersectional framework, the physician may recognize that Tina may experience at least two spheres of systematic marginalization, both as a woman and as a person with a mental health condition.

In recognizing Tina's identities, Tina's physician could be aware of the additive effects of symptom minimization in women and diagnostic overshadowing for patients with mental illness. As a result, Tina may experience symptom minimization not only if her physician dismisses her pain outright, but also if her physician attributes her pain to anxiety rather than an underlying physical condition without first checking or providing valid reasoning.

Many patients like Tina may have underlying physical conditions that account for early, nonspecific symptoms like gastrointestinal distress, joint pain, and fatigue (Knaack et al. 2017). They may only receive correct diagnoses when their condition significantly worsens, which could also affect their long-term prognoses and decrease their trust of the healthcare system.

Even though Tina's symptoms could reasonably be due to anxiety, they are also consistent with early signs of Crohn's disease. As such, Tina's physician could consider ruling out certain physical conditions in the same way she would have if Tina had no anxiety disorder diagnosis. These decisions could be made on a case-by-case basis depending on the severity of the symptoms and the management of the mental health condition.

3. Case Three

Frank is a 16-year-old, Caucasian teenage boy who identifies as LGBTQ. At his yearly check-up, Frank's pediatrician notices that Frank has lost a considerable amount of weight since his last visit, but Frank claims that this is simply due to his recent growth spurt.

Had Frank been female, rapid, unexplained weight loss would cause a physician to suspect an eating disorder. However, eating disorders are also thought to be stereotypically a "female" problem, and many men receive late diagnosis or do not receive a diagnosis at all. Although this in itself is problematic, for Frank, it is even more so because members of the LGBTQ community are at high risk of developing eating disorders (Cohn et al. 2016). Thus, although Frank's identification as male may be seen as advantageous in the traditional intersectional context, in this case, it may disadvantage him unless his physician recognizes (1) the potential biases in how she considers Frank's diagnosis and (2) Frank's intersectional identity. It is possible that in these kinds of cases, the physician will not know about her patient's sexuality. As such, it is important for physicians to be open to the possibility of unknown intersectional identities and to ask appropriate questions that may help aid them in their differential diagnosis.

The role of institutions

Of course, these intersectional issues are much more complex than the scenarios above make them seem. Individual awareness of potential biases and understanding of disparate diagnoses in medicine can only get physicians so far when dealing with complex, systematic issues that cannot be attributed simply to bias or discrimination, but also to the lack of understanding of what it means to live with these intersectional identities. Thus, to fully address these intersectional issues of misdiagnosis or delayed diagnosis, institutions should fund research on the underlying causes of misdiagnosis in various, intersectional populations, as well as various methods of diagnosing and treating the same condition in different populations. When patterns of disparities in diagnosis (or treatment or outcomes) occur, institutions should question why.

Conclusion

In conclusion, Wilson and colleagues' intersectional framework demonstrates how useful thinking about patients' multiple identities can be for treatment purposes. However, an intersectional framework can also be used to aid physicians in accurately diagnosing their patients. By incorporating the physician's response to their patients' identities, an intersectional framework may help address systematic issues of symptom minimization and diagnostic overshadowing for patients who face discrimination, marginalization, or disparities in the healthcare system.

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