Published in final edited form as:

Am J Bioeth. 2019 ; 19(2): 20–22. doi:10.1080/15265161.2018.1557289.

Intersectionality and Clinical Decision Making: The Role of Race

Yen Ji Julia Byeon¹, Sherrill L. Sellers², Vence L. Bonham¹

¹Social and Behavioral Research Branch, National Human Genome Research Institute, National Institutes of Health, Bethesda, Maryland ²Department of Family Science and Social Work, Miami University, Oxford, OH

Wilson and colleagues (2019) propose intersectionality as a framework that can make clinical medicine more attentive to the complexity of patients' and health care providers' social identities. We agree that "intersectionality acknowledges how multifaceted differences shape the patient-clinician interaction and forces a re-framing that can lead to improved outcomes" (Wilson et al. 2019, 8). In this commentary, we extend Wilson and colleagues (2019) by highlighting the significant influence of one social identity in medicine and the clinical encounter: race. In the midst of deliberations about the appropriate role of race in science and medicine, intersectionality can challenge an uncritical use of race and foster a more expansive consideration of social identities in clinical decision making.

Physicians' Consideration of Race in the Clinical Context

A straightforward understanding of how physicians employ race in medicine is complicated by the fact that they are exposed to highly varied and often competing narratives about the role of race in health. Today, many scientific studies aim to highlight genetic differences between racial groups, while an equal volume of literature adamantly criticizes the notion of race as having any biological basis. Epidemiological literature clearly shows that disease prevalence differs between racial groups, although the mechanisms behind these differences are not always clear. Additionally, racial stereotypes and assumptions are a source of unquestioned logics about who belongs to which racial group and how their culture, values, and habits influence health.

In our efforts to understand how physicians incorporate or reject these narratives in their own practice, we and others have conducted qualitative and quantitative studies with physicians about the clinical relevance of race (Sellers et al. 2018, Hunt et al. 2013, Snipes et al. 2011, Bonham et al. 2009). In these studies, we see that race frequently becomes a proxy for a variety of unobservable characteristics that may increase the risk of poor health outcomes. For example, physicians in focus-group studies have made connections between race and health behaviors by explaining that certain groups prefer unhealthier foods or larger body sizes, have alternative cultural practices surrounding health, or prioritize health in

Disclaimer

The opinions expressed in this article are those of the authors. No statement in this article should be construed as an official position of the National Human Genome Research Institute, National Institutes of Health, or Department of Health and Human Services.

different ways (Hunt et al. 2013). They also discuss a relationship between race and class, suggesting that certain racial groups may be at higher risk for many conditions because of their low health literacy, lack of quality health care, or limited access to the resources required to live a healthy lifestyle (Hunt et al. 2013, Bonham et al. 2009, Snipes et al. 2011). Finally, physicians have reported that certain racial groups may be genetically predisposed to specific conditions (Bonham et al. 2009, Hunt et al. 2013).

In some cases, these narratives about the relationship between race and health differences are codified into race-specific clinical guidelines. Physicians discuss examples of a number of race-specific recommendations (Hunt et al. 2013, Snipes et al. 2011, Bonham et al. 2009), such as those to screen for diabetes at a lower body mass index (BMI) for Asian Americans (American Diabetes Association 2018), adjust for race in measurements of lung function (Braun 2014), and consider the increased risk for prostate cancer in African American men when making decisions about prostate-specific antigen screening (U.S. Preventive Services Task Force 2018). Such guidelines adjust for differential disease risk based upon patients' perceived ancestral background and social characteristics, which are described using the construct of "race." The scientific and clinical basis for some of these guidelines have previously been critiqued through a broader examination of the history of the relationships between race, science, and medicine (Braun 2014).

Intersectionality and the Role of Race in Clinical Medicine

We recognize that race and other social identities can be important to consider in the clinical context, but the improper use of race lends itself to imprecise and inadequate care. Many contemporary critiques of the use of race in medicine have centered around the complex relationship between racial categories and genetic variation. Race is fluid, contextual, and does not map neatly onto genetic variation, and assuming that it does risks missing diagnoses, giving inappropriate treatment recommendations, and reinforcing the debunked notion of discrete biological races.

In this context, intersectionality adds another lens through which to challenge the uncritical consideration of race in the clinic. Underlying physicians' manifold explanations for the medical relevance of race, or the "adjustment" for race in clinical guidelines, can be the assumption that members of a racial group share the experience of race and its associated burdens, risks, and contexts in similar ways. However, intersectionality posits, and intersectional research has shown, that this is not the case.

At its core, intersectionality theorizes that multiple social identities interact to create wholly unique experiences of marginalization and privilege. Therefore, even individuals who share in an axis of identity such as race will have diverse experiences based on their unique social positions along other axes (Crenshaw 1989). In the biomedical realm, we see these ideas play out in the differential risks for diseases that are revealed through intersectional analyses of epidemiological data. For example, the relationship between hypertension and race is well established and is one that physicians frequently raise in discussions about race and medical treatment (Hunt et al. 2013, Bonham et al. 2009, Snipes et al. 2011). However, the prevalence of hypertension has been reported to be even higher in women of color than their

male counterparts, and in line with the intersectional reality of these women's lives, this effect is multiplicative rather than additive (Richardson and Brown 2016).

For physicians, these findings and intersectional thinking more broadly do not mean that they should simply use more complicated sets of heuristics or reference values that involve multiple social identities. As Wilson and colleagues write, "attention to intersectionality does not necessarily demand finer and finer grained distinctions in order to create new analytic categories of similarity...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" (Wilson et al. 2019).

We concur, and add that this "shift in thinking" for physicians can involve a revisiting of how they conceptualize race. Under an intersectional framework, race is not a constellation of social contexts, behaviors, or genomic information that can be packaged into a proxy or reference value. Rather, it is one of many identities that determine patients' unique location within interlocking societal structures, and it is the whole experience of this social position that shapes health.

What follows from this reconceptualization is that physicians, when they consider race, would consider it in conjunction with the entirety of a patient's identity and social context. They would be open to working through the many ways in which race, together with other social identities and structures, might make a patient more vulnerable in the healthcare system, susceptible to an illness, or suited for a treatment plan. We recognize that intersectionality is ambiguous in methodology and application – it certainly does not spell out the precise health consequences of specific combinations of identities. However, like Wilson and colleagues, we do not see this ambiguity as a weakness. To the contrary, it simply leaves room for health care providers to be open-minded, expansive, and even creative in how they consider the relationship between a patient's social context and health.

Our vision for the role of intersectionality in clinical decision making mirrors that of Wilson and colleagues in many ways. However, thinking through the implications of their proposal specifically for physicians' consideration of race highlights the ways in which intersectionality can address at least some of the tensions surrounding the relationship between race and medicine. First, the use of race in medicine is criticized for seeking the rationale for differences in health in biology, which can distract from efforts to address social health inequities. However, an intersectional framework unequivocally foregrounds the role of race in structural social inequities. Second, the use of race as a proxy or heuristic has been criticized for leading to inappropriate care when the assumptions underlying the heuristic are not necessarily true. An intersectional framework is not based upon assumptions about the relationship between a patient's race and disease risk, as it recognizes that social identities and structures can converge in unique and unexpected ways. In this way, intersectionality can foster a truly expansive and thoughtful consideration of a patient's social context in clinical decision making.

Acknowledgments

Funding

This research is supported in part by the Intramural Research Program of the National Human Genome Research Institute.

References

- American Diabetes Association. 2018 2. Classification and diagnosis of diabetes: Standards of medical care in diabetes-2018. *Diabetes Care* 41(Suppl 1): S13–S27. doi:10.2337/dc18-S002. [PubMed: 29222373]
- Bonham VL, Sellers SL, Gallagher TH, et al. 2009 Physicians' attitudes toward race, genetics, and clinical medicine. *Genetics in Medicine* 11(4): 279–286. doi:10.1097/GIM.0b013e318195aaf4. [PubMed: 19265721]
- Braun L 2014 *Breathing race into the machine: the surprising career of the spirometer from plantation to genetics*. Minneapolis: University of Minnesota Press.
- Crenshaw K 1989 Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, Feminist theory and antiracist politics. *The University of Chicago Legal Forum* 140: 139–167.
- Hunt LM, Truesdell ND, and Kreiner MJ. 2013 Genes, race, and culture in clinical care: Racial profiling in the management of chronic illness. *Med Anthropol Q* 27(2): 253–71. doi:10.1111/maq.12026. [PubMed: 23804331]
- Richardson LJ, and Brown TH. 2016 (En)gendering racial disparities in health trajectories: A life course and intersectional analysis. *SSM-Population Health* 2: 425–435. doi:10.1016/j.ssmph.2016.04.011. [PubMed: 28111630]
- Sellers SL, Cunningham BA, and Bonham VL. 2018 Physician knowledge of human genetic variation, beliefs about race and genetics, and use of race in clinical decisionmaking. *J Racial Ethn Health Disparities*. doi:10.1007/s40615-018-0505-y.
- Snipes SA, Sellers SL, Tafawa AO, et al. 2011 Is race medically relevant? A qualitative study of physicians' attitudes about the role of race in treatment decision-making. *BMC Health Services Research* 11: 183. doi:10.1186/1472-6963-11-183. [PubMed: 21819597]
- U. S. Preventive Services Task Force. 2018 Screening for prostate cancer: US preventive services task force recommendation statement. *JAMA* 319(18): 1901–1913. doi:10.1001/jama.2018.3710. [PubMed: 29801017]
- Wilson Y, White A, Jefferson A, and Danis M. 2019 Intersectionality in clinical medicine: The need for a conceptual framework. *American Journal of Bioethics* 19(2): 8–19.