Intersectionality in CBL case diversification

The concept of intersectionality (Crenshaw 1989) is important for understanding commonalities and differences in the experiences of persons who belong to priority communities and who experience health inequities.

"Intersectionality" originates in the Black feminist analysis of the shortcomings of anti-discrimination laws that focus on the single aspect of disadvantage "but for" which people would have had the same privileges enjoyed by the "normative" person (i.e. member of the minority of persons that are white, cisgendered, heterosexual, settler, male, with a post-secondary education).

Crenshaw famously used the image of an "intersection" in which a Black woman may be hit by oncoming traffic travelling in either direction—as a Black person and as a woman.

The concept of intersectionality is increasingly useful in health care (López and Gadsden 2016).

The following three aspects of intersectional analysis are important in the context of health care practice and curriculum:

(1) In Crenshaw's legal context, the concept of intersectionality **highlights the limitations of focusing on non-discrimination**. Non-discrimination is important: we all have a fundamental human right not to be actively discriminated against. However, it is not the whole story of how to achieve equity. It helps only those who are disadvantaged in only one domain, meaning people who, but for one feature, would achieve the privileged status considered normal. In healthcare, we are increasingly aware that if we only address discrimination, we are not addressing the deeper social determinants of health that disadvantage people in multiple, inter-related ways.

(2) "Intersectionality" **captures the multiple dimensions of disadvantage** imposed on many persons in priority communities. Each kind of disadvantage is often treated as a single issue, and their combination is not necessarily addressed "solutions" meant to deal with each single disadvantage.

(3) Representing intersectionality also **addresses the diversity of priority communities, counteracting stereotypes**. African Nova Scotians, for example, have come to the Maritime provinces in (at least) three distinct waves, alongside early European settlers and from the US as loyalists and refugees from the American Revolution and the War of 1812; Caribbean immigration of the early 1900s and ongoing, and more recent African immigration as Canadian immigration policy abandoned its most blatant forms of racism in the 1960s after Diefenbaker's 1960 Bill of Rights ruled out discrimination on the basis of race, national origin, colour, religion, or sex. There are commonalities and differences in their experience of structural racism and the effects of colonialism and the legacy of the slave trade for the communities that are racialized and grouped together as "Black."

The concept of intersectionality also counteracts stigmatization: it places historical and ongoing patterns of oppression at the centre of analysis. It captures the idea that the experience of oppression is different for people with multiple "non-normative" identities. For example, weight stigma is experienced differently by Black women; heteronormativity has a different impact on gay cis men, lesbian cis women, and trans and genderqueer persons with a variety of sexual orientations.

In the CBL cases, intersectionality is represented by the different combinations and experiences of oppression that patients face across the 200 different CBL cases discussed in tutorials. In the case diversification process, we have analysed local experiences and needs and discussed with communities the forms of intersectionality (for example, gender, race, and immigration status) that are important to their communities.

Case example

Keisha Tolliver (she/her), a Black trans woman from Hammonds Plains in HRM, Nova Scotia, was interested in the health professions growing up, despite almost exclusively white role models (who are not role models for her) and despite years of classroom experiences where many of her teachers do not encourage her participation or support her development.

Her parents have no title to their land due to the racist policy towards Black loyalists (policies promoted by Lord Dalhousie). The NS government had not yet remedied these policies when she was growing up, and has not yet done so now. As a result, her parents could not take out loans against their house to support her in her post-secondary education, and so she took on substantial debt. She succeeds in her program, despite micro-aggressions in the classroom, including teachers who blame “parenting styles” for the enduring poverty of people who still do not have title to the land they have lived on for four centuries.

She also experiences stigma and upheaval when she transitions during her post-secondary education to live in accordance with her gender identity. She faces many challenges in finding her Black identity in a world of queer activism that is very white and blind to trans issues—despite the leading role Black trans people played in the “gay liberation” movement of the late 1960s.

After her education, she gets a job despite the “unconscious bias” that filters out her applications due to the racialized associations of her name. She persists in a work environment characterized also by micro-aggressions based on both gender identity and race. At least one co-worker indicates subtly that she owes her promotions to her race or gender every time she advances at work. She also pays heavily the “minority tax” of being expected to educate her co-workers on the basics of racism and transphobia. No one else addresses co-workers' subtly or blatantly racist treatment of patients, or addresses the blatant racism that some patients direct at her. When she and her husband adopted two children within the community, they spend enormous amounts of emotional labour countering societal biases against a trans woman and her partner adopting.

In late middle age, she faces very hard choices about leaving that career or limiting her professional commitment due to her ageing parents’ care needs, given the poorly funded supports available for older adults living in the community. She has only just paid off the loans she had to take out for her education (because her parents had no capital); she and her husband have managed to buy a house they could afford, outside of their community—with land title, but in a neighbourhood with stagnant real estate values, requiring unpredictable emergency capital for repairs. They now have to re-mortgage that house to pay for her parents’ care requirements while her and her husband’s children are still in school, because her parents still don’t have title and can’t realize gains from their investment in their home by selling or taking out a reverse mortgage.

If her parents enjoyed the same life expectancy as people in an affluent neighbourhood, they would probably not require this care until much later, when her children's educations were already taken care of. (Life expectancy varies by health region in Canada—due to the social determinants of health—by as much as 13 years.) Keisha also needs to take some time away from work to help them navigate the healthcare system, impacting her income at a time when she once again has mortgage payments.

In addition, she has back pain that threatens her career, with limited coverage for physiotherapy and no time for the prescribed exercises and "active lifestyle." These challenges put her at risk of moving from being non-disabled to relying on the long-term disability support system.

These factors threaten her housing security as she approaches retirement. They also rule out her supporting her children's postsecondary education unless she can take on a second job or accept less adequate care for her parents. The family has not been able to save capital for the next generation: once again, her children take out loans for their own education.

A pandemic occurs. Keisha and her family are exposed to the risks of contracting COVID-19 and dying from it. They work in jobs where they do not have the luxury of isolating themselves and working from home, and their home does not allow much distancing. Her daughter contracts the virus—she is a personal care worker who splits shift work between 3 long term care facilities, none of which will offer her full-time job security. Thus, precarious housing security rooted in the historic and on-going mistreatment of persons of African descent in the Atlantic provinces make her and her family especially vulnerable to the differential risk they face of contracting COVID-19, and to harsher consequences when they do so. When they tune into the daily COVID news conference, the government sends the message that the first outbreak of the pandemic is in their community. The government spokesperson suggests this outbreak was caused by people hosting parties. The community organizes to counter this message, taking crucial time away from more concrete work of the pandemic response.

Sources and resources

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of Chicago Legal Forum*, 139-167.

López, N., & Gadsden, V. L. (2016). Health inequities, social determinants, and intersectionality. NAM Perspectives.

UN Human Rights Council, Report of the Working Group of Experts on People of African Descent on its mission to Canada, 16 August 2017, A/HRC/36/60/Add.1, available at: https://digitallibrary.un.org/record/1304262?ln=en

Black Cultural Centre for Nova Scotia https://bccns.com/our-history/

New Brunswick Black History Society https://www.nbblackhistorysociety.org

Students interested to connect with others who share the experiences of intersectionality described here are invited to contact Dr. Leah Jones, MD, CCFP (she/her), Academic Director - Black Health at plans@dal.ca.

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