

Guest editorial

The promise of intersectionality theory in primary care

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Whilst biomedical models of health and illness have undoubtedly improved health through medical interventions and treatments they are limited in what they can say about embodied experiences of illness. One common theme being promoted at the moment is patient centredness which purports to focus health care and research on what matters to patients about their health needs. Patient centredness helps us to understand the social determinants of health care,¹ and it is argued that this knowledge and direction will help illuminate some of the facilitators and barriers that characterise the often disembodied research and healthcare provision for patients.

Embodied health research represents the perceptual system – the intuitions and institutions and structural constraints that underlie patients' ability to negotiate and move through the complex maze of health information and perform activities and interactions with others in our environment that promote good health, or at least attempt to lessen the risks associated with ill health. Embodiment also encompasses how we understand the world and our relationship to it through our positionalities, affected through our identifications with gender, ethnicity, sexuality, class, nationality, religion, age and so on. We can assume then that all embodied human practices, including those related to health, illness and primary health care are interdependent and intersecting practices. Both embodied and material biomedical processes affect how patients are differently inculcated in primary healthcare systems in continuously renegotiated ways. However, the biomedical approach and embodied approaches to the study of health and illnesses of diverse populations have developed in ways relatively isolated from one another.

To this end, there is a growing interest in *intersectionality theory*^{2–4} as a process of clinical and health service enquiry and as a research approach that explores the complexity of multiple embodied social relations that ultimately impact disparately on people's health. Long before health researchers began speaking of multiple embodiments, intersectionality theory⁵ originated in black feminist critique of Western second wave feminism. Western feminism was rightly accused of

disregarding or downplaying differences of race, class and sexuality and treating multiple differences as the sum of distinct individual oppression.³ This wave of feminist critique argued against any notion that a singular oppression, i.e. patriarchy, can be considered more important than others, such as racism or homophobia, or that oppressions can be hierarchically situated universally through time.⁶ What the critique also illustrates is that relations of power cannot be seen as simple additive and quantifiable factors, each having equal impact in somebody's life, a positivistic dilemma in many biomedical models of illness, due to the research having to ignore, exclude or circumvent much embodied knowledge in order to produce invariant empirically based findings. Relational identifications are always overlapping, intersecting and variant in ways that make it impossible to view each variable as separate 'pure' causalities – in our case, of receiving and accessing primary health care. Therefore, where intersectionality theory considers the formation of genders, I think it is safe to say that we all have a sense of 'one' even though 'it' is constantly interpreted as a positionality, through differential patterns of vulnerability, needs and commitments to health and wellbeing and reinterpreted and adapted to according to ephemeral cultural and environmental situations.

The study of persistent patterns of health disparities and how to eliminate these has become a major priority for national health services, politicians, health advocates, researchers and patients themselves.⁴ It is therefore all the more surprising that in primary care intersectionality theory is still in its infancy, even though proponents of this method of inquiry describe major benefits, which include being able to incorporate more patient-centred dimensions that foster situationally specific interpretations⁷ and group and interrelational dynamics, and provide an explicit emphasis on social and institutional change⁴ that looks beyond simplistic demographics and medical conditions.⁸ These are mantras often heard from primary care practitioners in relation to the complex work and the heterogeneity of patient populations and their diverse responses to medical interventions.

Whilst feminist healthcare researchers are more attuned to critiquing and challenging the assumed universal generalisability of primary healthcare research findings and approaches to practice,⁹ they too have had difficulty in building the capacity to develop understandings about the multiple axes of identity and power relations that characterise patients in society, and which affect their health disparately. This work continues to be overshadowed by the standard work on singular axes that look at, for instance, ‘class’ as the primary aspect or ‘gender’ as a singular axis of health disparities. At best, when class and gender are combined to explore various healthcare issues,¹⁰ they minimise their scope by skating over or just ignoring more complex aspects of gendered power relations, gender relationships and other salient cultural relationships and how these may intersect with the multiplicity of axes that are implicated within each and everybody’s life.

In response to the challenges above, some research seeks to counteract one- and two-dimensional approaches by bringing to light the complexity of social locations and experiences for understanding differences in health needs and outcomes.¹¹ Within this paradigm the multiple axes that people identify with in society intersect with various intensities to affect access, presentation to practitioners, treatment choices and treatment in primary care. This moves the debate towards the structural aspects of social life, and structural aspects within the surgery, whilst retaining a focus on salient identifications that patients make in their lives as much as the particular illness that is being presented. Intersectionality theory ‘provides a powerful alternative way of addressing questions about health access, presentation and treatment (choice) disparities that traditional approaches have been unsuccessful in answering’ (p. 222).⁴ Despite this there has been little dialogue about how intersectionality is researched in practice, without the project becoming too cumbersome.

There are a few notable exceptions in primary care research. The intersectionality approach has been used to describe how primary health care can inform policy to improve the social determinants of child mental health.¹² McGibbon and McPherson¹³ combine intersectionality theory, complexity theory and the social determinants of health approaches to illustrate the individual’s experience and then extrapolate to the broader social location embodied by an individual, which contributes to understandings about healthcare access and practices in the area of women’s health inequities. What is interesting in this work is their application of geographical aspects of location and distance as other confounding factors of structural relations, which synergises with axes of identifications and identity markers to produce health inequities. For instance, immigrant women are usually in lower paid,

part-time, precariously safeguarded work, often a great distance away from friendship and kin networks; this, joined with racism and poor housing, results in unfavourable social conditions, all of which can add associated bodily stresses that may exacerbate ill health.¹³ Cole and Foster¹⁴ argue that hazardous waste facilities, landfill sites and incinerators are all disproportionately located near communities of colour or housing for the poor generally, producing increased risks to health. Insights into these social location aspects could be adapted and incorporated into research design and practice capacities to add depth and complexity to our understanding of health and illness and health care and perhaps provide more patient-centred care.

Perhaps one of the most important steps to consider in patient-centred primary health care, when thinking through intersectionality research, is how clinicians interact and intersect with patients. Primary healthcare practitioners are often unmarked and constantly evade problematisation when researching health care (disparities). Practitioners are intentional beings with intersecting identities working in institutions affected by hierarchies of power, gender, sexuality and other social relations and working with hierarchies of illness and disease.¹⁵ The ‘facelessness’ of healthcare providers in both research and practice must be exposed in future in order to ground more complex additions to our knowledge base and transference of knowledge. With a focus on the intersections of primary healthcare providers, and the axes that interconnect to patients, we may contribute to the study of patient centredness as an intersectional set of embodied processes in space and through time.

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