

An argument for the intersectional education of those working in international humanitarian medical non-governmental organisations

In this commentary we want to put forward two points. First, that if intersectionality is to help improve healthcare provision then its adoption cannot be limited to clinicians. Second, that the arguments presented by Yolonda Wilson et al. can be successfully expanded to include actors working in international humanitarian medical non-governmental organisations. For example, Doctors Without Borders. Even when it might appear that the first point is disjointed from the second one, they are actually related, as we will show.

In their paper *Intersectionality in Clinical Medicine: The Need for a Conceptual Framework*, Wilson et al. successfully show how adopting an intersectional conceptual framework could improve healthcare provision for people whose identities beget disadvantage, for example, black women and Latinos in the US. Their main point is that for medical practice to deliver its best results “it is important to recognize how all aspects of one’s identity –not just of marginalization- intersect and manifest themselves in and impact clinical interventions” (Wilson et al. 2018, 4). For example, racialisation of patients as black can affect their pain management within a clinical setting (Singhal, Tien, and Hsia 2016).

While we accept Wilson et al.’s main argument, it is important to explicitly point out that if the goal of adopting an intersectional framework is to improve healthcare outcomes across the board, then *all healthcare professionals* need to adopt such framework. We believe it is important to highlight that healthcare professionals beyond clinicians need to adopt an intersectional framework, because patients depend on them to receive appropriate care. Depending on how healthcare services are organised, there is a number of other healthcare professionals that either provide healthcare, or act as gatekeepers between clinicians and patients. If these healthcare professionals operate outside of an intersectional framework, then the “institutional and structural forces that create patterns of oppression, marginalization, and health disparities” (Wilson et al. 2018, 8) could keep operating during the healthcare provision, or during the decision-making process to refer the patient to a clinician. (Wilson et al. 2018, 8) For example, an intersectional approach to increase vaccination rates among US Hispanics would fail if centred exclusively on the patient-clinician interaction (Anandappa et al. 2018). If adopting an intersectional framework can improve healthcare outcomes while at the same time addressing structural injustices, then nurses, midwives, public health practitioners, mental healthcare professionals, oral care practitioners, paramedics, etc. must be educated in it. Let us finish this first point by highlighting that work on intersectionality and midwifery and nursery have already

been carried out. See, for example, (Thompson 2016; Herk, Smith, and Andrew 2011; Ion, DeSouza, and Kerin 2018).

Our second point is that Wilson et al.'s argument for adopting an intersectional framework in clinical practice can be expanded to include actors working in international settings, specifically in international humanitarian medical non-governmental organisations. While Wilson et al. developed their case for intersectionality with the US socio-political environment as their background, their arguments for adopting an intersectional framework in clinical medicine equally apply to those working in international humanitarian medical non-governmental organisations, as we will show next. Even when specifics may vary, such organisations do not depend on specific governments, are international in scope, and provide medical care in cases of disaster, war, or when national health services are either non-existent or extremely defective. For example, the Red Cross and Doctors Without Borders.

Wilson et al. contend that in adopting an intersectional framework clinicians "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" (Wilson et al. 2018, 20). If this is true for those working nationally, for example in the US, then it is also true for those working internationally. Why? Because one of the reasons for expanding such preparations is to improve healthcare outcomes, and the normative force of such reason works independently of whether we are acting at a national or international level.

A second reason for educating people working in such organisations in an intersectional framework is that it could prevent them from participating in and reinforcing patterns of disenfranchisement and oppression that in turn affect the health prospects of certain sectors of the population. This is of utmost relevance when we take into consideration that international organisations are required to work within the constraints that the host government imposes onto them. Foreign governments are sometimes interested in maintaining conditions that oppress and disenfranchise certain groups. The constraints imposed to international humanitarian medical non-governmental organisations could be designed by governments precisely to maintain the status quo. For example, in 2011 Bahraini authorities targeted medical professionals for providing healthcare for people that had been part of pro-democracy protests in the country (Stewart 2011). An intersectional framework can help healthcare professionals in reflecting on how their activities might perpetuate injustices. While cultural competence might help healthcare professionals in being sensitive to difference, the goal of intersectionality is an awareness of how social identities impact access to social and material goods. An intersectional framework could therefore help make sure international humanitarian medical non-

governmental organisations are not used by corrupt governments to further prevent access to social and material goods to some members of society.

Furthermore, being educated in an intersectional framework can also help in counteracting pressure imposed by donors to such organisations, that might also lead to the disenfranchisement and oppression of certain groups (Heiss and Kelley 2017). For example, pressure from donors can make an organisation focus on places that require less aid rather than those that require more aid. And finally, being educated in an intersectional framework can also counteract certain practices within an organisation itself. For example, in considering how salaries are allocated between national and international healthcare providers within the same organisation (Denskus 2017).

At this point two things must be noted. First, it might seem that the three previous reasons for adopting an intersectional framework are not directly tied to the provision of healthcare. However, intersectionality in an international setting as examined above might help in: (1) designing courses of treatment that take into consideration patients' access to social and material goods, and (2) designing courses of treatment that could mitigate unequal access to social and material goods. Nevertheless, even if the intersectional framework was not *directly* tied to the provision of healthcare, this would not detract from our position since an intersectional framework does not limit itself to actions that are directly tied to healthcare provision, but rather those seeking a just society. In this case members of international humanitarian medical non-governmental organisations would help in building a just society, which could in turn have an effect, for example, on how healthcare is distributed.

The second thing to note is that those working in such organisations might also face a moral dilemma. The dilemma comes from the fact that sometimes they will have to choose between helping those in need while being complicit in oppressive regimes, or failing to help some in dire need because they refuse to cooperate with oppressive regimes. In recent work, Buth et al. have explored how this possible situation, where complicity would ensue, is more complicated than just asserting that we should categorically reject being complicit in wrongdoing (Buth et al. 2018).

Let us close this commentary by threading the points that we have presented. First, we argued that it is not only clinicians but all healthcare providers who should adopt an intersectional framework. This is so because some patients are actually never treated by clinicians and because certain healthcare professionals serve as gatekeepers in terms of allowing patients access to clinicians. And this is important because healthcare provided by international humanitarian medical non-governmental organisations is not limited to that provided by clinicians. We argued that if an intersectional framework can lead to better healthcare outcomes, then the fact that healthcare professionals operate at national or international level is moot since the goal is improving healthcare outcomes.

Adopting such framework can aid in resisting structural oppression and disenfranchisement that could stem from host governments, donors, or even organisations' own structure.

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