From Singularity to Plurality: The Case forIntersectionality in Cardiothoracic Surgery

Research

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Health services research is increasingly highlighting gaps in equitable cardiothoracic surgical care delivery, but the challenge translating these findings to interventions remains. Preventza et al. evaluated how the interplay between socioeconomic factors and sex may influence thoracic aortic surgery outcomes. Between 2000 and 2020, men undergoing thoracic aortic surgery at Baylor College of Medicine were associated with more favorable socioeconomic factors, reduced hospital length of stay, and lower rates of complications compared to women [1].

Existing studies exploring sociodemographic disparities in cardiac surgery have failed to elucidate whether the etiologies of disparities are driven by historical marginalization and discrimination versus other (e.g., biological) differences. For instance, after thoracic aortic surgery, female sex is an independent predictor of mortality and morbidity [2]. It is unclear if this is due to systemic social discrimination towards women, whether female sex is associated with accelerated thoracic aortic aneurysm growth and aortic stiffness compared to male sex, or a combination of both [3]. This distinction between social versus biological factors is important to target interventions to alleviate these gaps.
Remarkably, this is one of the first studies to explore the intersection between multiple social determinants of health in cardiac surgery, even if only a combination of two factors. Kimberlé Crenshaw coined the term ‘intersectionality’ in 1989 to reject single-axis frameworks of anti-discrimination [4]. Collins and Bilge later stated: “When it comes to social inequality, people’s lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, [...] but by many axes that work together and influence each other” [5]. Indeed, the combination of social determinants is not simply additive. Each patient presents with a unique psychosocial location composed of identities, such as age, sex/gender, race/ethnicity, sexual orientation, level of education, social class, immigration status, and geographical location, that likely influence their access to, experience of, and outcomes following surgery. To address patients’ unique needs, inclusive interventions are needed by surgical teams and their multidisciplinary colleagues, particularly those who serve the most marginalized communities. Hospitals in low-income or remote neighborhoods, serving proportionally more people of color, may need to tailor their surgical care to include social interventions for improved surveillance, medication coverage, or housing [6–9].

Various research approaches can promote an intersectionality lens. Firstly, recruiting diverse teams is crucial to conduct research in a respectful, inclusive, and culturally safe and humble manner. Second, quantitative studies can study intersecting social identities, qualitative approaches may start off indicative and only later become deductive, and mixed-methods research can incorporate both. Further, representative participant recruitment must be pursued, and participants must be enabled and encouraged to self-report social identities to ensure accurate data collection [10]. Lastly, including patients as active partners in the study design and clinical
decision-making facilitates patient-centered research and the delivery of equitable and high-quality clinical care.

Embracing intersectionality in research is challenging but poses an opportunity for the field to move from singularity to plurality and optimize surgical care for all.
References


Access to and outcomes following cardiothoracic surgical care