

Age Difference in the Clinical Encounter: Intersectionality and Phenomenology

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Wilson and colleagues (Wilson et al. 2019) argue that an intersectional approach to the clinical encounter can facilitate trust and understanding between patients and clinicians. An intersectional perspective reinforces the clinician's self-reflection, confronting her with her own biases and urging her to know as much about her patients' sociodemographic characteristics as about their pathobiology. While we welcome the introduction of intersectional thinking to the clinical encounter, we find the framework envisaged by Wilson and colleagues insufficient to address all of its aspects. Wilson and colleagues focus on the interpersonal differences that dominate the intersectional approach: gender, race, and class. What they miss is the difference of age.

Shifting the emphasis on age difference does not in itself challenge the intersectional approach, since age is generally considered to be one of the intersectional axes (Lutz et al. 2016). Our claim is, rather, that intersectionality alone is insufficient to account for the lived, existential realities that underlie the age difference between patients and clinicians. Accordingly, the intersectionality framework, as developed by Wilson and colleagues, needs to be supplemented by a phenomenological approach to aging.

THE IMPACT OF AGE IN THE CLINICAL ENCOUNTER

An intersectional conceptual framework, as suggested by Wilson and colleagues, can be considered an appropriate methodological tool to make visible the multifaceted differences that shape the interactions of patients and clinicians. It does not imply a neutral methodology, but understands differences as situating people on multiple social-cultural power axes. Crenshaw (in Lutz et al. 2016) describes intersectionality as a prism, a hermeneutical tool that brings into view the often obscure power dynamics at work in human

interactions. In the debate on intersectionality within gender studies, three such power axes—the “trinity” gender, race, and class—have come to denote the main structural forces situating individuals (Lutz et al. 2016). It is understandable, therefore, that Wilson and colleagues mainly focus upon these three axes in introducing intersectionality as a viable framework for the clinical context.

One may ask, however, whether gender, race, and class are the most relevant categories of difference at play in the encounter of patients and clinicians. Statistics reveal that in a Western European country like the United Kingdom the majority of physicians are aged under age 44 years, while the majority of patients are over 53 years (Eurostat 2018; NHS Digital, Secondary Care Analysis Team 2016). In addition, recent studies show that age difference is a frequent cause of poor communication (Ek Dahl et al. 2012). By drawing attention to age differences in the clinical encounter, we do not intend to hierarchize differences, but aim at enlarging the intersectional conceptual framework to include other critical differences. This aim is in line with the intentions of Wilson and colleagues, who also claim—citing Crenshaw—that an intersectional analysis can and should be expanded in this way. They add that an essential principle of intersectionality is that “axes of disadvantage cannot simply be added together, but ... coalesce to create their own unique forms of disadvantage” (10). Age, we argue then, is one of the axes of difference that should be considered in the clinical encounter—alongside gender, race, and class.

Our focus on age brings to light a limit of the intersectionality framework that, we think, is critical in the encounter of patient and clinician: an existential difference that relates to their different modes of being in the world. Because of their age difference, clinicians and patients often inhabit distinct “time zones”—that is, they relate to

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health, illness, life, and death in different ways. Ignorance of this existential, experiential dimension of age difference may lead to miscommunication and subsequently to overtreatment (e.g., a doctor in full bloom of her life might be prepared to do anything to prolong an older person's life, while the latter might be ready to die) or undertreatment (e.g., a surgical oncologist might easily assume that elderly women don't need a breast reconstruction anymore) (Mason 2014). This existential dimension cannot be fully articulated in an intersectional frame, because of the latter's focus upon social-cultural power axes.

According to Wilson and colleagues, an intersectional analysis requires one to consider how one's social identity contributes to one's experience of the world. Their intersectional approach is, in fact, preoccupied with the social factors of interpersonal differences, such as the clinician occupying a privileged position relative to the patient (Case One) or the workings of social class in the communication of patient and clinician (Case Two). As age difference reveals, however, it is not merely one's social identity that is at stake here, but also one's existential perspective on others and the world.

THE PHENOMENOLOGICAL PERSPECTIVE ON AGE DIFFERENCE

The phenomenological-existential perspective acknowledges that aging carries an experiential significance that is not captured by mere numerical values. Under the regime of chronometric time (Baars 2012), it is assumed that the statistically and scientifically sanctioned ways of measuring time express precisely what age is: the amassing of lifetime by an individual organism, a number (measured in, for instance, years) that correlates with a certain developmental stage, level of functionality, or proneness to illnesses. To take a phenomenological-existential perspective, by contrast, is to view aging as a process that continuously transforms the individual's bodily and temporal reality, as well as her attitudes toward questions of health and illness, life and death. Numerical differentials, therefore, are not decisive in themselves, but can serve as a useful heuristics, by pointing to an experiential gap that potentially affects the communication between patients and clinicians.

As people age, their bodily, mental, and social realities transform. In his lectures on child psychology, Maurice Merleau-Ponty (2010) argues that children are not miniature adults but beings with unique styles of inhabiting and interpreting the world. Development, in his view, does not connect child and adult in a linear way, but produces their difference from each other. A similar argument could be made for development in late life. The bodily, mental, and social changes that go along with aging do not simply mark a decline from the position of the "normal" adult. Rather, they inaugurate a radical transformation.

The transformative force of aging is especially visible in the field of temporal experience. In *The Coming of Age*, Simone de Beauvoir (1996) describes how aging changes

one's perception of the future: What used to be an infinite openness becomes a finite horizon. This transformation affects one's relation to the past as well. Bereft of an infinite future, the elderly person can no longer sustain the accumulated weight of her past, which turns into an inert mass.

The radical transformation that is aging also extends to the level of existential attitudes. Bodily frailty, the experience of illness, the already-discussed changes of temporal experience, and the loss of loved ones confront individuals with the precarity of their existential condition. Contemporary phenomenologists underline that this existential confrontation with finiteness does not simply involve experiences of decay. As Leder (2018) describes, if we consider aging from an existential perspective, quality of life is not simply a matter of the degree to which elderly people are free from medical (and financial) problems. "Aging well," according to Leder, can manifest itself in archetypes such as the Contemplative (introspective withdrawal), the Contributor (social involvements), the Compassionate Companion (learning from suffering and mortality), or the Creative (humor and rebirth). These archetypes do not stand for totally different personalities. It is rather expected of "a full experience of later life to incorporate elements of all four archetypes" (Leder 2018, 234).

We believe it is critical to point out the potential difference in existential attitudes between younger people (medical professionals) and older people (patients). By underlining this difference, we do not mean to essentialize the experience of the older or the young. We merely suggest that Leder's pallet of archetypes may be helpful in recognizing how diverse older people's stances in life can be.

In conclusion, we believe that to prevent "existential miscommunication" in the clinical encounter, physicians should adopt a phenomenological-existential view on aging together with an intersectional account of age difference. In addition, we expect that this view will also enrich the intersectional analysis of gender, race, and class, because it brings to light the existential dimension of these social differences. ■

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Is There Cross-Cultural Evidence for an Association Between Intersectionality and Bioethical Decision Making? Not Yet, but Awaiting Advances in Mental Mapping

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One of the most interesting questions before a thinking being is whether we can comprehend the ideas and thoughts of other beings. To better understand this question, we need to know how we make decisions about bioethical issues. Furthermore, when considering clinical decisions, how do professionals facilitate other persons who are making such decisions? What are the lessons of cross-cultural bioethics? How is our identity constructed and how does it affect our decisions?

Studies in descriptive bioethics have traditionally included a range of methods of social sciences including anthropology, sociology and psychology (Macer 1994). As academics have tended to narrow down their fields of studies to narrow ranges of disciplinary territory, we can see approaches such as gender studies, race studies, whiteness, virtue ethics, indigenous studies, and so on. In that regard we can regard intersectionality (Wilson et al. 2019) as a necessary reframing of social and human science approaches to examine the factors that affect decision making. It is arguing for a more holistic approach than the reductionism that has accompanied explorations of human knowledge in the 20th century. It shares similarities to critically conscious research (Freire 1970) and multidisciplinary studies in its emphasis on inclusion of diverse views and the reframing of questions.

Our identity does affect our decisions. Each person has various aspects of our identity that are usually deeper than the name that we call ourselves. These

include ancestral (e.g., Italian, English, Apache, Tongan, African Sikh, etc.), occupational (butcher, gardener, nurse, etc.), relational (mother, daughter, sister, wife, etc.), spatial (living on the prairie, or on our Island, etc.), gender (male, female, transgender, etc.), sexuality (heterosexual, homosexual, celibate monk, etc.), political, religious, age, personality type, and so on. Although we may think that our own experiences in life, such as trauma or education, make us unique, it is not possible without a deep understanding of someone to know their identity. Some of our identities are linked to particular demographic markers.

Societies play roles in setting limits on the constuctions of identity, sometimes limiting the classifications of extremes of identity to white or black, and not to a continuum of gray. Laws are also often defined in terms of allowing use of a medical option, such as active euthanasia, to either yes or no, and not a situation-based flexibility. Space and place shape identity, especially for indigenous peoples who may be connected to a tribal homeland or identifying animal or some other marker.

Despite the multiple identities that we may have, when it comes to bioethical decision making there is no demographic predictor of our response to a dilemma. There is universal diversity of responses to bioethical dilemmas, meaning a full range of responses has been observed in every country surveyed (Macer 1994). Even for some apparently simple choices, such as whether to

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