

Intersectional Lenses of DEI: Bioethicists' Duty to Advocate

Jillian Boerstler, Nanette Elster, Kayhan Parsi and Bryan Pilkington

Volume 9, Number 1, 2026

Advocates, Activists, Architects of Moral Space?

URI: <https://id.erudit.org/iderudit/1122840ar>

DOI: <https://doi.org/10.7202/1122840ar>

[See table of contents](#)

Publisher(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (digital)

[Explore this journal](#)

Cite this document

Boerstler, J., Elster, N., Parsi, K. & Pilkington, B. (2026). Intersectional Lenses of DEI: Bioethicists' Duty to Advocate. *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, 9(1), 14–16. <https://doi.org/10.7202/1122840ar>

Article abstract

Building on the historical foundation of bioethics, we argue that bioethicists, with inherently interdisciplinary approaches and backgrounds, are well positioned to promote Diversity Equity and Inclusion (DEI) in the healthcare setting through the practice of clinical ethics. In the current cultural and political climate, bioethicists cannot remain silent while staying true to the tenets of the field. Provisions in the American Society for Bioethics and Humanities (ASBH) Code of Ethics and the lived experience of Canadian bioethicists offer relevant guidance. We argue that competence in clinical ethics obliges bioethicists to identify and seek to remove systemic barriers facing those whom clinical ethicists are privileged to serve. By adopting an intersectional approach to clinical bioethics, bioethicists can become advocates for the promotion of just healthcare.

© Jillian Boerstler, Nanette Elster, Kayhan Parsi and Bryan Pilkington, 2026



This document is protected by copyright law. Use of the services of Érudit (including reproduction) is subject to its terms and conditions, which can be viewed online.

<https://apropos.erudit.org/en/users/policy-on-use/>

This article is disseminated and preserved by Érudit.

Érudit is a non-profit inter-university consortium of the Université de Montréal, Université Laval, and the Université du Québec à Montréal. Its mission is to promote and disseminate research.

<https://www.erudit.org/en/>

TÉMOIGNAGE / PERSPECTIVE

Intersectional Lenses of DEI: Bioethicists' Duty to Advocate

Jillian Boerstler^a, Nanette Elster^b, Kayhan Parsi^b, Bryan Pilkington^c

Résumé

En nous appuyant sur les fondements historiques de la bioéthique, nous soutenons que les bioéthiciens, avec leurs approches et leurs parcours intrinsèquement interdisciplinaires, sont bien placés pour promouvoir l'équité, la diversité et l'inclusion (EDI) dans le milieu des soins de santé grâce à la pratique de l'éthique clinique. Dans le climat culturel et politique actuel, les bioéthiciens ne peuvent rester silencieux tout en restant fidèles aux principes de leur domaine. Les dispositions du code de déontologie de l'American Society for Bioethics and Humanities (ASBH) et l'expérience vécue par les bioéthiciens canadiens offrent des orientations pertinentes. Nous soutenons que la compétence en éthique clinique oblige les bioéthiciens à identifier et à chercher à éliminer les obstacles systémiques auxquels sont confrontés ceux que les éthiciens cliniques ont le privilège de servir. En adoptant une approche intersectionnelle de la bioéthique clinique, les bioéthiciens peuvent devenir les défenseurs de la promotion de soins de santé équitables.

Mots-clés

équité, justice, bioéthiciens cliniques, EDI, code de déontologie, intersectionnalité, devoir

Abstract

Building on the historical foundation of bioethics, we argue that bioethicists, with inherently interdisciplinary approaches and backgrounds, are well positioned to promote Diversity Equity and Inclusion (DEI) in the healthcare setting through the practice of clinical ethics. In the current cultural and political climate, bioethicists cannot remain silent while staying true to the tenets of the field. Provisions in the American Society for Bioethics and Humanities (ASBH) Code of Ethics and the lived experience of Canadian bioethicists offer relevant guidance. We argue that competence in clinical ethics obliges bioethicists to identify and seek to remove systemic barriers facing those whom clinical ethicists are privileged to serve. By adopting an intersectional approach to clinical bioethics, bioethicists can become advocates for the promotion of just healthcare.

Keywords

equity, justice, clinical bioethicists, DEI, code of ethics, intersectionality, duty

Affiliations

^a School of Nursing, Faculty of Applied Science, University of British Columbia, British Columbia, Canada

^b Neiswanger Institute for Bioethics & Healthcare Leadership, Stritch School of Medicine, Loyola University Chicago, Maywood, Illinois, United States

^c Department of Medical Sciences, Hackensack Meridian School of Medicine, Nutley, New Jersey, United States

Correspondance / Correspondence: Kayhan Parsi, kparsi@luc.edu

In the span of a few months, the current US administration has waged an intense onslaught against diversity, equity, and inclusion (DEI), a set of principles meant to bolster fairness and promote participation of equity-deserving groups (1). This agenda has prompted several regressive responses. Private corporations that were previously publicly committed to DEI principles have abandoned their commitments. US government agencies have purged any mention of DEI in their public-facing materials. Even US universities that are presumably committed to the ideals of academic freedom and free speech have turned away from DEI.

Purging DEI has a direct impact on bioethics and clinical bioethicists. Bioethicists have a long history of advocating for social change. As documented by historians such as Robert Baker, some historical roots of bioethics are tied to the civil rights movements of the 1960s and 1970s. In *Making Modern Medical Ethics*, Baker states the following:

A Patient's Bill of Rights was negotiated to assert the rights of welfare recipients and later those of all clinic and hospital patients in the context of a nonviolent populist insurrection against ableist, ageist, classist, racist, and sexist practices perpetrated by American hospitals that viewed "charity" through the lens of a white middle-class scientific medical paternalist gaze (2).

Baker argues that traditional histories of bioethics focus on the role of formal commissions, think tanks, and reports. In his historical account, however, bioethics, like other social movements, was shaped by many unrecognized individuals who challenged and confronted prevailing norms and institutions. Building on this historical foundation, we argue that bioethicists, with inherently interdisciplinary approaches and backgrounds, are well positioned to promote DEI in the healthcare setting through the practice of clinical ethics. In the current cultural and political climate, bioethicists cannot remain silent while remaining true to the tenets of the field. Provisions in the American Society for Bioethics and Humanities (ASBH) Code of Ethics (3) and the lived experience of Canadian bioethicists offer relevant guidance. We argue that competence in clinical ethics obliges bioethicists to identify and seek to remove systemic barriers facing those whom clinical ethicists are privileged to serve. By adopting an intersectional approach to clinical bioethics, bioethicists become advocates for the promotion of just healthcare. This is when bioethicists are needed the most.

Clinical ethics facilitation may involve decisions affecting patients identifying as First Nations, Indigenous and/or other equity-deserving groups. Colonialization has harmed First Nations and Indigenous communities who lived in North America for

millennia (4). In Canada, generations suffered in Residential Schools and understaffed and overcrowded “Indian hospitals.” (5) This may explain why those identifying as First Nations or Indigenous and their families are fearful and perhaps distrustful in their encounters with the Canadian healthcare system and Western medicine’s often paternalistic approach.

Despite this history, clinical bioethicists are witness to some of the most complex cases facing patients and their loved ones. Through their interdisciplinary training in mediation, facilitation, and ethical analysis, clinical bioethicists have a unique opportunity as members of the care team to ask probing questions in a case: how might systemic inequities affect this patient’s circumstances? What conscious or unconscious biases may be influencing the team’s perspectives? How should cultural or religious worldviews be considered? How might scarce healthcare resources be allocated so that those most in need are prioritized? The role of the clinical bioethicist is to ask these questions. This inquiry allows patients’ goals and values to be prioritized, and their voices amplified. In the process of asking these questions and by facilitating ethical dialogue, clinical bioethicists also serve as architects of moral space, opening opportunities for reflection by all stakeholders on the needs and values of patients.

To place patients’ wellbeing at the centre of clinical ethics consultation, bioethicists have a duty to identify, challenge, and promote DEI considerations. Members of the care team may be unaccustomed to consideration of DEI matters; some may not be able to see beyond the clinical facts or inherent biases in a case. In those situations, clinical bioethicists must highlight DEI, illuminating patterns facing equity-deserving groups experiencing systemic bias in provincial/state and/or federal systems.

ASBH offers guidance to bioethicists in its Code of Ethics (3). Highlighting tenets such as competence and a responsibility to promote justice, the Code offers scaffolding to clinical bioethicists in their practice. Competency in clinical ethics consultation means that uncertainties or conflicts regarding value-laden concerns are illuminated and addressed. Advocating for DEI is a way of promoting justice. Doing so requires an intersectional approach.

In an interview with the “Antiracism in Medicine” series of *The Clinical Problem Solvers* podcast, legal and sociology scholar Dorothy Roberts discussed the topic of intersectionality. She said:

we also have to recognize that race intersects with other statuses as well. It intersects with socioeconomic status, with education, with geography, with sexual orientation, with religion. We could go on and on. And all of those statuses I just mentioned, in our racial capitalist, anti-immigrant society, also affect gender. All of that. These are all hierarchies that intersect in our lives and they intersect in society (6).

In integrating DEI into clinical ethics, bioethicists should adopt an intersectional approach within their ethical analysis and throughout the facilitation process. Kimberlé Crenshaw defined “intersectionality” as the connection between two constructs such as race and gender (7), and exposed the limitations of “single-axis” thinking. Intersectionality examines the dynamics of difference and sameness, playing a major role in facilitating consideration of gender, race, and other axes of power (8). A commitment to intersectionality in clinical bioethics implies that care teams must consider different lenses; for instance, a white cis male will have a different lived experience than an Indigenous person who identifies as Two Spirit.¹

Scholars such as Brunig and Salloch (10) have also called for the use of intersectionality in bioethics. Because of the interdisciplinary and multidisciplinary nature of the field, an intersectional bioethics approach is apropos. They state that “intersectional perspectives should complement the work of bioethicists to make structural discrimination visible, to make marginalized voices heard, and to advance work toward more self-reflection, as well as a diversification of bioethics itself.” (10) Bioethicists are equipped with multiple lenses, each sharpening and adding dimension to the DEI issues that often underlie and underpin clinical ethics cases. For example, end-of-life treatment options may favour individual autonomy, ignoring some cultures’ priority of family and community in decision making. Bioethicists’ training and positionality can prepare them to be attuned to issues that “single-axis thinking” misses.

Consider the term “framework” as it pertains to bioethics; clinical bioethicists rely on frameworks, at times, which can be understood as colonial ways of organizing concepts. Intersectional bioethics acknowledges worldviews beyond those of white colonizers; some cultures embrace ways of thinking and knowing that are not linear, that may occur in steps, akin to braiding, or weaving a tapestry.²

While clinical bioethicists are trained in and rely on Western biomedical ways of thinking about ethics, ethical exploration must not stop there. In other words, the four principles of autonomy, beneficence, non-maleficence, and justice may serve as a starting point but ought not end there. Western bioethics tends to prioritize personal autonomy, but patients’ cultures may conceive of autonomy differently, focusing instead on family or community wholeness (11). Other approaches provide additional lenses for intentional inquiry related to areas of DEI. For instance, principlism acknowledges the importance of justice and self-determination in the clinical encounter. A narrative approach enriches the understanding of justice as not just a theoretical concept but one that is embedded in a larger historical narrative that is unique and personal to the patient. A narrative approach recognizes both subjective and objective aspects. Feminist and care ethics include historically excluded

¹ For additional information on intersectionality in clinical ethics practice, see (9).

² The term “framework” is not an inherently colonial term but use of it can perpetuate systems of power, white supremacy and/or elitism. The authors offer an attempt to decolonize clinical bioethics thinking and they are unable to cite this section, as citations themselves could be considered a colonial imposition.

groups and individuals. Used together, these various approaches can provide a richer, more nuanced, and holistic understanding of the intersectionality inherent in clinical ethics work.

An intersectional approach also offers opportunities to avoid or remedy challenges and pitfalls particular to the use of any single approach. For example, a consequentialist framework — which is often employed in public health bioethics — might ignore the aforementioned richness of the lives of particular persons. A virtue theoretical approach, while taking seriously particular persons, might lack the robust action-orientation that is often called for in clinical bioethics. A deontological framework may lend itself to bioethics-related policies but may leave out the humanity of the clinician and their own history and values, even if it attends to the explicit duties of clinicians toward patients. In considering and bringing together various ways of thinking and knowing, bioethicists can do their work best and, in so doing, make implicit arguments for DEI, which they ought to (also) make explicitly.

Current events suggest another rights movement lies ahead, furthering those of the 1960s and 1970s. In their clinical work, scope, and *raison d'être*, clinical bioethicists are well-suited to address DEI using both the practical and theoretical tools that are part of the bioethicists' specific training. The conceptual approaches of casuistry, feminist bioethics, virtue ethics, and care ethics, for example, combined with the practical tools of narrative ethics and principlism, can and must “intersect” to ensure that DEI remains a central priority of clinical ethics. This approach highlights the ongoing need for diversity, equity, and inclusion, which is currently facing perilous pressure in the US.

Reçu/Received: 07/07/2025

Remerciements

Nous remercions respectueusement que cet article a été rédigé en partie sur les terres du peuple Syilx Okanagan, qui prend soin de ces terres depuis des temps immémoriaux. Nous remercions également les terres ancestrales du Conseil des Trois Feux (les tribus Ojibwa, Ottawa et Potawatomi).

Conflits d'intérêts

Aucun à déclarer

Publié/Published: 20/01/2026

Acknowledgements

We respectfully acknowledge that this paper was written in part on the lands of the Syilx Okanagan people who have cared for these lands since time immemorial. We also acknowledge the ancestral homelands of the Council of the Three Fires (the Ojibwa, Ottawa, and Potawatomi tribes).

Conflicts of Interest

None to declare

Édition/Editors: Hazar Haidar & Aliya Afddal

Les éditeurs suivent les recommandations et les procédures décrites dans le [Core Practices](#) de COPE. Plus précisément, ils travaillent pour s'assurer des plus hautes normes éthiques de la publication, y compris l'identification et la gestion des conflits d'intérêts (pour les éditeurs et pour les auteurs), la juste évaluation des manuscrits et la publication de manuscrits qui répondent aux normes d'excellence de la revue.

The editors follow the recommendations and procedures outlined in the COPE [Core Practices](#). Specifically, the editors will work to ensure the highest ethical standards of publication, including: the identification and management of conflicts of interest (for editors and for authors), the fair evaluation of manuscripts, and the publication of manuscripts that meet the journal's standards of excellence.

REFERENCES

1. Jecker NS, Caplan A, Ravitsky V, et al. [Bioethicists must push back against assaults on diversity, equity, and inclusion](#). *American Journal of Bioethics*. 2025;25(8):5-11.
2. Baker RB. *Making Modern Medical Ethics: How African Americans, Anti-Nazis, Bureaucrats, Feminists, Veterans, and Whistleblowing Moralists Created Bioethics*. Cambridge, MA: MIT Press; 2024.
3. American Society for Bioethics and Humanities. [Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants](#). ASBH. 2014.
4. Drees LM. [Indian hospitals and Aboriginal nurses: Canada and Alaska](#). *Canadian Bulletin of Medical History*. 2010;27(1):139-61.
5. [Indian Hospitals in Canada](#). Indian Residential School History and Dialogue Centre. University of British Columbia; Vancouver, BC.
6. AMA. [Episode 8 – Towards justice and race conscious medicine](#). *Clinical Problem Solvers*. 2 Jun 2022.
7. Santovec ML. [The necessity of intersectionality: a profile of Dr. Kimberlé Crenshaw](#). *Women in Higher Education*. 2017;26(3):8-9.
8. Cho S, Crenshaw KW, McCall L. [Toward a field of intersectionality studies: theory, applications, and praxis](#). *Signs: Journal of Women in Culture and Society*. 2013;38(4):785-810.
9. Provincial Health Services Authority. [PHSA Ethical Practice Guide](#). PHSA Ethics Service, 2nd ed. Aug 2025.
10. Brüning L, Salloch S. [Making structural discrimination visible: a call for intersectional bioethics](#). *American Journal of Bioethics*. 2022;22(3):42-4.
11. Health Quality BC. [Culturally Safe Engagement: What Matters to Indigenous \(First Nations, Metis, and Inuit\) Patient Partners Companion Guide](#). Aug 2024.