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Intersectional contributions to critical race theory concerning health inequality

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Abstract

Racial discrimination in the healthcare system of the United States is the product of the long nineteen century and present discriminatory institutional practices are indebted to the existing racially stratified society and its mechanisms. The intention of critical race theorists is to shed light on the historical embeddedness of racism, and by retaining the category of race as a cultural construct; they locate and challenge racial discrimination. Perhaps one of the main benefits of critical race theory is its history orientation, researchers are capable of pointing out the discursively produced nature of racism, however, it has a single category focus, and thus, intersectional theory can prove to be a positive tool that is sufficiently sensitive to address discrimination resulting from multiple sources of oppression. In this paper, some of the healthcare related benefits of the combination of these approaches will be discussed.

Keywords: critical race theory, intersectionality, racism, health inequality

Introduction

Contemporary racial discrimination in the healthcare system of the United States is the product of the long nineteenth century and present, discriminatory institutional practices are rooted in the racially stratified society – understood as a cultural, historical construct – and its mechanisms. The intention of critical race theorists is to shed light on the historical embeddedness of racism and by retaining the category of race as a construction; they locate and challenge racial discrimination. Perhaps one of the main benefits of critical race theory is its history orientation, researchers are capable of pointing out the discursively produced nature of racism, however it has a single category focus, and thus, intersectional theory can prove to be a positive tool that is sufficiently sensitive to address discrimination resulting from multiple sources of oppression. In this paper, some of the healthcare related benefits of the combination of these approaches will be discussed.

In the first part of the paper, the historical roots of critical race theory is explained because it is necessary to understand where the contemporary understanding and sensitivity towards racial categorization is stemming from. The main goal of critical race theorists is to address the complexities of racial discrimination. The aim is not to discard race, but to offer a re-conceptualized vision about how to discuss race based discrimination and propose mechanisms that can minimize and even eradicate these practices. Critical race theorists concern themselves with institutional racist practices, starting out from the legal discourse; they address the everyday experiences of non-white citizens suffering from discrimination. Central problems that critical race theorists address are related to

colorblindness, marginalization, and thus, the integration of the experiences of people of color into the political-legal discourse, thus producing racially equal institutional systems and a just society.

Intersectional contributions are useful because they enable researchers to address multiple forces of oppression. Black feminist scholars, who realized that their problems differ from the problems articulated by white middle-class women, conceptualized intersectionality as a theoretical and methodological framework. Intersectional scholars contend that social categories can act as labels, and individuals whose subjectivities are configured at the intersections of multiple categories experience a qualitatively different form of oppression than those women's experience whose oppression is the result of their sex. The application of these insights are valuable in the healthcare discourse, because with this approach researchers can address how health related discrimination occurs at different identity configurations.

Foundations, key tenets, and main areas of intervention

In the United States during the 1960s the civil rights movement arrived at a plateau, it was perceived by scholars and activists alike that the proposed racial reforms were not working and were not properly implemented to change institutional practice and give equal opportunity and equal results for every racial stratum of the society. A movement called critical race theory developed as a response of these problems. It started to emerge in the 1970s with the works of the legal scholars Derrick Bell and Alan Freeman. They were interested in developing a critical legal discourse that could address the complexities of racism; one that could take into account the everyday experiences of non-white Americans who suffer from the injustices of various institutions.[1] Civil rights activists such as Martin Luther King, Rosa Parks, or Malcom X inspired critical race theorists early on, and, parallel to the effects of political activism, they were also influenced by the works of critical legal theorists, feminists, and continental social and political philosophers.

Critical race theorists build their work on five basic tenets that concern racism, material determinism, conceptualization of race, racialization, and the thesis of unique voice of color.[2] The most important starting point in their works is the thesis that racism is ordinary, by this they mean that racism is so engrained into the everyday practices of social

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[1] Richard Delgado, and Jean Stefancic, "Introduction," In *Critical Race Theory: The Cutting Edge* (Philadelphia, PA: Temple University Press, 2000), xvi.

[2] Richard Delgado, and Jean Stefancic, *Critical Race Theory: An Introduction* (New York and London: New York University Press, 2001), 6–8.

life that it is hard to recognize every form of it especially if one tries to approach equality from a color-blind perspective. Addressing color-blindness means in this case that they try to move beyond formal conceptualizations of equality and integrate racialized experiences to point out what are the problems with neutrality in educational, legal, or a healthcare environment. The second feature is material determinism or 'interest convergence' – to use the concept of Derrick Bell. This states that racism works to advance the economic state of white elites, and it also advances the situation of the working class whose majority belongs to the white strata therefore they are interested in keeping the status quo unless their political and material interest dictates otherwise (Bell provides an example in the case of Brown v. Board of Education[3]). Another central theme in critical race theory is how to understand the concept of race. Although the movement places emphasis on materialism and the materialist consequences of racism, it would be a misunderstanding of the movement to view the term from a classical philosophical-realist perspective. Critical race theory builds on sociological, historical, philosophical, and linguistic scholarship that understands race from a social constructivist position.[4] By this critical race theorists mean that race and racial classification are social products, it is not possible to find biological structures that are objective equivalents of racial categories. Social discourses produce races and these categories are contextually, that is, historically and culturally varied. Certainly, critics do not argue that race is fluid in the sense that there is no possibility of finding biological similarities that make it possible to group people together; they rather want to take issue with a very problematic understanding of social constructivism. In this understanding, there is no materiality to race, but this group of critical race theorists argues that there are real, material consequences of race – albeit these are operationalized differently in various social contexts – that we need to confront in our societies. People attach different stereotypical traits to the hierarchically understood racial types that fuels various forms of racial discrimination across all aspects of social life. The last tenet is when someone works from the framework of critical race theory to give voice to the subordinated, racially silenced people. This is what critics term, voice-of-color thesis[5]; and by contrast to an essentialist understanding they do not mean that people of color have a biologically unique voice that one can identify with that particular racial group, but

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[3] Delgado, and Stefancic, *Critical Race Theory,* 18–20.

[4] Delgado, and Stefancic, *Critical Race Theory,* 7–8; Michael W. Byrd, and Linda A. Clayton, "Race, Medicine, and Health Care in the United States: A Historical Survey.," *Journal of the National Medical Association* vol. 93, no. 3 (2001): 11S-34S; Ian Haney López, "Race and Colorblindness after Hernandez and Brown," *Chicano-Latino Law Review* vol. 25 (2005): 61–76; Ian Haney López, "Is the Post in Post-Racial the Blind in Colorblind?," *Cardozo Law Review* vol. 32 (2010): 807–31.

[5] Delgado and Stefancic, *Critical Race Theory,* 9.

this draws on their unique experiences as a racialized group. Because of their racialized ways of lives, members of these communities have access to perspectives, which are not available to people who belong to the privileged racial group. The thesis entails that these people of color are capable of authentically describing race and racism thus critical theorists seek to integrate their narratives into their institutional critiques, or when it is not possible to include their voices, to point out how, why, and where institutional practices omit their perspectives. They claim that without the views of the non-white population on institutional racism it is not possible to attain a racially just society.

Contemporary scholarship deals with issues of color-blindness that goes back to the era of the civil rights movement when Martin Luther King called for a social practice that would judge people based on their actions and not based on their skin color. A related issue today is to develop a language that deals with racial identity and how other social categories intersect with racialized micro-level experience. A similarly important theme is addressing how globalization affects the economic circumstances of domestic minorities and their Third World counterparts. Critical race theorists argue that the exploitation of both groups by the elite is an interconnected issue thus it should be addressed simultaneously. Another important development in the field is that is has been open to feminist, queer, Latino/a issues and scholars successfully established these critical subdisciplines. With the insights of critical race theory scholars can address issues related to the intersections of race, gender, sexuality, and racial discrimination that directed towards people of color of non-African-American descent.[6] As critical race theory expands into other disciplines it remains an important force that can direct social transformation.

Critical race theory concerning health inequality

In a society where different forms of racial oppression are still normal, critical race theorists find it important to bring to the forefront of social discussions the embedded racialized practices of different institutions. Medicine is no exception to that. In a society, such as the United States, where the health standards of African Americans are significantly lower than members of the white racial group, scholars from various disciplines seek to address the structural barriers to race equality in health care. One of the most important steps that helps scholars, medical professionals, and everyday medical interactions is to acknowledge the historical roots of racial medical practice in any cultural context. One such example of the contemporary significance of this issue is the protest against the statue of J. Marion Sims, who was a gynecologist in the nineteenth century and he has statues in

[6] Delgado and Stefancic, *Critical Race Theory*.

several places in the United States.[7] Sims pioneered surgery for fistula, gallbladder problems, and also, he was the first gynecologist who performed the first successful artificial insemination. The problem with Sims, and his scientific feats, is the path that he took in order to develop successful methods to cure women. He practiced medicine in Alabama between 1835 and 1849 where it was possible for him to experiment with slaves, and thus his medical practice raises important ethical issues. He performed surgeries without the consent of slave women, and because at the time anesthesia was only recently discovered it was not normally used during surgeries thus Sims operated on slave women without painkillers. He held the belief that black women do not feel any pain. In a contemporary analysis, Carolyn Moxley Rouse in her work on health care treatment of African American patients with sickle cell disease points out the long-lasting effect of this racial stereotype.[8] Rouse discusses the culturally constructed nature of suffering regarding the racialized patient. "Culturally accepted notions of who is a victim, and who suffers are not stable across time. Conceptualizations of suffering are dependent on notions of causation, accountability, innocence, agency, rationality, and selfhood, all of which change relative to the age, race, wealth, gender, and assumed intelligence of the sufferer."[9] Sickle-cell anemia is a medical condition that describes the shape of the blood cells that basically block the capillaries thus obstructing blood flow and consequently withholding oxygen from bodily organs. This process causes immense pain on the one hand and irreversible organ damage on the other hand. Thus, it is crucial to treat the pain of the patient as quickly and efficiently as possible. Despite the protocols accepted by the physicians and hematologists working with SCD patients, Rouse points out how health professionals' understanding of pain differs from each other's understanding, and also from the actual experiences of African-American patients; thus, their treatment practices vary as well.[10] But it is not only the physical inaccessibility of the feeling that patients experience, it is also the vocabulary that patients and healthcare workers use that makes treatment racialized. In a story related to a patient called Max, Rouse explains that the description Max gave about his experience was simply incomprehensible to the medical staff. Max used cultural signifiers in his interactions which were meaningless for his caregivers, who instead of putting effort into precise cultural translation substituted his words with racist, classist, and gendered tropes.[11]

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[7] DeNeen L. Brown, "A Surgeon Experimented on Slave Women without Anesthesia. Now His Statues Are under Attack.," *The Washington Post,* 2017.

[8] Carolyn Moxley Rouse, *Uncertain Suffering: Racial Health Care Disparities and Sickle Cell Disease* (Berkeley and Los Angeles: University of California Press, 2009).

[9] Rouse, *Uncertain Suffering*, 124.

[10] Rouse, *Uncertain Suffering*, 24–25.

[11] Rouse, *Uncertain Suffering,* 40.

In the case that Rouse describes she notes that she does not want to place emphasis on racism or on the racist practices of medical professionals in her account, rather she wants to describe the hidden dimensions of institutionalized racism in the medical sphere. Her aim is to show how racist beliefs are acted out unconsciously by medical staff thereby perpetuating racial inequality in their profession. If the aim is to treat patients equally it is mandatory to bring practices of racialization to the foreground by for example, integrating the experiences of individuals such as Max into critical understandings of healthcare. Critical race studies in the field of history of medicine such as the works of W. Michael Byrd and Linda A. Clayton, both of whom are health policy researchers and trained physicians, are crucial contributions to the field that aims at reconfiguring healthcare.[12] In their work, they explore the history of medical treatments that African American's have received since the foundation of American colonies. They claim that the institution of slavery laid down the groundwork for a dual health system that persists until the present. Byrd and Clayton start out their analysis from reviewing the works Western medical professionals from ancient times. Fundamentally, they argue that color based classification of races existed in some preliminary form as a result of the works of the Greek philosophers Plato and Aristotle who assigned inferior status to slaves indifferent of their racial ancestry. Later the works of the Roman physician Galen and the Moslem Avicenna also contributed to the ideology of racial hierarchy by teaching that blacks are physically and psychologically inferior types.[13] Medieval monks accepted and relied on the teachings of ancient philosophers and physicians. And by the time of the fifteenth and sixteenth centuries Western physicians developed and widely accepted the thesis of 'separate and unequal creations' – which is attributed to the Swiss physician, Paracelcus, – that was later used to justify racial separation and subordination of peoples who are different from whites.[14] Thus, the hierarchical understanding of races was a historically embedded ideology by the time of the Enlightenment when philosophers and naturalists tried to use reason to explore, classify, give explanation as to how and why things work the way they do in our human centered universe. In this endeavor the classification of races was a central concern for many naturalists. For example, Carl Linnaeus, who is considered to be the father of biological classification, Johann Blumenbach, George Leclerc de Buffon, and George Cuvier all contributed to Western European imperialism by providing pseudo-scientific

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[12] Michael W. Byrd and Linda A. Clayton, *The Medical History of African Americans and the Problem of Race: Beginnings to 1900* (New York and London: Routledge, 2000); Michael W. Byrd and Linda A. Clayton, *An American Health Dilemma: Race, Medicine, and Healthcare in the United States, 1900-2000* (New York and London: Routledge, 2002).

[13] Byrd and Clayton, "Race, Medicine, and Health Care in the United States: A Historical Survey," 17.

[14] Byrd and Clayton, "Race, Medicine, and Health Care in the United States: A Historical Survey," 17.

justification for the subordination of non-white people across the globe.[15] The knowledge that these naturalists produced was used to strengthen stereotypes such as the idea that poor health of black people is normal, they are biologically weaker in comparison to whites. Byrd and Clayton argue that the difference between the health standards of white and non-white Americans thus is a product of racialization and racism that was present in the American discourse since its beginning, but importantly, they claim that it has lasting effects in the twenty-first century.

Byrd and Clayton underscore that the basic infrastructure of the health delivery system of the United States was ready by 1920 and it has changed little regarding its accessibility by marginalized citizens.[16] It was developed into a racially segregated institution that is very inaccessible for people from lower socioeconomic classes. Unfortunately, the authors claim, this has changed little during the twentieth century. Instructive examples from the first half of the twentieth century are the eugenics informed efforts to sterilize the socially subversive members of the population. Sterilization laws were enacted in the 1920s by a dozen states and these concerned people who were incarcerated, who were deemed mentally handicapped or mentally ill.[17] Kevles claims that in California alone, more people were sterilized by 1933 than in the other states combined. And he makes an important distinction regarding the class based and racialized nature of the law: those who had private care were not subjected to the process. This also means that poor people, African Americans, and other minorities were much more often subjected to sterilization than Anglo-Saxon whites were. Another example for institutional racism by misusing medical power in the recent history of American public health that affected African Americans is the Tuskegee syphilis study that was conducted between 1932 and 1972.[18] In this experiment, African American patients with late-stage syphilis were deceived by the staff members of the Public Health Service who basically observed the progress of the disease by pretending to give free health care to those who took part in the clinical study. The time-span, its scale, and its institutionally organized nature makes the Tuskegee study still a prominent example of contemporary racism and makes understandable the distrust of African Americans towards the U.S. medical apparatus. The situation started to change in 1964 when the Civil Rights Act was enacted.[19] With the hospital desegregation

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[15] Byrd and Clayton, "Race, Medicine, and Health Care in the United States: A Historical Survey," 18.

[16] Byrd and Clayton, "Race, Medicine, and Health Care in the United States: A Historical Survey," 20.

[17] Daniel J. Kevles, "Eugenics and Human Rights," *The British Medical Journal* vol. 319, no. 7207 (1999): 436.

[18] Susan M. Reverby, ""Special Treatment ": Bidil, Tuskegee, and the Logic of Race," *Journal of Law, Medicine, and Ethics* vol. 36, no. 3 (2008): 478.

[19] Byrd and Clayton, "Race, Medicine, and Health Care in the United States: A Historical Survey," 21.

ruling and the start of the health center movement the health of African Americans has gradually improved. Michael Byrd and Linda Clayton write that they had more access to healthcare because of the reforms, and efforts were made to improve minority access to medical education – though these latter efforts were very symbolic instances. They further claim, that the positive change that started in 1964 had stopped by the end of the 1970s and the health status of African Americans has deteriorated since that time. Byrd and Clayton claim: "until persistent institutional racism and racial discrimination in health policy, medical and health professions education, and health delivery are eradicated – all of which play significant roles in access, availability, and quality of care – African Americans will continue to experience poor health status and outcomes."[20] Without systematic transformations, it is not possible to reach an egalitarian healthcare system that can work according to a new non-racializing paradigm.

In the 1990s with the launch of the Human Genome project it seemed that geneticists will provide scientific knowledge for the world within the scope of ten years that settles the doubts that has still surround that the idea of race and racial difference. But instead of accomplishing this goal racial science takes new shape through genetic studies. Dorothy Roberts claims, this is mainly because of two scientific developments: scientists wanted to abandon race and suggested a focus on statistical genomic similarities and an alternative to this was the suggestion that geographic ancestry be used as a substitute that leaves behind the discriminative baggage of the concept.[21] With this move scientists basically re-dressed the concept in genetic terms. Roberts argues that race persists because it is politically useful, thus she emphasizes that "racial science and politics are inseparable."[22] Because of these interconnections, Roberts finds it important to analyze the political function of race in its context and provide a thorough critique that justifies its rejection from the scientific discourse.

Not only the history of eugenics but a contemporary focus on race/ethnicity necessitates the use of a critical framework that allows for the mapping of continuities in terms of racialization among different historical periods. Critical race theory can help the analysis by shedding light on the historical embeddedness of racial structures in Central European societies and how it is represented in medical discussions. The contemporary racial/ethnic focus of medicine is rooted in the discussions of the socialist period, while some of the arguments present in the socialist discourse can be traced back to the early eugenic concerns of the twentieth century.

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[20] Byrd and Clayton, "Race, Medicine, and Health Care in the United States: A Historical Survey," 25.

[21] Dorothy Roberts, *Fatal Invention: How Science, Politics, and Big Business Re-Create Race in the Twenty-First Century* (New York and London: The New Press, 2011), 57.

[22] Roberts, *Fatal Invention*, 79.

Intersectional contributions to critical race studies on public health

Intersectionality, defined as "analytic sensibility", became a widely deployed theoretical and methodological tool in feminist studies since its inception at the end of the 1980s.[23] In an earlier work she articulates the definition in a more detailed manner: intersectionality addresses the multiple dimensions of social relations and their relevance to possible subjectivities that can be formed within the social worlds.[24] This new approach was developed to shed light on the complex nature of discrimination that women experience depending on their class, race and gender. Feminist researchers are working with the concept in political science,[25] in philosophy,[26] in sociology,[27] and in public health as well.[28] In the following pages, some of the contemporary directions suggested by feminist scholars will be discussed, with a focus on public health.

The first critical works that pointed towards the direction of intersectional theorizing appeared in the late 1970s and early 1980s. These were works of black feminist scholars and

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[23] Sumi Cho, Kimberlé Williams Crenshaw, and Leslie McCall, "Toward a Field of Intersectionality," *Signs: Journal of Women in Culture and Society* vol. 38, no. 4 (2013): 795.

[24] Leslie McCall, "The Complexity of Intersectionality," *Signs: Journal of Women in Culture and Society* vol. 30, no. 3 (2005): 1771–1800.

[25] Kimberle Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color," *Stanford Law Review* vol. 43, no. 6 (1991): 1241–99; bell hooks, *Feminism Is for Everybody: Passionate Politics, Ideals and Ideologies: A Reader* (Cambridge, Massachusetts: South End Press, 2000); Gloria Wekker, "Still Crazy after All Those Years... Feminism for the New Millennium," *European Journal of Women's Studies* vol. 11, no. 4 (2004): 487–500; Ange Marie Hancock, "When Multiplication Doesn't Equal Quick Addition: Examining Intersectionality as a *Research Paradigm,*" Perspectives on Politics vol. 5, no. 1 (2007): 63–79; Avtar Brah and Ann Phoenix, "Ain't I a Woman ? Revisiting Intersectionality," *Journal of International Women's Studies* vol. 5, no. 3 (2004): 75–86; Myra Marx Ferree, *Varieties of Feminism: German Gender Politics in Global Perspective* (Stanford, California: Stanford University Press, 2012).

[26] Sandra Harding, "Rethinking Standpoint Epistemology: What Is Strong Objectivity?," in *Feminist Epistemologies,* ed. Linda Alcoff and Elizabeth Potter (New York: Routledge, 1993), 49–82; Rosi Braidotti, *Metamorphoses: Towards a Materialist Theory of Becoming* (Cambridge: Polity, 2002); Karen Barad, "Posthumanist Performativity: Toward an Understanding of How Matter Comes to Matter," Signs vol. 28, no. 3 (2003): 801–31; Iris van der Tuin, "'Jumping Generations': On Second- and Third-Wave Feminist Epistemology," *Australian Feminist Studies* vol. 24, no. 59 (2009): 17–31.

[27] Leslie Mccall, *Complex Inequality: Gender, Class, and Race in the New Economy* (New York and London: Routledge, 2001); Mccall, "The Complexity of Intersectionality"; Nira Yuval-Davis, *The Politics of Belonging: Intersectional Contestations* (Los Angeles, CA: Sage, 2011).

[28] Lisa Bowleg, "The Problem With the Phrase Women and Minorities: Intersectionality — an Important Theoretical Framework for Public Health," *American Journal of Public Health* vol. 102, no. 7 (2012): 1267–74; Olena Hankivsky, "Women's Health, Men's Health, and Gender and Health: Implications of Intersectionality," *Social Science & Medicine* vol. 74, no. 11 (2012): 1712–20.

activists whose aim was to call attention to the inherent inequalities within identity politics and to shed light on the deterministic/marginalizing nature of social categories that rather act as labels for those who are identified as others. In 1977 within the black liberationist movement feminists published a statement about the different experiences of black women, which can be read as an early work towards intersectional thinking. In their work, titled The Combahee River Collective Statement, they argued that different kinds of oppressions construct their living conditions in the United States. They emphasized that their main aim was to "struggle against racial, sexual, heterosexual, and class oppression."[29] In a similar manner, bell hooks stated[30], that black women experience discrimination differently from white women, and therefore traditional identity politics is not solving their problems. These examples from early intersectionally-tuned works were calling theorists to develop new perspectives to fight multiple-discrimination. Intersectionality, developed in view of with these problems, seemed to be a promising, sensitive, and open new framework.

It was the legal scholar, Kimberlé Crenshaw's article in which she first proposed the use of the term to address multiple discrimination of black women in court cases.[31] In her work, she argues that the problem with traditional anti-discrimination movement and identity politics is that they are addressing only one axis of oppression that is either race or gender, when in fact oppression works on bodies from multiple directions. In her later work, developing the concept further, she proposed three different aspects for intersectional research, namely structural, political, and representational intersectionality.[32] In this paper, she argues for a more precise approach that can correct the problems of identity politics.[33] She says, that the problem with identity politics is not the often-mentioned idea that it fails to transcend difference, but its inherent force that identity categories homogenize groups and thus intra-group differences are silenced. In her essay, she starts out from structural problems such as racism and sexism and claims that these analytically and conceptually different discriminatory forces are readily intersect in the lives of ordinary people. Through legal cases, Crenshaw pointed out that battering and rape affect women of color differently. In this work, one of the most important contributions of Crenshaw was to underscore in these

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[29] Combahee River Collective, "The Combahee River Collective Statement," in *Home Girls. A Black Feminist Anthology*, ed. Barbara Smith (New Brunswic, New Jersey, and London: Rutgers University Press, 2000 [1977]), 264.

[30] bell hooks, *Ain't I a Woman: Black Women and Feminism* (Boston: South End Press, 1981).

[31] Kimberlé Crenshaw, "Race, Reform, and Retrenchment: Transformation and Legitimation in Antidiscrimination Law," *Harvard Law Review* vol. 101, no. 7 (1988): 1331–87.

[32] Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color."

[33] Crenshaw, "Mapping the Margins," 1242.

empirical cases that the boundaries of identity constructs are not neatly distinguishable from each other thus an intersectional analysis demands a careful look at various crossroads of subjective experiences where individuals try to negotiate their subject positions to avoid economic or political marginalization, stigmatization, or any other type of discrimination. By adopting an intersectional lens, social scientists are in a better position to address inequalities because they can rely on a multidimensional method that can handle the dynamics between multiple identities.

An intersectional perspective in analyzing the production of oppressed, marginalized, and silenced subject positions allow for considering multiple dimensions of identities, so that it enables us to view subject positions as configurations of discursive power relations. In other words, by looking at the locational, that is individual or group level interactions, and interpreting the lived experience of subjects in relation to greater structural inequalities, an intersectional approach allows the incorporation of infinite variables (social categories) into its sociological investigation. The openness of intersectionality can be viewed both as its strength and its weakness and the stances researchers take in applauding or rejecting its usefulness sometimes hark back to this characteristic.[34]

In the initial stages of the discipline, intersectional studies addressed different forms of aggravated discrimination that were based on sex, sexuality, language, political opinion, religion, social origin etc. As is evident from recent studies cited above, that although intersectionality is a recent sociological development to study complex discriminatory mechanisms, it is notable that struggles for political recognition in the women's movement around the turn of the nineteenth and twentieth centuries implied the identity category of class and gender. Women's everyday experiences were articulated from different social economic positions thus class positions led to the division of women because priorities were different and those in power, particularly middle-class women, silenced the voices of those who were economically marginalized.[35] This example is only one instance to suggest that the problem, that intersectional scholars address, namely that social identities like gender are not homogenous categories, but with the interaction of other social identities such as class and race, they create qualitatively different subjectivities.

In most feminist studies race, gender, and class are treated with equal importance; they are understood to be mutually constituting and reinforcing each other. Angéla Kóczé and

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[34] Kathy Davis, "Intersectionality as Buzzword: A Sociology of Science Perspective on What Makes a Feminist Theory Successful," *Feminist Theory* vol. 9, no. 1 (2008): 67–85; Evelien Geerts and Iris Van der Tuin, "From Intersectionality to Interference: Feminist onto-Epistemological Reflections on the Politics of Representation," *Women's Studies International Forum* vol. 41 (2013): 171–78.

[35] Angéla Kóczé, "Missing Intersectionality: Race/Ethnicity, Gender, and Class in Current Research and Policies on Romani Women in Europe" (Budapest: Center for Policy Studies, CEU, 2009), 18.

Raluca Maria Popa emphasize that it is necessary in Central Eastern Europe to accept that only with the recognition of class as a crucial element of inequality thus a vital element of social analysis, will we get sufficient understanding of racialized differences.[36] We must recognize that class plays a key role in the dynamics of marginalization along with race and gender. Drawing on the works of intersectional scholars, Enikő Magyari-Vincze underscores that studies can focus on structural problems, namely how race, class, and gender work on the structural level and provide frames or limitations for subjectivities at the crossroads of power vectors.[37] Patricia Hill Collins who is a sociologist, termed these structural forces as matrix of domination.[38] By this expression she means that oppression operates in four domains and can be visualized as a complex web of forces. These four interrelated domains are the structural, disciplinary, hegemonic, and interpersonal domains. Regarding this problem, Hill Collins says that "the structural domain organizes oppression, whereas the disciplinary manages it. The hegemonic domain justifies oppression, and the interpersonal domain influences everyday lived experience and the individual consciousness that ensues."[39]

Although intersectional perspectives are applied in various social science disciplines it is not true of studies that are within the broad field of public health. It is a new methodological framework as discussed above: it only started to become integrated into social science disciplines in the 1990s, and it is a tool that researchers have used only recently to address public health inequalities. Lisa Bowleg, a social psychologist, argues that intersectionality is beneficial for public health studies because it can be integrated with health equality goals.[40] Intersectional studies are about social inequalities, their aims are exploring and exposing invisible obstructions to equal treatment and opportunity, thus as a perspective, it is compatible with critical works that address public health issues with the aim of leveling health standards among different social groups. According to Bowleg one of the main benefits of the perspective is its compatibility with a recent direction in public health that also places emphasis on "social determinants of health, or eco-social determinants, or social inequality" in this new approach an "ever-growing chorus of public health scholars have advocated for a greater focus on how social-structural factors beyond the level of the individual influence health."[41] Bowleg further asserts that an intersectionally informed research starts out from

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[36] Kóczé, "Missing Intersectionality," 25.

[37] Kóczé, "Missing Intersectionality," 26.

[38] Patricia Hill Collins, *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (New York: Routledge, 1991).

[39] Hill Collins, *Black Feminist Thought,* 276.

[40] Bowleg, "The Problem With the Phrase Women and Minorities: Intersectionality — an Important Theoretical Framework for Public Health."

[41] Bowleg, "The Problem With the Phrase Women and Minorities," 1269.

the experiences of historically oppressed communities, thus it can assist the development of well-targeted and cost-effective health promotion campaigns, medical interventions, or public health policies.

One of the most important problems in addition to single-category analyses is when a category is treated with a single focus such as in the case with gender when conflated with the category of women. This is problematic for various reasons. The first is that gender is not synonymous with the category of women, and, it is not a homogenous category, it should be further divided by taking sexuality, class, religion, and race/ethnicity, and other contextually relevant identity categories into account. But another crucial problem is that gender is often used interchangeably with women thus men and their equally diverse groups are left out of the analysis. This also means that their gender specific healthcare needs are not visible.[42] Without the integration of these perspectives it is not possible to move ahead in creating conditions for equal treatment in healthcare.

But as Olena Hankivsky notes, we must also move beyond the binaries such as interest in the health of men and women.[43] The problem with such research designs is that it tries to answer questions which are formulated with a stereotypical gender bias in mind. To take an example, a question such as: do women and men have the same risk of getting cancer is problematic because it re-creates two seemingly homogenous groups based on the sex of the participants when there is evidence that women and men can both share certain genetic mutations that would make them similarly susceptible to cancer. Thus, research questions that focus on for example genetic traits which are linked to cancer are more beneficial for the public health needs of both men and women and would help to create hybrid groups in which sex is only one social category among many others that complicates our understanding of susceptibility.

Intersectionality must not be understood as a prescriptive method. It rather contributes to scientific analyses by opening analytical frames and letting us bring in analytical categories that were – and perhaps still are – incompatible with each other in single dimensional methodological paradigms. It facilitates discussion by pointing out complexities that were previously glossed over because of insensitive methodological lenses. Thus, the most important contribution of intersectionality to critical race studies is that it makes visible elements in the medical discourse that thwart healthcare equality or perhaps even implicitly support discriminative practices in healthcare. Identities such as race/ethnicity, gender, and class work as structuring principles in organizing social hierarchies in the professional

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[42] Hankivsky, "Women's Health , Men's Health, and Gender and Health: Implications of Intersectionality," 1713.

[43] Hankivsky, "Women's Health , Men's Health, and Gender and Health," 1714.

narratives of healthcare workers. Healthcare professionals, perhaps inadvertently, produce medically significant subject positions in their narratives along the lines of said identities, and by doing so, they reproduce distinct groups and fail to stress the shared biological and social characteristics across groups.

Conclusion

Critical race studies as a framework is useful because with its theoretical and methodological tools it is possible to address racial inequality and its historical embeddedness in racially stratified societies. The category of race is understood in the framework as a social construct that has material consequences. In other words, in order to tackle racial inequalities it is important to retain the category of race with the implication that race is the product of local discursive forces that inscribe cultural values into biological differences and thus make racial discrimination possible. Although critical race studies sensitively address issues around the identity category of race, those studies that have a single category focus were criticized, just as feminist single category analyses were criticized regarding their inability to address intragroup differences and overlaps between groups. Intersectional studies with their open approach are capable of addressing oppressive forces that intersect in individual lives, thus, making intersectionality a viable asset for social science researchers interested in exploring racial inequalities in public health.

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