How to cite:
Lisa S. Parker, Joel Michael Reynolds, and Patrick Smith. “Philosophy: Standpoint Theory and Intersectionality – Gender, Race and Disability” in Methods in Medical Ethics: Bioethics Scholarship and Practice, 3rd edition, eds. Jeremy Sugarman and Daniel P. Sulmasy (Georgetown University Press, forthcoming).

Chapter 4

Philosophy: Standpoint Theory and Intersectionality – Gender, Race and Disability

Lisa S. Parker, Joel Michael Reynolds, and Patrick T. Smith

<A> Overview

In the late 20th century, when countering medical paternalism that had previously informed medical decision-making and practice, bioethicists argued that the values, lived experience, and perspectives of patients should be central to bioethical reasoning. It is patients’ conceptions of their own well-being that, for example, should inform their medical care and their informed consent to (or refusal of) recommended interventions. However, feminist bioethics noted that bioethical theorizing frequently seemed to conceptualize patients rather thinly as bearers of rights and interests with little attention paid to the social, cultural, economic, and familial context or particularities of embodiment and lived experience that actually shape people’s values, interests, and worldviews (Scully 2023). Instead, bioethics tended to adopt the worldviews of healthcare professionals and academics engaged in bioethics. This chapter examines methods subsequently used in bioethics to counter this myopia.

This chapter discusses the contributions that standpoint theory and intersectionality make as philosophical methods in bioethics. It opens by articulating foundational claims of standpoint theory and by examining how developing a critical consciousness of power relationships can transform perspectival knowledge into an epistemologically privileged standpoint that challenges the uncritical partiality of dominant perspectives. Next, the analysis of power relationships provided by feminist ethics is used to demonstrate how recognition of differing epistemological perspectives is transformed into feminist standpoint theory. It then examines how the method of intersectionality emerges, in part, from criticisms of feminism’s own shortsightedness and exclusionary practices. Then, a review of the methods of critical race theory describes its origins, basic tenets, and contribution in developing a critical consciousness relevant to bioethics. Finally, the chapter presents key insights from the field of disability studies, demonstrating how lived experiences of disability may provide a standpoint to inform medical and bioethical analysis, particularly in discussions of quality of life. Though perspectives informed by other features of social context are important for bioethical analysis—for example, social class, educational background, linguistic and cultural differences—this chapter focuses on gender, race, and disability to illuminate features of standpoint theory and intersectionality.

<A> Description of Standpoint Theory and Intersectionality in Bioethics

<B> Foundations of Standpoint Theory

Standpoint theory begins with the insight that people’s social locations affect what and how they know—indeed, even what they *can* know. This “situated knowledge thesis” has three implications. First, social location not only limits and shapes one’s experience and thus one’s beliefs about the world, but also concurrently shapes one’s worldview, the perspective through which one interprets experience and makes sense of the world.

Second, when a system or institution of knowledge production (e.g., medical science) is dominated by people occupying particular social locations, its norms, methods, and outcomes are likely to be influenced by their perspectives with two results. One, their perspectives are unlikely to be recognized as particular, situated perspectives, but instead mistaken for general truths. Because society “does not conceive of men in terms of their gender” but instead “conceives of them gender-neutrally, as persons,” for example, “… men’s identity and experience serve, in effect, as the characterization or standard of what it is to be a person," so that the perspective of white cisgendered, able-bodied heterosexual males, has traditionally not been regarded as a perspective, but rather as the norm from which other perspectives differ (DeBruin 1994, p. 123). Two, because others lack similar opportunities to influence knowledge production through the contribution of their perspectives, the outcomes of systems of knowledge production will be both incomplete and as likely serving the interests of those involved as opposed to being "impartial."

This partiality has ethical relevance for bioethics. It is a material injustice, as well as an epistemic injustice, that omission or exclusion of some people and perspectives from the process of knowledge production is likely to result in outcomes that fail to adequately serve their interests (while, at the same time, unselfconsciously serving the interests of those whose perspectives are included). From the perspective of those dominating knowledge production, the interests of non-dominantly situated groups may be deemed "special interests" to be served, if at all, by special pleading to take their perspective, needs, or interests into account. Early HIV/AIDS research, for example, failed to address the interests of women living with HIV, instead taking AIDS's manifestations in men as the norm and focusing on women living with HIV largely insofar as their infection affected the health of others (e.g., in vertical transmission studies) (Faden, Kass, and McGraw 1996). Moreover, bioethics's traditional way of evaluating fair subject selection did not facilitate identification of this injustice: while genuine uncertainty persisted regarding the research outcome, there was no clear benefit from which women could be said to be excluded (Merton 1996). Women's exclusion could be deemed unfair only by considering its implications for future women who, unlike men, would have to make decisions about accepting medical interventions without reliable data about their outcomes in women.

A third implication of knowledge being situated, perspectival, and thus partial is that a collaborative process of knowledge production can reduce error and bias. Feminist philosopher of science Helen Longino argues that knowledge production requires a social process of gathering and subjecting to critical scrutiny multiple partial knowledges, which is to say, claims, theories, and beliefs (Longino 2002). Conceiving of knowledge production in this way helps to address a concern inherent in connecting social positionality to epistemic perspective—namely, the practical and conceptual problem of how differently situated people can share knowledge. On this view, communities, not individuals, are sites of knowledge production. Given that participants' biases cannot be eliminated, it is better that they be diversified rather than compounded (Jeong 2024). Increasingly accurate knowledge is generated by scrutinizing knowledge claims made by people occupying a range of different social locations and thus reflecting a range of perspectives and worldviews. Resultant, tentatively-accepted knowledge claims will not be aperspectival or free of background assumptions, but will reflect perspectives—and represent a perspective—broader than that of any one person or social location.

This "epistemic diversity thesis" in standpoint theory considers "the effect of group composition on collective epistemic performance and is largely silent about what kind of characteristics lead to individual epistemic excellence" (Jeong 2024, p. 97). The greater the diversity of perspectives represented in this social process of knowledge production, the wider the range of empirical information introduced into the process, and the greater the likelihood that background assumptions—value-laden beliefs, methodological assumptions, and empirical claims informing dominant or widely-shared perspectives—will be identified and subjected to scrutiny. "When … background assumptions are shared by all members of a community, they acquire an invisibility that renders them unavailable for criticism. They do not become visible until individuals who do not share the community's assumptions can provide alternative explanations of the phenomena without those assumptions" (Longino 1990, p. 80). Social disadvantage may thus make visible what social advantage obscures.

<C> From epistemic advantages of marginalized perspectives, to achieving epistemically privileged standpoints

Standpoint theory's "epistemic advantage thesis" focuses on the role played by social location in the development and exercise of *individuals'* epistemic capacities (Jeong 2024; Toole 2023). It claims that nondominant social locations place "one in a position to gather more evidence" or "to develop certain beneficial epistemic virtues and habits" relevant to correcting the dominant group's perspective (Toole 2023, p. 2). Occupying disadvantaged or marginalized social locations does not automatically confer these epistemic advantages on nondominant epistemic agents because people may systematically misapprehend their own interests or have strong motivational pressures to maintain beliefs that support dominant perspectives and their own continued marginalization (Dror 2022).

In contrast to socially located perspectives that *offer* epistemic advantages, "the epistemic privilege of marginalized standpoints … must be *achieved* through the practice of consciousness-raising," much like acquiring the knowledge, skills, and cognitive capacities requisite for expertise in a specific domain (Toole 2023, p. 2, emphasis added). This "achievement thesis" in standpoint theory not only distinguishes the *epistemic advantages offered* by disadvantaged social locations from the *epistemic privilege achieved* by epistemic agents, but also "clarifies that the privileged knowledge derived from marginalized standpoints is not in principle inaccessible to those who are dominantly positioned" (Toole 2023, p. 3). "Epistemic privilege does not come from viewing things from the perspective of those in subordinate positions, but rather from that perspective together with an awareness of social, political, and other factors that maintain the status quo" (Crasnow 2006 p. 1093-1094).

Embracing standpoint as a method involves making a "normative commitment" to understand and reform epistemic practices so as to ultimately abolish the ways in which power structures limit knowledge production (Intemann 2010, p. 785-786). The achievement of epistemically privileged standpoints enables epistemic agents to challenge the epistemically and ethically problematic partiality of dominant perspectives that serve to maintain structures of power and social marginalization.

<B>Feminist Standpoint Theory and Intersectionality

Feminist standpoint theory illuminates how the power structure of gender and sexism shape knowledge production. This section briefly reviews feminism's commitment to the development of critical consciousness and abolition of sexism, and the key concepts of gender and power in feminist theory. It sketches criticisms of feminism's exclusion of women of color and their perspectives, thereby setting the stage to introduce intersectionality as a method with corrective implications for feminist theory, feminist standpoint theory, and bioethics.

<C>Gender, power, and feminist standpoint theory

Feminism may be defined most basically as "a movement to end sexism, sexist exploitation, and oppression" (hooks 1984, p. xii). Despite never being monolithic or developing along a single trajectory, the movement in the US is often described in terms of "waves." Its first wave, beginning in the mid-19th century, focused on establishing women's equality with men and securing civil rights, such as suffrage. Second wave feminism (1960s–1980s) continued to press for equal rights, especially reproductive rights; however, this "women's liberation" movement extended beyond asserting juridical rights. It promoted consciousness-raising, asserted the epistemic and ethical importance of women's "lived experience," and challenged systemic sexism and women's traditional social roles. Informing the early development of feminist standpoint theory, women's experience was recognized to be shaped by systemic sexism; sociopolitical context was acknowledged to shape personal experience.

In the 1990s, feminism's third wave began to reveal practical and conceptual limitations of attempting to establish women's equal worth as persons by reforming liberal democratic structures that themselves operated within social hierarchies of power systematically disadvantaging women. During this third wave, dismantling such underlying power structures became the still persisting project of feminism. Whether third wave feminism is itself persisting, splintering, or transforming into a fourth wave is currently contested (e.g., Crozier-De Rosa 2024; Courtemanche 2019; Grady 2018). Third wave feminist theorizing explicated many of the concepts employed in feminist political theory, standpoint theory, and ethics. Definitions of key concepts were frequently contested (and still are). This section focuses on power and gender.

Power has multiple forms, including a generative power or the "power-to," the capacity to create or act, as in "girl power." There is also "power-over," as in one person's exercise of power over another. Structural power is the arrangement of power—e.g., wealth, social advantages, expertise, authority—in such a way as to influence social norms, processes, institutions, and relationships (including interpersonal relationships). Those advantaged in hierarchies of structural power have an interest in maintaining the status quo and seek to do so by exercising exercise social power, including through knowledge production (Allen 2022).

Sex was initially distinguished as a biological concept that differs from gender, which is performative, i.e., constituted through the "*stylized repetition of acts*," such as gesture, posture, dress, and exercise of power (Butler 1999, p. 179). Sex has subsequently been retheorized as also performative, socially constructed through medicolegal performative acts (e.g., genotyping, signing a birth certificate), rather than being naturally given. Relative to the gender binary of men and women, or masculine/feminine, exercising power *qua* power-over is typically gendered as masculine and has historically been exercised by men. The capacity for dual vision—understanding the worldview of those in power, while also understanding how the power hierarchy maintains others at a disadvantage—is a generative power-to-effect-change developed particularly, but not uniquely, by those who are socially disadvantaged. Lower positionality in hierarchies of power—e.g., wealth, class, ability, racialization—is typically and historically gendered feminine; however, it is a site not only of oppression (being subordinated to power-over), but also of (generative power-to) resistance (hooks 1990).

The concept of gender, understood within the specific power structure of sexism, informs feminist standpoint theory; however, power (and the lack thereof) may be a more fundamental concept than gender *per se*. Uses of feminist standpoint theory may elide a gendered perspective with a nondominant or marginalized perspective when discussing the epistemic advantages offered by less powerful social locations. Over time, in feminist theorizing (and in much of US society) the binaries of male/female and masculine/feminine have become more fluid. ‘Genderqueer’ describes those whose resistance to “the assumption that *men* and *women* are discrete, exclusive, and exhaustive gender categories” arises from their “felt or desired gender categorization outside this exclusive and exhaustive binary” (Dembroff 2019, p. 15). For some, the gender binary has dissolved entirely. Nevertheless, for some theorists and purposes (as in the balance of this section), ‘gender’ may remain a useful heuristic to describe relationships of power, despite rejecting a gender binary or indeed any stable concept of gender.

Within medicine, feminist standpoint theory illuminates gendered relationships and features of the social world pertaining to healthcare. By providing an analysis of the power dynamics of information disclosure and decision making within the gendered doctor-patient relationship, it can enrich bioethical analysis of informed consent, truth-telling, and other traditional bioethical issues. Using feminist standpoint theory to analyze social structures forming the context of healthcare—e.g., economics, politics, capitalism, the “social safety net” (or its absence), and social attitudes about responsibility for health—can provide a less partial frame for ethical arguments to help ensure they address the interests of more vulnerable, nondominant participants in the healthcare ecosystem, not merely those of the powerful (Scully 2023).

<C>From criticisms of feminism’s myopia and exclusionary practices to the foundations of intersectionality

Even as feminism and feminist bioethics focused on women’s experience and analyzed gendered structures, they were faulted for replicating the myopic and exclusionary practices they had criticized in androcentric theorizing and politics. While it worked to secure women’s full recognition as persons, feminism often seemed to conceive of women as White women and of their experience as the norm. As both a social movement and theory, feminism has been criticized for its erasure of feminists of color and its inattention to the experiences and interests of non-White women (e.g., hooks 1991).

Early Black feminists like Ida B. Wells and Sojourner Truth were marginalized, even as they demonstrated how racism and sexism interact to disadvantage Black women. First wave feminism helped secure White women’s right to vote in 1920, while women of color were not enfranchised until 1965. Legal access to contraception and abortion were reproductive rights that

White second wave feminists sought, while Black feminists also argued against forced sterilization and for the opportunity to conceive, bear, and raise children in conditions unmarked by precarity (Roberts 2017). The right to work “outside the home,” of interest to socially privileged White women, was not a priority for African American women who, as a group, had always labored outside their homes.

In the early 1980s, Alice Walker coined and elaborated ‘womanism’, a term marking a movement and set of commitments borne of the experience of women of color. Though it is sometimes considered a branch of feminism, Walker wrote that “womanist is to feminist as purple [is] to lavender” (1983). This characterizes womanism as the broader, more encompassing theory and practice, seeking as it does to dismantle both sexism and racism. Indeed, womanism sought to dismantle multiple interlocking systems of power: in the decade before legal scholar and critical race theorist Kimberle Crenshaw coined the term ‘intersectionality’, the Combahee River Collective articulated the need to “combat the manifold and simultaneous oppressions that all women of color face” (1977).

Women of color feminists may be credited with identifying multiple axes of oppression—i.e., multiple ways that individuals and groups can be simultaneously disadvantaged within multiple hierarchical systems of power, while perhaps also having some social advantages *vis-à-vis* others (Hill Collins 2000). A particular Black woman in the US, for example, is simultaneously subject to racism and sexism, while perhaps also having advantages afforded by education and social standing in her religious community, but still lacking intergenerational wealth. Today, racism and sexism, along with the hierarchically socially constructed concepts of race and gender, are frequently cited as dual axes of power and oppression, with attention to social class, wealth, and (dis)ability among the other axes most frequently discussed.

<C>Intersectionality

Intersectionality developed from the fundamental insight that individuals (or groups) simultaneously occupy multiple social locations and experience the operation of multiple intersecting power structures. Intersectionality is a method that enables and insists on the analysis of multiple, simultaneous dimensions of inequality and inequity. It argues for the ethical, political, and epistemic importance of conducting and responding to such analysis. Development of an intersectional critical consciousness mitigates the myopia that can result from the development of critical consciousness borne out of nonintersectional feminism’s narrow focus on gender and sexism.

Crenshaw’s initial use of ‘intersectionality’ takes aim at critical inquiry focused only on one axis of oppression. She argued that that legal structures focused on *either* sexism *or* racism fail Black women who suffer workplace discrimination resulting from the intersection of both. Instead, what is needed is an analysis of “double-discrimination—the combined effects of practices which discriminate on the basis of race, and on the basis of sex” (Crenshaw 1989, p. 149). “Intersectionality fills out the Venn diagrams at points of overlap where convergence has been neglected, training its sights where vectors of inequality intersect” (MacKinnon 2013, p. 1020). Nevertheless, it is too simplistic to think of intersectionality as averring that “even if some people cannot seem to think more than one thought at a time, almost anyone can add” (MacKinnon 2013, p. 1021). Instead, as Crenshaw explains, “intersectional experience is greater than the sum of racism and sexism,” and thus “any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated” (Crenshaw 1989, p. 140).

Moreover, employing intersectionality as a method benefits everyone. Dorothy Roberts makes this point when employing intersectionality in a bioethical analysis of the doctor-patient relationship (Roberts 1996). She argues that “adding the perspective of women of color” does not “merely supplement” but “reconstructs” a feminist analysis of the relationship by revealing how it is “determined by political arrangements” (Roberts 1996, p. 124). “Women of color,” she argues, “may be more likely to see the political nature of the doctor-patient relationship because racism has not allowed them to assume that they enjoy a private, protective relationship with their doctors” (Roberts 1996, p. 125). Their epistemically privileged standpoint affords them “insight into this political dimension that is hidden from white middle-class women” (Roberts 1996, p. 125). Indeed, exercising intersectionality reveals ethical concepts themselves as “determined according to power. … [T]he very meaning of truth, consent, and confidentiality depends on social arrangements” (Roberts 1996, p. 126). Patients who do not manage their own finances may not be able to keep their medical treatment private, for example, if their spouses review insurance claims or medical bills. Patients who use emergency departments as their site of primary care do not enjoy the degree of privacy and confidentiality afforded by office visits with a chosen provider. Habitually subjected to racism, sexism, ageism, or other marginalizing social structures, some patients may not feel empowered to ask questions to obtain information needed to make informed medical decisions.

Essential to the method of intersectionality is recognition that “racism and patriarchy are not two separate institutions that intersect only in the lives of Black women,” but are “interrelated, mutually supporting systems of domination” (Roberts 1996, p. 123). Racism and patriarchy are also not separate from ableism, which Talila A. Lewis defines as “a system of assigning value to people's bodies and minds based on societally constructed ideas of normalcy, productivity, desirability, intelligence, excellence, and fitness. These constructed ideas are deeply rooted in eugenics, anti-Blackness, misogyny, colonialism, imperialism, and capitalism" (2022). Understanding this interaction is not only "essential to understanding the subordination of all women," but also valuable in understanding the social construction of the patient (Roberts 1996, p. 123).

In the hierarchical power structure of medicine, the social role of physicians is generally "gendered" as powerful/dominant/expert/masculine *vis-à-vis* the patient role, which is gendered as vulnerable/subordinated/lacking expertise/feminine. This power relation may hold even when a White patient seeks care from a medical expert of color, yet that professional is simultaneously subject to racism and other axes of power. Referring to relationships and institutions as gendered may be a useful heuristic; however, it may also obscure the operation of intersecting axes of power. Racism and sexism are systems of power with profound historical and material importance yet are but two of the manifold marginalizations to be understood and abolished. The next section extends the discussion of intersectionality along racialized lines by examining critical race theory and its contribution to bioethics methodology.

<B>Critical Race Theory

In the 1970s, as the gains of the US civil rights movement were increasingly challenged, critical race theory (CRT) developed to confront systemic forms of racism that extend beyond direct interpersonal encounters. CRT considers how extensive and intensive racism is within US society, its impact as a repressive system of power, and the roles of law and policy in its entrenchment. While CRT emerged within the domain of legal studies, its influence and development extend into other fields including healthcare (Delgado and Stefanic 2012, p. 4-7).

CRT begins with recognition that the story of racialization in the US is not a morally neutral narrative. As social historians have shown, an ethical justification was needed for the economic exploitation involved in commodification of enslaved bodies, their dehumanizing treatment, and the accumulation of vast wealth by slave owners, their communities, geographical regions, and eventually the nation (Baptist 2014, p. 215-260). This justification involved seeing those enslaved as less than fully human in order to establish the superiority of the dominant class over those dominated (Aulette 2017, p. 47). To be *racialized*, then, is "to be systematically subordinated or privileged, in virtue of being perceived as '*appropriately* occupying certain kinds of social position'" (Ney 2014, p. 265, emphasis added). In such contexts, regardless of grouping, all people are *racialized* whether it is known or acknowledged. Racialization generates marginalization, alienation, revulsion, and disparate treatment for those on the lower ends of this social hierarchy, while generating dominance, privilege, unearned praise, and preferential treatment for those on the higher ends.

As an analytical approach, CRT analyzes the political, ethical, and epistemic dimensions of racism with the goal of transforming unjust relationships of power. Building on feminist standpoint theory, it uses insights of intersectionality and critical legal studies to develop an intersectional critical consciousness that is useful in bioethics.

<C> Basic Features of Critical Race Theory

Though CRT should not be considered a uniform conceptual framework, it has six key features (Delgado and Stefanic 2012). First, CRT emphasizes the ordinariness of racism as it permeates every aspect of society. Critical race theorists argue that with racism shaping the structures underlying everyday life. Racialized disenfranchisement ranges across every aspect of social, economic, and civic life, including law, employment, housing, transportation, media, voting rights, criminal justice, education, religion, politics, music, film, entertainment, sports, and healthcare (Desmond and Emirbayer 2016). Racism's mundanity renders it difficult to address because for those who are in privileged positions, racism may be difficult to see.

Second, is the principle of "interest convergence," articulated by Derrick Bell, who argued that advances in racial justice are only made when they converge with the psychical and material interests of those in the racially dominant group (Bell 1980). There is little incentive for those who are part of the dominant group to change the economic, political, and legal structures of their social world unless it is in their interests to do so.

Third, CRT's "social construction" thesis recognizes how social, cultural, and political factors shape phenomena, including phenomena that seem to be natural (Delgado and Stefanic 2012, p. 8). CRT explicates the connections between law, religion, and the political economy of the transatlantic slave trade to elucidate the emergence of the modern concept of race as an invented social category that has historically divided human beings into hierarchical groups based on differences in physical appearance, geographical origin, and ethnic background (Barr 2019, p. 91). "Race is the product of racism; racism is not the product of race" (Roberts 2011, p. 25).

Fourth, is "differential racialization," CRT's observation that the "dominant society racializes different minority groups at different times, in response to shifting needs such as the labor market" (Delgado and Stefanic 2012, p. 9). In agriculturally based economies, for example, Black people were thought to be well-suited to contentedly work the fields. When manufacturing required rote, repetitive, and often uninspiring work, they were thought diligently capable but not very intelligent, and thus deemed fit for such work. Later, a racialized narrative portraying Blacks as lazy with a poor work ethic emerged to justify industry moving overseas for greater profit margins (Basile and Black 2019, p. 381). Narratives of the criminality and cultural pathologies of racialized minorities accompanied the rise of the prison-industrial complex. Most recently, the myths that Black youth are super-predators and Mexicans are rapists and criminals flooding the country have become “pillars of the economic, political, and cultural infrastructure of America” (Muhammad 2019, p. xiv).

Fifth, CRT recognizes that a group organizing for social change must have a clear idea of its goals and may embrace essentialism in its “search for the proper unit, or atom, of social analysis and change” (Delgado and Stefanic 2012, p. 62). As a result, the *particular* needs created by the intersection of identities often go unaddressed in broad movements—like the racial justice movement— as general concerns are given priority. While acknowledging that there is something oppressed groups share, namely their oppression, CRT recognizes that people situated at multiple sites of intersectionality experience oppression differently. CRT embraces anti-essentialist ways of understanding identity and urges that strategies to combat oppression must take account of particular intersectional oppressions, because generic approaches may be inadequate or even exacerbate some oppressions.

Sixth, CRT affirms a unique “voice-of-color” thesis that emphasizes the importance of racialized minorities telling their stories in light of “their different histories and experiences with oppression” “to communicate to their white counterparts matters that the whites are unlikely to know” (Delgado and Stefanic 2012, p. 10). Those acquainted with narrative theory and narrative ethics are aware that the use of storytelling can be just as challenging as it is powerful (See chapter 9). Nevertheless, CRT maintains that the use of stories can open others to realities they have not personally experienced, provide space for empathy, and constitutes an authentic source of knowledge production. Narrative resources serve both this constructive function and the important deconstructive function of challenging or displacing deeply embedded dominant narratives containing prejudices that marginalize or conceal the humanity of nondominant groups and individuals (Delgado and Stefanic 2012, p. 48).

<C>Critical Race Theory’s Contributions to Standpoint Theory in Bioethics

CRT has been used in some contexts to address particular bioethical issues, e.g., in medical education to advance to advance health equity (Tsai, Lindo, and Bridges 2021), health research (Ford and Airhihenbuwa 2010), and clinical ethics consultation (Fassiner et al. 2024). Three conceptual implications of CRT make it an especially valuable method in bioethics.

First, CRT provides a conceptual frame for contextualizing the significant health and healthcare disparities between racial minorities and their counterparts at the population level. Generally speaking, compared to White Americans, racial and ethnic minorities face more significant challenges accessing healthcare, experience a lower quality of service, receive basic medical procedures at a lower rate, have poorer health outcomes, and have shorter life expectancies (Crossley 2022; Ndugga, Hill, and Artiga 2024). Sources of these disparities are found at all levels of the healthcare system. Moreover, the field of public health identifies health as a social phenomenon affected by factors such as education, transportation, housing, proximity to pollution, and access to medical care, technology, and recreation (Valles 2018). Work in the field is increasingly drawing attention farther upstream to the drivers of the social conditions that impact health; for example, environmental racism influences proximity to pollution, which in turn affects health and results in health disparities (Smith and Sonke 2023, p. S100). CRT provides conceptual tools to understand how racism is connected to social and political determinants of health, contributes to health and healthcare disparities, and is itself a public health problem.

Second, CRT can illuminate deep bioethical concerns regarding racialized medicine, such as the use of race-based algorithms that attempt to correct for observed differences among members of different racial groups (Vyas, Eisenstein, and Jones 2021). In the case of preoperative risk assessments for cardiac surgery, empirical data show that Black patients have a higher risk of complications and death after surgery. These data inform preoperative risk calculators. As a consequence, Black patients are often judged as too high-risk for a potentially beneficial surgery and are less likely to receive the procedure. At issue is whether racial correlations in clinical outcomes necessitate inclusion of race in diagnostic and predictive tools. Incorporating adjustments for race in these tools assumes—and reinforces—that there are clear differences between groups of patients who are grouped by applying the construct of race. Beyond being scientifically unsound, such an approach distracts from clinical and epidemiological consideration of other factors like racism, other health conditions, and socioeconomic status. In this way, racialized medicine may deepen rather than improve health disparities.

Third, in clinical encounters and more broadly in healthcare, CRT provides conceptual resources to detect different types of epistemic injustices—wrongs done to people in their capacity as knowers. *Testimonial injustice* occurs when "prejudice causes a hearer to give a lower level of credibility to a speaker's word" (Fricker 2007, p. 1). *Hermeneutical injustice* refers to a "gap in collective interpretive resources [that] puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (Fricker 2007, p. 1) as well as to "the overabundance of distorting and oppressive concepts which function to crowd-out, defeat, or pre-empt the application of a more accurate hermeneutical resource" (Falbo 2022, p. 344). *Contributory injustice* is "caused by an epistemic agent's situated ignorance, in the form of willful hermeneutical ignorance, in maintaining and utilizing structurally prejudiced hermeneutical resources that result in epistemic harm to the epistemic agency of a knower" (2012, p. 31). By "willfully refusing to recognize or acquire requisite alternative hermeneutical resources" that would better situate the claims of a knower, one contributes to epistemic injustice with regard to that knower (Dotson, 2012, p. 32).

CRT provides a means to identify and address epistemic injustices arising from the racial prejudices, stereotypes, and biases that infect healthcare as a microcosm of broader US society. For example, CRT can inform analysis of the experience of Dr. Susan Moore, a Black woman and physician who was hospitalized with COVID-19 (Eligon 2020). From her hospital bed, she posted a video describing her racist treatment by healthcare providers that resulted in her continued pain and further deterioration. She eventually died. Her concerns and descriptions of her subjective experience of COVID-19 were not taken seriously, a testimonial injustice. Overcoming this type of epistemic injustice requires the practice of epistemic humility: dominant listeners must become aware of how prejudice affects their judgment of the testimony of differently situated individuals.

Though her video demonstrated that Dr. Moore had clear understanding of how racism affected her (lack of) treatment—i.e., she had no lack of hermeneutical resources to make sense of her situation—it is possible to understand the unjust treatment she received as resulting from contributory injustice—namely, "willful hermeneutical ignorance," whereby "the dominantly situated [healthcare providers] refuse[d] to adopt the hermeneutical resources of those from marginalized groups and instead use[d] other, often prejudiced, resources instead" (Falbo 2022, 345). In addition to filling gaps in hermeneutical resources needed to make sense of social experience, what is "equally (if not more) important [to address hermeneutical and contributory injustice] is unlearning and dislodging the distorting ideological grip of controlling images and oppressive concepts that are operative within one's [dominant] social milieu" (Falbo 2022, p. 357). Thus, "combating hermeneutical injustice demands collective social movements aimed at disrupting and reforming dominant conceptual frameworks and social scripts" (Falbo 2022, p. 357).

By employing insights provided by CRT, bioethics may serve as such a social movement to raise consciousness concerning how the history of racialization has formed the collective social imagination, including in health-related domains. In the minds of Dr. Moore's caregivers, distorted, prejudiced views of Black patients (e.g., as drug-seeking, as inaccurately reporting their pain levels, or simply as less deserving of resources than White patients) crowded-out both Dr. Moore's reported self-knowledge as a patient and her professional knowledge as a physician. Racist and ableist assumptions led to this "hermeneutical clash" between the caregivers' concept of a knowledgeable, fellow healthcare professional and their concept of a Black patient seeking treatment for pain and underlying disease (Falbo 2022, p. 349). Bioethical analysis that employs CRT can facilitate development of the critical consciousness necessary to transform perspectival knowledge into an epistemologically privileged standpoint. Further, bioethics can champion adoption of epistemologically privileged standpoints to challenge the uncritical partiality of dominant perspectives, including those of healthcare providers and institutions.

By fostering development of an *intersectional* critical consciousness, bioethics can mitigate omissions resulting from feminist bioethics' preoccupation with gender and sexism. Employing CRT in this way demonstrates how the method of standpoint theory may take account of people's multiple identities, positionalities, and lived experiences, including, as we will now discuss, experiences of disability. Though their connection may be underappreciated because of differences in language and approach between Black disability politics and White disability rights movements (Schalk 2022), racism and ableism, they have identified sources of medical errors and poorer health outcomes (Crossley 2022, Peña-Guzmán and Reynolds 2019), as well as material and epistemic injustices.

<B>Disability Studies' Contributions to Bioethics

Originating in the early 1980s, disability studies is today a multidisciplinary and interdisciplinary field involving researchers from nearly every discipline across the humanities and social sciences (Davis 2017; Reynolds and Wieseler 2022). While disability and disabled people have been taken as objects of study for far longer, the field of disability studies is distinguished by two methodological features: (1) a critical understanding of disability and (2) centering of testimony and data concerning the lived experience of disabled people.

To appreciate the import of (1) and (2), consider this case. A person in their mid-40s wishes to attend a local theater production. The would-be theatergoer uses a wheelchair for mobility and upon following Google Maps, encounters a long flight of stairs at the foot of the building. It seems to be the only way to enter. Someone who is ambulatory views this individual's situation from across the way and interprets it as ill-fated: in the observer's mind there is unfortunately something *wrong* with the individual's body, mind, or both such that they are disabled and must use a wheelchair. But, the would-be theatergoer, sees it quite differently. They express frustration and anger not at their body or mind, but at the way these stairs (and thereby this building) exclude them. There are plenty of ways to design a space to get humans from point A to point B over an incline that allow mobility devices of all sorts to make the trek. Instead of including people who do not ambulate, those involved in the planning, design, and construction of those stairs *chose* to exclude the non-ambulatory.

While it appears simple, this shift in perspective—from disability as something wrong with an individual to disability as a question of fit or misfit with the human world—is monumental (Scully 2008; Garland-Thomson 2011). It marks the first step on the path to critical consciousness concerning the meaning of disability. In the literature, this shift is described in terms of a distinction between the medical versus social models of disability. The ambulatory bystander invokes a *medical model* of disability: disability understood as an individual tragedy or misfortune due to genetic or environmental insult. The disabled wheelchair user instead invokes a *social model* of disability: disability understood as a result of misfit created by an inaccessible world, a world that is stigmatizing and discriminatory towards people with impairments, and so on (Reynolds 2022). What links (1) and (2)—i.e., what links a critical understanding of disability with centering of the testimony and data concerning disabled people's lived experience—is the fact that disabled people have long pointed out that their experience of the world does not comport with how able-bodied people describe or interpret being disabled. On the contrary, able-bodied people have historically not only been wrong about disability but have also been wrong in ways that negatively impact—even fatally impact—disabled people's lives.

What explains this? And what are these data supporting the accounts of disabled people regarding the quality and character of their own lives? Around the 1980s, social scientists took the question of quality of life seriously as an important, if not central measure in discussions of everything from individualized clinical care to global development (cf. Nussbaum and Sen 1993). Disabled people were among the populations studied, and the findings were routinely surprising. Researchers expected disabled people to report lower quality of life given their "objectively" worse health and functional and social status. Yet, with few exceptions, study after study showed disabled people reporting similar levels of quality of life as those without disabilities. This unexpected finding was sufficiently well-known by the late 1990s to get its own nickname: *the disability paradox* (Albrecht and Devlieger 1999).

To fully appreciate this finding, one must start by realizing that then, just as today, most researchers were able-bodied people using a medical model framework to understand disability. This explains why they didn't see any issue contrasting what was supposedly "objectively" true about disabled people with what disabled people merely "subjectively" reported. On a medical model of disability, disability is a natural feature of the world best described by tools in the natural sciences. Just as we know what water is thanks to organic chemistry, we know what disability is thanks to modern medicine. But upon just a bit of reflection, that view proves false. Disability is a thoroughly social phenomenon. It is every bit as social as gender, race, and other concepts shot through with power relations and the ever-dynamic mess of human norms, habits, and institutions. Research in philosophy of disability has repeatedly shown that while a given individual's body and mind of course play a role, the lived experience of disability is fundamentally relational, contextual, and political (Barnes 2016; Howard and Aas 2018; Reynolds 2016; Reynolds 2022; Wieseler 2023).

Another finding from research on the "disability paradox" and wider qualitative and quantitative studies on disability since the 1990s is that although disabled people *on the whole* live good lives, they face significant barriers because of inequitable and unjust social factors ranging from discrimination in employment and housing, to lower-quality or inaccessible education, to poverty-inducing restrictions on various social supports to barriers in accessing health care (Iezzoni and O'Day 2006). On September 26, 2023, the National Institute on Minority Health and Health Disparities, part of the US National Institutes of Health (NIH), designated disabled people as a health disparity population. This designation indicates federal recognition that an independent, partial cause of the health outcomes of disabled people is *not* due to their bodies or minds, but is instead due to unjust treatment both inside and outside of the clinic (Reynolds 2024). Expectedly, this explanation of the health disparities faced by disabled people was noted by disability activists and community organizers long before it was studied by social scientists or recognized by federal health bodies (Russell 1998). The experience of being disabled produces a standpoint with knowledge that is not readily available to those who are able-bodied—unless they make the effort to develop critical consciousness and achieve the privileged knowledge afforded by experience of disability (cf. Toole 2023).

A central takeaway of this chapter is that if one has not experienced what it is like to live in X way or with X identity, then one will lack relevant knowledge and understanding of X—unless, that is, one works to listen and learn and change one’s own ways of knowing and acting accordingly. What’s more, if X is stigmatized, one’s knowledge and understanding may be actively skewed towards inaccuracy. Many regularly misunderstand these points, especially when it comes to disability. On a medical model, disability is often assumed to simply be the *lack* of some ability: for example, on a medical model to be deaf means to be without hearing. So, someone who hears will assume that they know what it's like to be deaf: they just need to imagine what it would be like if they couldn’t hear. Or instead of imagining, they can just put in some heavy-duty earplugs and try to go about their day. But that’s not how things work. Deafness is *not* experienced as *not hearing*. The testimony and data from deaf people instead demonstrate a much more complex picture (Bauman and Murray 2014; Mauldin 2016).

Many of those who are born deaf and raised in signing communities experience deafness as *being able* to communicate with their friends, family, employees, and others—being able to do so through a shared language, whether American Sign Language, Spanish Sign Language, or some other signing language. From this fact it doesn't follow that if someone who is hearing woke up tomorrow deaf, they wouldn't experience it as a loss and would instead experience it as a gain. Whether and how they come to be a part of Deaf communities will depend upon a host of factors (Mauldin 2016; Kolb 2022). That's the point: in the same way that hearing people, merely by virtue of hearing, *don't know* what it's like to be deaf, able-bodied people, merely by virtue of being able-bodied, *don't know* what it's like to be disabled. Deafness, like all forms of disability, is highly contextual, and it is those with actual lived experience of a given disability who have knowledge, who are the experts, concerning what a given disability is like.

<A> Concluding Comments

Feminist thought, intersectionality, CRT, and disability studies each supply substantive insights to inform development of the critical consciousness requisite to transform perspectival knowledge into an epistemically privileged standpoint, a consciousness essential to bioethical inquiry. While none is a monolithic theory or approach, each has core concepts and tenets that their practitioners share. Moreover, they share some core commitments, such as an anti-essentialist stance and embrace of the social construction of key concepts they employ. Each is concerned with analyzing power relationships, though each focuses on a different axis of power: gender, race and disability. Each seeks to dismantle oppressive social hierarchies with the common goal of advancing social justice by empowering those occupying relatively disempowered social positionalities. Each seeks to achieve greater equity, justice, and improved material conditions for those positioned at the margins of power through epistemic, as well as ethical, political, and legal reform. By employing the methods of standpoint theory and embracing an intersectional analysis of interlocking systems of power, bioethics may achieve a more accurate, comprehensive, and nuanced understanding of the issues it analyzes and the human needs it aims to address. Though not the only systems of power that serve to marginalize those with relatively less power, gender, race and disability intersect in the lives of many who can contribute to bioethics' critically informed understanding and who stand to benefit from bioethics' advancement of health equity and social justice.

<A> Note

We thank H. Timothy Lovelace for helpful suggestions regarding the section on critical race theory.

<A> References

Albrecht, G. L., and P. J. Devlieger. 1999. "The Disability Paradox: High Quality of Life against All Odds." *Social Science & Medicine* 48, no. 8: 977–988. https://www.sciencedirect.com/science/article/abs/pii/S0277953698004110?via%3Dihub

Allen, A. 2022. "Feminist Perspectives on Power", *The Stanford Encyclopedia of Philosophy* edited by Edward N. Zalta and Uri Nodelman (Fall 2022 Edition). https://plato.stanford.edu/archives/fall2022/entries/feminist-power/

Aulette, J. R. 2017. *A Global View of Race And Racism*. New York: Oxford University Press.

Baptist, E. E. 2014. *The Half Has Never Been Told: Slavery and The Making of American Capitalism*. New York: Basic Books.

Barnes, E. 2016. *The Minority Body: A Theory of Disability*. New York: Oxford University Press.

Barr, D. A. 2019. *Health Disparities in The United States: Social Class, Race, Ethnicity, and the Social Determinants of Health*, Third Edition. Baltimore, MD: Johns Hopkins University Press.

Basile, V. and R. Black. 2019. "They hated me till I was one of the "good ones": Toward Understanding and Disrupting the Differential Racialization of Undergraduate African American STEM Majors." *The Journal of Negro Education*, 2019, Vol. 88, No. 3: 379-390.

Bauman, H. L. and J. J. Murray, eds. 2014. *Deaf Gain: Raising the Stakes for Human Diversity*. Minneapolis: University of Minnesota Press.

Bell, Jr., D. A. 1980. "Brown v. Board of Education and the Interest-Convergence Dilemma." *Harvard Law Review*, Jan., 1980, Vol. 93, No. 3 (Jan., 1980), 518-533.

Butler, J. 1999. *Gender Trouble: Feminism and the Subversion of Identity*. Oxford: Routledge.

Combahee River Collective. 1977. "A Black Feminist Statement." First printed in Eisenstein, Zillah R. 1978. *Capitalist Patriarchy and the Case for Socialist Feminism*. New York: Monthly Review Press.

Courtemanche, E. 2019. The Fourth and Fifth Waves. *Arcard: A Digital Salon.* January 8, 2019. https://shc.stanford.edu/arcade/interventions/fourth-and-fifth-waves

Crasnow, S. 2008. "Feminist Philosophy of Science: 'Standpoint' and Knowledge." *Science & Education* 17, no. 10: 1089–1110. https://doi.org/10.1007/s11191-006-9069-z

Crenshaw, K. 1989. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." *University of Chicago Legal Forum*: Vol. 1989, no. 1: 139-167. http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Crossley, M. 2022. *Embodied Injustice: Race, Disability, and Health*. Cambridge University Press.

Crozier-De Rosa, S. 2024. What are the four waves of feminism? And what comes next? *The Conversation.* March 7, 2024. https://theconversation.com/what-are-the-four-waves-of-feminism-and-what-comes-next-224153

Davis, L. J. 2017. *The Disability Studies Reader*. 5th edition. New York: Routledge.

DeBruin, D.A. 1994. “Justice and the Inclusion of Women in Clinical Studies: An Argument for Further Reform.” *Kennedy Institute of Ethics Journal* 4, no. 2 (June): 117–46. https://doi.org/10.1353/ken.0.0110

Delgado, R. and J. Stefanic. 2012. *Critical Race Theory*: *An Introduction*. New York: New York University Press.

Dembroff, R. 2019. “Beyond Binary: Genderqueer as Critical Gender Kind.” *Philosopher’s Imprint.* https://philsci-archive.pitt.edu/id/eprint/16317

Desmond, M. and M. Emirbayer. 2016. *Race in America*. New York: W. W. Norton & Company.

Dotson, K. 2012. “A Cautionary Tale: On Limiting Epistemic Oppression.” *Frontiers: A Journal of Women Studies* 33, no. 1: 24-47.

Dror, L. 2023. “Is There an Epistemic Advantage to Being Oppressed?” *Noûs (Bloomington, Indiana)* 57, no. 3: 618–40. https://doi.org/10.1111/nous.12424.

Eligon, J. 2020. “Black Doctor Dies of Covid-19 After Complaining of Racist Treatment.” *The New York Times.* December 23. Accessed June 30, 2024. https://www.nytimes.com/2020/12/23/us/susan-moore-black-doctor-indiana.html

Faden, R., N. Kass, and D. McGraw. 1996. “Women as Vessels and Vectors: Lessons from the HIV Epidemic.” In *Feminism and Bioethics: Beyond Reproduction* edited by Susan M. Wolf, 252-281. New York: Oxford University Press.

Faissner, M., L. Brünig, A. Gaillard, A. Jieman, J. Gather, and C. Hempeler. 2024. “Intersectionality as a Tool for Clinical Ethics Consultation in Mental Healthcare.” *Philosophy, Ethics, and Humanities in Medicine*, 19, no. 1: 6–6. https://doi.org/10.1186/s13010-024-00156-w

Falbo, A. 2022. “Hermeneutical Injustice: Distortion and Conceptual Aptness.” *Hypatia*, 37 (2): 343-363. https://doi.org/10.1017/hyp.2022.4

Ford, C.L., and C.O. Airhihenbuwa. 2010. “The public health critical race methodology: praxis for antiracism research.” *Social Science & Medicine (1982)* 71, no. 8: 1390-13988. doi:10.1016/j.socscimed.2010.07.030

Fricker, M. 2007. *Epistemic Injustice: Power and the Ethics of Knowing*. New York: Oxford University Press.

Garland-Thomson, R. 2011. “Misfits: A Feminist Materialist Disability Concept,” *Hypatia* 26, no. 3: 591–609, https://doi.org/10/ctsfpw.

Grady, C.. 2018. "The Waves of Feminism, and Why People Keep Fighting Over Them, Explained." Vox. July 20, 2019. https://www.vox.com/2018/3/20/16955588/feminism-waves-explained-first-second-third-fourth.

Hill Collins, P. 2000. "Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment." 2nd ed. New York: Routledge. https://doi.org/10.4324/9780203900055.

hooks, b. 1984. "Feminist Theory from Margin to Center." Boston, MA: South End Press.

———. 1990. "Yearning: Race, Gender and Cultural Politics." Boston: South End Press.

———. 1991. "Ain’t I a Woman: Black Women and Feminism." Boston, MA: South End Press.

Howard, D., and S. Aas. 2018. "On Valuing Impairment." Philosophical Studies 175 (5): 1113–1133.

Iezzoni, L.I., and B. O’Day. 2006. "More Than Ramps: A Guide to Improving Health Care Quality and Access for People with Disabilities." New York: Oxford University Press.

Intemann, K. 2010. "25 Years of Feminist Empiricism and Standpoint Theory: Where Are We Now?" Hypatia 25 (4): 778–96. https://doi.org/10.1111/j.1527-2001.2010.01138.x.

Jeong, T. 2024. "Epistemic Diversity and Epistemic Advantage: A Comparison of Two Causal Theories in Feminist Epistemology." Hypatia 39 (1): 97–117. https://doi.org/10.1017/hyp.2023.106.

Kolb, R. 2022. "How Masking Changed My Experience of Being Deaf." The Atlantic. https://www.theatlantic.com/ideas/archive/2022/09/covid-deaf-mask-lipreading-sign-language/671398/.

Krieger, N. 2021. "Ecosocial Theory, Embodied Truths, and the People's Health." New York: Oxford University Press. https://doi.org/10.1093/oso/9780197510728.001.0001.

Lewis, T.A. 2022. "Working Definition of Ableism - January 2022 Update." https://www.talilalewis.com/blog. Accessed July 8, 2024.

Longino, H.E. 1990. "Science as Social Knowledge: Values and Objectivity in Scientific Inquiry." Princeton: Princeton University Press.

———. 2002. "The Fate of Knowledge." Princeton: Princeton University Press.

MacKinnon, C.A. 2013. "Intersectionality as Method: A Note." Signs: Journal of Women in Culture and Society 38 (4): 1019–30. https://doi.org/10.1086/669570.

Mauldin, L. 2016. "Made to Hear: Cochlear Implants and Raising Deaf Children." Minneapolis: University of Minnesota Press.

Merton, V. 1996. "Ethical Obstacles to the Participation of Women in Biomedical Research." In "Feminism and Bioethics: Beyond Reproduction," edited by Susan M. Wolf, 216–251. New York: Oxford University Press.

Muhammad, K.G. 2019. "Preface." In "The Condemnation of Blackness: Race, Crime, and the Making of Modern Urban America." Cambridge: Harvard University Press, 2010.

Ndugga, N., L. Hill, and S. Artiga. 2024. "Key Data on Health and Health Care by Race and Ethnicity." Accessed at: https://www.kff.org/key-data-on-health-and-health-care-by-race-and-ethnicity/?entry=executive-summary-introduction.

Ney, A. 2014. "Metaphysics: An Introduction." New York: Routledge.

Nussbaum, M., and A. Sen, eds. 1993. "The Quality of Life." Oxford: Oxford University Press.

Peña-Guzmán, D.M., and J.M. Reynolds. 2019. "The Harm of Ableism: Medical Error and Epistemic Injustice." Kennedy Institute of Ethics Journal 29 (3): 205–242. https://doi.org/10.1353/ken.2019.0023.

Reynolds, J.M. 2016. "The Ableism of Quality of Life Judgments in Disorders of Consciousness: Who Bears Epistemic Responsibility?" AJOB Neuroscience 7 (1): 59–61. https://doi.org/10.1080/21507740.2016.1150911.

———. 2022. "The Life Worth Living: Disability, Pain, and Morality." Minneapolis: University of Minnesota Press.

———. 2024. "National Institutes of Health Designates Disabled People a Health Disparity Population." JAMA Health Forum 5 (6): e241185. https://doi.org/10.1001/jamahealthforum.2024.1185.

Reynolds, J.M., and C. Wieseler, eds. 2022. "The Disability Bioethics Reader." New York: Routledge.

Roberts, D.E. 1996. "Women as Vessels and Vectors: Lessons from the HIV Epidemic." In "Feminism and Bioethics: Beyond Reproduction," edited by Susan M. Wolf, 116–143. New York: Oxford University Press.

———. 2011. "Fatal Invention: How Science, Politics, and Big Business Re-Create Race in the Twenty-First Century." New York: The New Press.

———. 2017. "Killing the Black Body: Race, Reproduction, and the Meaning of Liberty." 2nd ed. New York: Vintage Books.

Russell, Ma. 1998. "Beyond Ramps: Disability at the End of the Social Contract." Monroe, ME: Common Courage Press.

Schalk, S. 2022. "Black Disability Politics." Durham: Duke University Press.

Scully, J.L. 2008. "Disability Bioethics: Moral Bodies, Moral Difference." Lanham, MA: Rowman & Littlefield Publishers.

———. 2023. "Feminist Bioethics." "The Stanford Encyclopedia of Philosophy," edited by Edward N. Zalta and Uri Nodelman. (Fall 2023 Edition). https://plato.stanford.edu/archives/fall2023/entries/feminist-bioethics.

Smith, P.T., and J.K. Sonke. 2023. "When Artists Go to Work: On the Ethics of Engaging the Arts in Public Health." Hastings Center Report 53 (5): S99–S104.

Toole, B. 2020. "Demarginalizing Standpoint Epistemology." Episteme 19 (1): 47–65. https://doi.org/10.1017/epi.2020.8.

———. 2023. "Standpoint Epistemology and Epistemic Peerhood: A Defense of Epistemic Privilege." Journal of the American Philosophical Association: 1–18. https://doi.org/10.1017/apa.2023.6.

Tsai J, E. Lindo, and K. Bridges. 2021. "Seeing the Window, Finding the Spider: Applying Critical Race Theory to Medical Education to Make Up Where Biomedical Models and Social Determinants of Health Curricula Fall Short." Frontiers in Public Health 9:1-10.

Valdez, R.S., and B.K. Swenor. 2023. "Structural Ableism—Essential Steps for Abolishing Disability Injustice." The New England Journal of Medicine 388, no 20:1827-1829. doi:10.1056/NEJMp2302561.

Valles, S. 2018. "Philosophy of Population Health: Philosophy for a New Public Health Era." New York: Routledge.

Vyas, D.A., L.G. Eisenstein, and D.S. Jones. 2020. "Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms." The New England Journal of Medicine, 383, no. 9: 874-882. doi: 10.1056/NEJMms2004740.

Walker, A. 1983. "In Search of Our Mothers' Gardens: Womanist Prose." San Diego: Harcourt Brace Jovanovich.

Wieseler, C. 2023. "The Import of Critical Phenomenology for Theorizing Disability." The Journal of Philosophy of Disability 3: 116-146. doi:10.5840/jpd2023102324.