

**S/A 4071: Social/Cultural Aspects of Health and Illness:**  
**Class 25: The Medical Care System: Critical Issues 2**

\* Today we look at the critical issue of sexism in medicine. We review:

- (1) the relevant parts of chapter 13
- (2) Findlay & Miller's article on medicalizing women's bodies/lives
- (3) the Courtenay article on masculinity & men's health

**(1) Clarke: Sexism in Medicine:**

\* While both women & men have historically been healers (e.g. ancient times, the early Middle Ages), the drive toward professionalization served to largely exclude women from medicine

\* England in the 15-16th centuries prohibited "undesirable & uneducated" people from medical work (largely women)

\* Midwives were persecuted by the Catholic church as witches from the mid 1400's - mid 1700's

\* Mid-19th century: women began being admitted to medical schools in North America (1895 in Canada)

\* Today sexism & patriarchy still prevail in medicine & medical institutions today: the higher the prestige & power, the fewer females (e.g. doctors vs. nurses, administrators & service staff)

\* Yet, since the late 1960's, women have gone from a small minority of medical students to the majority (but at same time doctors have lost some status compared to other workers in health care field)

- \* In medicine, women still predominate in “female” specialty areas with lowest pay & prestige (pediatrics, family medicine, gynecology)
- \* Women doctors under-represented in upper echelons of medicine, and have lower average salaries than men. Nurses fare much worse, & same differentials occur within other health care specialties
- \* Women often subject to sexual harassment (e.g. colleagues, patients)
- \* Nursing is largely a female job ghetto, & male nurses have the edge on the powerful administrative positions
- \* Nurses comprise about 4.5 times the number of doctors, but only half as much money is spent on them
- \* Explanations: male as breadwinner  
women as “reserve army” of labor
- \* New focus on women’s health: male body traditionally seen as the norm in medical research: lack of focus on women has left gaps in knowledge. Must be redressed in research & practice
- \* Feminist focus on women as informal “hidden healers” in the home/ outside of medical sphere. Concern that increasing chronic conditions/ move to home care will overburden women/ prevent outside work
- \* Medicalization of women’s lives: every stage of women’s lives have become subject to medical scrutiny & intervention (e.g. puberty, childbirth, menstrual periods, birth control, menopause, etc)
- \* Women’s emotions are frequently medicalized, not seen as the result of an unequal, stressful society, but as something “all in their heads” which pills can be prescribed for

- \* Historical example of “hysteria” in 19<sup>th</sup> century, fed by patriarchal ideas about good vs. bad women, the predominance of the reproductive system in women’s “energy system”, & reinforced by the patent medicine industry, surgical removal of the ovaries, & the “rest cure”
- \* Simultaneously, working class women expected to work very hard
- \* Today we can see parallels in the ways that women predominantly receive psychotherapy, tranquilizers & anti-depressants to help manage feelings of stress, anxiety, & help them cope with life in a sexist society
- \* Gynecological surgery today still male-dominated, bureaucratic, & overused (e.g. hysterectomies, D & C’s) Follows decline in birth rate & specialists, working fee for service, “need something to do.” Aided by broad definitions of “diseased womb” & fact that drug companies can profitably synthesize replacement hormones
- \* Explanations for medicalization of women: doctors & certain women patients “marketing” certain types of diseases to serve each others’ short term needs (e.g. pain relief). However, the cost to women is power & knowledge. Selective demedicalization would help in routine areas
- \* Doctors becoming aware of these issues, but much remains to be done

## **(2) Findlay & Miller:**

### **The Medicalization of Women’s Bodies & Women’s Lives:**

- \* Medicalization = process whereby an activity/condition becomes defined as an illness & is moved into the sphere of medical control
- \* Hand in hand with the advance of medicalization was the fact that healing gradually became dominated by men:

- the male body became the norm (androcentric biases)
- “men’s work” pushed aside women healers & medicalized things like childbirth
- professionalization added to this (monopoly, maintaining demand, links to science)
- continuing attempts to ward off competition & extend medicalization into new areas: more often women’s ones
- resulted in a real reduction in women’s control over own lives

\* Medicalization of mothering, child-rearing & childbirth:

- early medical promotion of full time mothering/ blaming the employed mother for “depriving” children of a normal upbringing: enforced by “horror stories” & (sometimes) removal of “at risk” children
- many women who work still sense the social implication of “bad mothering” lingering from this ideology (despite no evidence of its veracity)
- the issues of fertility, pregnancy, labor & childbirth gradually came to be controlled or reconstructed as medical issues/problems as the male medical profession pushed midwives aside
- partly driven by female demand for safe, pain-controlled births (given early mortality stats during childbirth)
- medicalization also increasingly prominent in prenatal period: pregnancy: focus on the fetus, technological interventions, all pregnancies as potentially pathological unless monitored, the discourse of “bonding” & “fetal rights”

\* The medicalization of women’s appearance:

- physical appearance & the shape of women’s bodies have increasingly come under medical control
- ideas about beauty, self & goodness closely intertwined

- emerging professional/business/state focus on overweight as unhealthy/unproductive
- once ideology internalized, we police ourselves - though proposals like health “report cards” reinforce
- women particularly at risk of anorexia due to self-monitoring, “body work,” & cultural standards of beauty/respectability
- aside from feeding the fitness, cosmetic, & diet industries, the medical profession may step in to deal with women who either “let themselves go” or “go too far” (e.g. plastic surgery & force feeding)
- feminists argue the problem is not in women’s bodies, but in the cultural, structural & institutional forces that create the demand to be thin

\* Anorexia as a “disease”:

- a women’s “disorder of the modern age”
- despite psychiatric explanations, linked to women’s contradictory social positions: (passive & competitive, producer vs. consumer, indulgence & denial, binging & purging)
- misguided attempts at control: “if not otherwise, I can control my body”
- medicalization looks for causes in individual, not social pressures

\* Ultimately:

- medicalization tends to individualize & depoliticize women’s problems/issues & focus attention inward/avoiding patriarchy
- it also props up dominant ideas about family
- However, women can use medical discourse to highlight previously invisible problems (e.g. abuse)
- Women can also use medical discourse to avoid moral responsibility for “the problem” (e.g. addiction)

\* Are there alternatives?

- new emphasis on alternative therapies
- self-help groups
- patients' rights movement
- however, no straightforward march to demedicalization: allopathic medicine still dominant & opposition split
- more likely that women will instead gradually achieve a greater consumer voice
- situation now like negotiation /ongoing struggle between groups

### **(3) Courtenay:**

#### **Constructions of Masculinity & their Influence on Men's Well-Being**

\* Men suffer more chronic conditions, have higher death rates for all 15 leading causes of death, & die nearly 7 years younger than women

\* This is linked to health-related beliefs & behaviors, interactive (& relatively risky) social practices that serve as a means of demonstrating femininities & masculinities/power & status

\* Research on "gender & health" largely hasn't included men as gendered beings: why don't men engage in more healthy behaviors?

\* Gender & its socialization is not static, but involve dynamic, continually reproduced, evolving structures in interaction

\* Nevertheless, gender stereotypes elicit high consensus & influence (especially among men). Actively reproduce them in things like language, sports, crime, sex, etc.

\* Health beliefs & behaviors may be understood as a set of strategies for negotiating the landscape, differentiating men/women from one another

\* Health behaviors often implicated in activities involving power & status (e.g. suppressing needs, refusing to admit/acknowledge pain, denying weakness or need for help, displaying aggression & physical dominance)

\* These not only enact & reinforce dominant stereotypes of masculinity, they lead to relatively risky/unhealthy behaviors (e.g. working when ill, boasting “I haven’t seen a doctor in years”)

\* Such behaviors also involve rejection of stereotypical female behaviors in relation to health (e.g. foregoing health care as a means of rejecting “girl stuff”)

\* Different men may act out their masculinities (& consequent health behaviors) in different ways depending on age, class, ethnicity & sexuality. Whatever the form, masculinity requires compulsive practice because it can be contested & undermined at any moment

\* Men also exercise varying degrees of power among themselves, reflected in dominant, marginalized, & alternative masculinities as well as their respective health practices (e.g. compulsive, oppositional, compensatory & protest masculinities & their manifestations)

\* Institutions populated by men provide opportunities to act out - & reinforce - both masculinities & their attendant risky health behaviors (e.g. dangerous work in the workplace)

\* Men-specific health issues may have been left out of the medical gaze as such until recently as “a body defined is a body controlled”

\* While women have traditionally been encouraged to seek health care, mens’ participation has been as powerful health-care providers

- \* Men also receive less information/advice than women during examinations
- \* Behavioral indices of health may even reflect female biases when applied to men
- \* The poor health beliefs & behaviors men use to demonstrate gender remain largely invisible, or are dismissed as “natural”
- \* Suicide is a good example: while much higher among men, seen as stereotypically female/ related to greater early (measured) incidence of female depression/ female willingness to seek help/male tendency to deal with themselves instead of admitting “failure”
- \* Ultimately: by enacting/reproducing culturally favored forms of masculinity to maintain self-conceptions of power & status relative to women, men engage in a variety of unhealthy behaviors resulting in higher disease & death rates. Patriarchy can negatively affect men too





