When Care Colludes: Nursing and Medical Misogyny

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Framing the Problem: Medical Misogyny and the Illusion of Reform

Systemic misogynistic beliefs and practices do more than harm women: they produce and sustain cultural conditions in which gender-based violence and abuse proliferate and become normalised. They devalue women and create environments where harm is tolerated, excused or rendered invisible. While many public institutions make visible commitments to achieving gender equality through policy statements, strategic frameworks and symbolic gestures, such rhetoric rarely translates into structural change. The result is a clear disjuncture between the language of equity and the persistence of inequity, where institutional commitments often work to obscure and even reinforce, rather than dismantle, entrenched power relations.

Gendered inequities remain deeply embedded in healthcare, where disparities in leadership, access, treatment, and outcomes continue to occur despite the language of reform (Smith & Sinkford, 2022; Lim, Benjasirisan, Tebay, et al., 2025). Even policy initiatives that claim to advance equity often reproduce the same gendered hierarchies they purport to challenge, meaning equity becomes little more than a rhetorical performance rather than a catalyst for real structural change.

Within healthcare, misogyny is not simply an abstract concept but is enacted through everyday institutional practices that shape how women's experiences are received, validated, or dismissed. Men can also face dismissal or neglect, but women's experiences are uniquely shaped by institutional and cultural regimes that systematically question their credibility. It is also important to recognise that not all men enact or perpetuate misogyny; indeed, many men openly reject misogyny and are valuable allies in resisting it. Similarly, some women can also act as agents in reproducing misogynistic discourses. Misogyny should not therefore be understood as a matter of individual prejudice, but as a powerful discourse that constructs norms, regulates behaviour, and secures patriarchal dominance.

In this commentary, we interrogate misogyny as a structural and cultural force that constrains women's lives and speech. We use the term 'medical misogyny' to describe the systemic reproduction of practices that delegitimise women's symptoms, shape diagnostic trajectories, and determine the credibility afforded to women's accounts of their own bodies. Framing medical misogyny as systemic discourse exposes its role in reproducing gendered hierarchies at the clinical, educational and policy levels. For nursing, this recognition brings ethical and political responsibilities: not only to name misogyny, but to resist complicity, and to collectively advocate for more equitable and accountable practices of care.

Unpacking misogyny

Misogyny functions as a regulatory system within patriarchal social orders that polices women's speech, credibility and conduct (Manne 2017). As a normalised and taken-for-granted force, it structures everyday life and constrains women's actions and speech. Misogyny is closely connected to, but distinct from, sexism. Sexism operates through assumptions that naturalise and affirm male dominance and female subordination. Together, sexism and misogyny function as integral components of patriarchy, helping to reproduce and legitimise its power relations (Savigny, 2020). Women routinely encounter antagonistic behaviours simply by existing within social and institutional orders organised through patriarchal norms. Hostility is often directed at women perceived to deviate from patriarchal ideals of femininity. Challenging sexist attitudes

and behaviours can be difficult (Ayers, Friedman & Leaper, 2009), because these institutionalised forms of hostility extend beyond individual prejudice and instead sustain systems where women are disciplined, regulated, marginalised, controlled, or vilified. Across these interpersonal, organisational and professional layers, misogyny operates as a regulatory force that reasserts patriarchal authority and polices the boundaries of acceptable womanhood.

While misogyny is a global phenomenon that structures the lives of women, its manifestations are neither uniform nor evenly distributed. The intensity, visibility, and form of misogynistic practices are shaped by intersecting systems of power, including geography, race, class, culture, and religion. Women positioned at the margins through colonial, racialised, classed or heteronormative hierarchies may experience overt violence, exclusion, and systemic neglect. Ostensibly egalitarian contexts are not exempt; in these settings, misogyny is rearticulated in subtle but no less powerful interactions, professional hierarchies, structural inequalities, and cultural stereotypes. What unites these diverse expressions is that they are all organised through patriarchal regimes of power that regulate women's behaviour and reinforce subordination. Misogyny thus functions as a pervasive regulatory force, simultaneously local and global, shaping women's lives in uneven and intersectional ways.

Misogyny as discourse

Understanding misogyny as a discourse recognises its operation beyond individual prejudice or hostility. Discourses shape what can be said, what is considered legitimate, who is authorised to speak, under what conditions, and what is suppressed or deemed inappropriate. In this sense, misogyny circulates through language, institutions, and cultural norms, normalising the idea that women's roles are secondary, their credibility questionable, and their needs optional or negotiable. When women resist these positions, the discourse of misogyny acts to discipline them, labelling their objections as irrational, their anger as dangerous, or their boundaries as selfish. Thus, misogyny does not only describe behaviour, it actively structures the conditions under which women must live and act and determines the penalties for deviation.

Viewing misogyny discursively also highlights the productive nature of discourse as a social practice, where conformity is rewarded and resistance is sanctioned. Through everyday talk, policy documents, media narratives, and professional practices, misogyny is embedded in cultural understandings of what it means to be a woman. This makes it difficult to challenge, because its power lies in its apparent normality. Treating misogyny as a discourse, rather than isolated, individual acts, reveals how it sustains patriarchal authority at multiple levels, from interpersonal relations to institutional structures, including health care settings where neutrality is assumed but gender hierarchies are reproduced. This demonstrates that resistance requires collective strategies rather than simply individual goodwill**.**

The risks of naming misogyny in professional spaces

Women in workplaces encounter sexism and misogyny in multiple forms, from unrecognised labour and barriers to advancement through to exclusion, unequal treatment, and harassment. However, naming these experiences remains fraught, as organisational cultures frequently minimise, deflect, or discipline those who speak out (Vachhani & Pullen, 2019). This silencing leaves many women unable to safely articulate the realities of patriarchal power while continuing to navigate its consequences. In this way, misogyny functions not only through harm, but through controlling the very language available to describe that harm.

In reality, engaging with gender is inherently political, as gender itself is a site where power is organised, contested, and enforced (Vachhani & Pullen, 2019). The feminist maxim that *the personal is political* reminds us that everyday experiences of gender are never neutral but are produced within broader systems of power. When women name misogyny and speak to its damaging effects, the response is frequently one of hostility and dismissal. Such reactions are not incidental; they operate as regulatory techniques designed to contain dissent and protect institutional authority. They reveal both an institutional discomfort with confronting patriarchy and an active investment in preserving the status quo by casting those who challenge it as problematic, disruptive or professionally inappropriate.

A common rhetorical strategy in this backlash is the deflection that "men also face challenges," (Bradbury-Jones & Keeling 2020) which shifts attention away from structural gendered power relations and reframes misogyny as a matter of individual grievance rather than systemic harm. Similarly, while concerns about referencing gender binaries are valid in many other contexts, in this context, such claims may be mobilised to silence discussion. In this way, even progressive-sounding critiques can function discursively to delegitimise women's testimony, pre-empt discussion of misogyny, and neutralise resistance to patriarchal authority under the guise of inclusivity or neutrality. Here, the institutional language of neutrality and inclusivity does not create space for feminist critique but actively contains it, adopting its vocabulary while inhibiting its political force.

Women scholars and researchers who speak about gender-related issues do so at personal and professional risk (Bradbury-Jones & Keeling 2020). This reflects a broader pattern in which women's scholarship on gender is positioned as exclusionary or biased, despite its clear grounding in evidence and theory. Such responses function to delegitimise the voices of women researchers and to warn others against adopting similar positions. In the context of domestic violence (DV), the effect is to deflect attention from the substantive problem, thereby impeding the collective effort required to strengthen evidence, improve services, and reduce the harm associated with DV (Bradbury-Jones & Keeling, 2020). In this sense, misogyny acts not only on those experiencing this form of harm, but also on those who produce knowledge about it.

Medical misogyny as structural practice

Having established misogyny as a discursive force that regulates credibility and speech, it is necessary to consider how these dynamics materialise in clinical practice and shape women's encounters with healthcare systems. Medical misogyny manifests as the systemic dismissal, devaluation, and neglect of women's health concerns within medical systems (Iacobucci, 2024). This includes attributing complex conditions to stress or hormonal fluctuation, minimising or psychologising symptoms, and inadequate investigation of and dismissal of pain. These dynamics delay accurate diagnosis and treatment, foster self-doubt, and weaken trust in health services. For women, especially those navigating additional layers of marginalisation, the cumulative effect of these interactions can be both physically and psychologically harmful, reflecting the deep entanglement of gender bias and structural inequity within healthcare practice (Dhillon, 2025).

Medical misogyny also operates epistemically, undermining women's knowledge of their own bodies. It is evident in the diagnostic delays for conditions like endometriosis (Breton et al., 2025), and in the crisis of maternal mortality, especially among minority women, such as women from Black and Indigenous communities (Dhillon, 2025). Here, healthcare does not simply fail women; it actively reproduces conditions of vulnerability and mistrust. A recent

parliamentary investigation in the United Kingdom found that medical professionals frequently downplay or overlook women's symptoms when they seek care for reproductive health issues (Iacobucci, 2024).

Misogyny, nursing and the limits of gender-responsive practice

Misogyny manifests in everyday practices and structures that sustain subordination. In healthcare, this includes contempt, dismissal, and disbelief towards women's concerns, delaying care, and reinforcing dynamics of power, control, and silencing. Nursing does not stand outside these dynamics; it operates within them. As the largest health profession, nursing has a unique responsibility and opportunity to address misogyny in healthcare practice. Nurses are often the first point of contact, positioned with the potential to validate and advocate for women. Yet, nursing itself is disciplined by the same patriarchal logics that shape medicine. Nurses, too, are educated, regulated and appraised within systems that reward compliance and discourage critique, raising questions about whether nursing is prepared to act against medical misogyny.

The history of nursing has been shaped by gendered, racialised, and class-based hierarchies, sustained through traditionalism that reinforces gender stereotypes. Effectively challenging medical misogyny requires a critical examination of nursing education, clinical guidelines, and institutional policies. It also demands an intersectional approach that acknowledges how race, class, disability, sexuality, and gender identity compound the effects of misogyny in care. Strong nurse leaders are needed across health, education and policy to advance rights, priorities, and leadership development (Smith & Sinkford, 2022). However, calls for 'inclusivity and gender-responsive care' risk becoming little more than symbolic if they do not disrupt the discursive and structural forces that render women's health concerns as secondary.

Traditional nursing and medical education can reproduce inequalities when equity is treated as optional rather than structural. Medical knowledge and training have historically centred the male body as the default clinical template, positioning women's bodies as deviations from that male norm. This is evident in the design of diagnostic tools and training equipment, such as cardiac assessment, cardiopulmonary resuscitation mannequins and personal protective equipment (Herrero-Izquierdo et al., 2025; Chopra et al., 2021; Khairul Hasni, Ismail, Muhamad Robat, 2023). Such designs are not neutral; they reproduce a patriarchal clinical order in which women's bodies are treated as deviations rather than standard.

A claim to gender-responsiveness is often positioned as a solution to these issues. However, without a concurrent disruption of the misogynistic assumptions embedded in clinical knowledge, such approaches risk becoming superficial and procedural rather than transformative. To meaningfully challenge medical misogyny, nursing education must go beyond content inclusion to acknowledge and address how clinical authority is calibrated against women's accounts of their own bodies. Gender-responsive practice then becomes not a checklist, but an act of resistance, it means listening, believing women when they say something is wrong, and refusing the urge to psychologise when physical causes are unclear. Such practices are not only clinical but also political, as they require nurses to navigate and sometimes contradict institutional expectations that reward neutrality over advocacy**.**

Conclusion: naming, resisting, and transforming

Misogyny in healthcare is not an unfortunate byproduct of poor bedside manner; it is a structural form of gender-based oppression that has consequences for women that include

material, clinical, and epistemic harm. To centre women as credible knowers of their own bodies is more than a gesture of empathy, it is a clinical and political refusal to collude with systemic and institutional oppression. To challenge these systems is to reject neutrality and advocate for accountability and structural redistribution of authority. Transformation will not come from curriculum reform or policy language alone. Gender-responsive care, without a deliberate disruption of misogynistic discourse, risks becoming another institutional gesture that leaves patriarchal structures intact. Nursing has a political responsibility to refuse systems that render women's experiences marginal, and to insist that women are taken seriously as authoritative subjects, whose voices are heard, believed and respected.

References

Bradbury-Jones, C. and Keeling, J. (2020), Can we stop the violence, please? Moving forward to address domestic violence. *Journal of Clinical Nursing*, *29 (*3-4). https://doi.org/10.1111/jocn.14985

Breton, Z., Gouesbet, S., Indersie, E., Gabillet, M., Tran, V.-T., Aflak, N., Borghese, B., Petit, E., Roman, H., Millepied, A.-C., Nève De Mevergnies, M., & Kvaskoff, M. (2025). Endometriosis diagnostic delay and its correlates: Results from the ComPaRe-Endometriosis cohort. *Journal of Women's Health, 34*(9). https://doi.org/10.1177/15409996251380129

Chopra, J., Abiakam, N., Kim, H., Metcalf, C., Worsley, P., & Cheong, Y. (2021). The influence of gender and ethnicity on facemasks and respiratory protective equipment fit: A systematic review and meta-analysis. *BMJ Global Health*, *6*(11), e005537. https://doi.org/10.1136/bmjgh-2021-005537

Dhillon, J.K. (2025). Psychological Effect of Medical Gaslighting on Female Patients: A Systematic Review. *International Journal of Innovative Science and Research Technology*, 10(6), 845-852. https://doi.org/10.38124/ijisrt/25jun646

Herrero-Izquierdo, L., Alconero-Camarero, A. R., Abajas-Bustillo, R., Sarabia-Cobo, C., & Ortego-Maté, C. (2025). Female anatomical manikins in basic life support training: A mixed methods study. *Nurse Education in Practice*, *88*, 104533. https://doi.org/10.1016/j.nepr.2025.104533

Iacobucci, G. (2024). "Medical misogyny" leaves many women in pain, MPs' inquiry finds. *British Medical Journal*, *387*, q2780. https://doi.org/10.1136/bmj.q2780

Khairul Hasni, N. A., Ismail, R., Muhamad Robat, R., Mohamad, N., Suib, F. A., Pahrol, M. A., ... & Shaharudin, R. (2023). The effect of N95 designs on respirator fit and its associations with gender and facial dimensions. *PLOS one*, *18*(11), e0288105. https://doi.org/10.1371/journal.pone.0288105

Lim, A., Benjasirisan, C., Tebay, J., Liu, X., Badawi, S., Himmelfarb, C.D., Davidson, P.M. and Koirala, B. (2025). Gender Differences in Disease Burden, Symptom Burden, and Quality of Life Among People Living With Heart Failure and Multimorbidity: Cross-Sectional Study. *Journal of Advanced Nursing*. *https://doi.org/10.1111/jan.16797*

Manne K. (2017). *Down girl: The logic of misogyny*, Oxford University Press. https://doi.org/10.1093/oso/9780190604981.001.0001

Savigny, H. (2020). Sexism and Misogyny. In The International Encyclopedia of Gender, Media, and Communication (eds K. Ross, I. Bachmann, V. Cardo, S. Moorti and M. Scarcelli). https://doi.org/10.1002/9781119429128.iegmc092

Smith, S. G., & Sinkford, J. C. (2022). Gender equality in the 21st century: Overcoming barriers to women's leadership in global health. *Journal of Dental Education*, *86*(9), 1144–1173. https://doi.org/10.1002/jdd.13059

Vachhani, S. J., & Pullen, A. (2019). Ethics, politics and feminist organizing: Writing feminist infrapolitics and affective solidarity into everyday sexism. *Human Relations, 72*(1), 23–47. https://doi.org/10.1177/00187267187809