Systems thinking in gender and medicine

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If there is a single thread running through this issue of the journal, it may be the complex interplay between the individual and the system(s) of which they are apart, highlighting a need for systems thinking in medical ethics and public health.^{1 2} Such thinking raises at least three sorts of questions in this context: normative questions about the locus of moral responsibility for change when a system is unjust; practical questions about how to change systems in a way that is morally appropriate without triggering unintended, potentially harmful side-effects; and epistemic questions about how to predict the multidimensional consequences of a proposed change or set of changes to an intricate social system such as healthcare.³ These questions crop up throughout the issue, as I will discuss, but my focus is the target article and linked commentaries on gender bias in the surgical profession.

Hutchison (*see pages 236–241*) conducted in-depth interviews with 46 Australian women surgeons and surgical trainees, taking care to avoid leading questions regarding gender bias or gendered mistreatment. Nevertheless, despite minimal prompting, at least four types of gender-related concerns were described by the surgeons, whether directly or indirectly:

1. **structural bias** in workplace factors, including insufficient (or stigmatised) parental leave for women, exclusion from men's spaces (eg, changing rooms) where informal training may occur, and a dearth of senior female role models;
2. **epistemic injustices** including unfair doubting of women's surgical competence or knowledge relative to men;
3. **stereotyped expectations** that women surgeons would or should shoulder the burden of medical carework, for example, by attending to patients' emotional needs; and
4. **objectification**, both by colleagues and patients, including sexual innuendo, remarks about clothing, and even outright sexual assault.

Each of these concerns is disturbing on its own, and yet they do not operate in isolation. Rather, they interact with each other, often in mutually reinforcing ways, and they may cause aggregate harms to women that are greater than the sum of

their parts. As Hutchison notes, addressing such harms thus requires (a) “understanding the functioning of the system” from which they emerge, (b) “making the harms and the way they aggregate visible,” and (c) “challenging expedient practices that support them.”

Hutchison's study makes a valuable contribution primarily to (b), while leaving (a) and (c) ripe for further discussion. How, then, should we make sense of the wider system from which the harms identified by Hutchison flow; and who is responsible for challenging the structures and practices that support those harms?

To answer these questions, we must first step back and acknowledge analogous biases and harms befalling women in other fields traditionally dominated by men—for example, academic philosophy.⁴ As McCleod notes in a linked commentary (*see pages 242–243*), “objectification of women or the assumption of credibility deficits among them” are not unique to the world of surgery; rather, they are “common to disciplines in which women are seriously underrepresented.” More broadly, they are a predictable consequence of any gendered system in which access to resources, positions of authority, and the concomitant power to shape norms and institutions are not distributed equally among stakeholders of different genders.⁵

The usual way of theorising such a situation is by appeal to patriarchy. On classic models, this refers to a gendered system of male dominance and female subordination, wherein gender is analysed in terms of binary, hierarchical, sex-based positioning in social or institutional space.⁶ Yet as Scully observes in another of the linked commentaries (*see pages 244–245*), “biases and epistemic injustices undoubtedly affect not just female surgeons, but minority and LGBT surgeons as well.” Of course, some racial/ethnic minority or LGBT surgeons are also female; some have non-binary gender identities, some are recently immigrated, some are dealing with physical or mental disabilities, and so on. The remark by Scully thus underscores the need for an intersectional analysis of gender (whether in the context of medicine or in any other domain). Classic models typically fail to achieve this.

In a forthcoming book, Dembroff seeks to rectify this problem by proposing a new, more sophisticated account of patriarchy that is intersectional to its core.⁶ Dembroff calls this account the Real Men view. In a nutshell, it holds that the defining feature of patriarchy is not male dominance and female subordination per se—although that is certainly part of the picture—but rather, the dominance of “real men” over everyone else. Here, “real men” refers to the group of persons taken to sufficiently exemplify the characteristics of “natural” manhood, as that concept applies in a given context.⁶ These characteristics thus include the cluster of physical traits typically considered to ground membership in the male biological sex category,⁷ but also the whole suite of biopsychosocial attributes that are prototypically “masculine” in the relevant culture.¹

A strength of this account is that it preserves the notion of male dominance—reflected in the “old boys club” quality of surgical culture noted by participants in Hutchison's study—without ignoring the ways in which patriarchal gender systems can confer structural disadvantages along numerous social-identity axes. Thus, on Dembroff's account, even males can be harmed by patriarchy, to the extent that they fail to qualify as “real men” according to the prevailing gender ideology.ⁱⁱ If that is right, the surgical culture described by Hutchison's participants might best be understood, not as an “old boys club,” but rather, as a “real men's club,” with various harms and biases befalling everyone who

ⁱFor my own take on a biopsychosocial understanding of gender, see the video “What is (your) gender? A friendly guide to the public debate,” <https://youtu.be/LZERzw9BGrs>.

ⁱⁱThus, in many cultures, adolescent boys—or older males who have not yet “proven” their manhood by, for example, undergoing a prescribed rite of passage¹¹—as well as gay men, trans men, men of color, disabled men, and others, may be disadvantaged as men within the logic of patriarchy, alongside women, non-binary people, and others who are “not real men.” For an important discussion of the need to study (at least) male and female aspects of a gender system holistically and together (ie, in relation to each other) in order to understand either aspect of the system, much less the system as a whole, see the essay by Merli¹².

does not fit the—presumably white, male, heterosexual, etc.—stereotype of a “proper” surgeon.⁸ Future research should consider this possibility.

Now to the question of responsibility. If we assume that Real Men patriarchy is at least one of the systems behind the harms, biases, and injustices identified by Hutchison, who is responsible for changing that system? Brennan (*see page 246*) argues that change must be sought and pursued at the level of the institution, as opposed to the level of individuals, advising against strategies that involve finger-pointing and blame—at least when it comes to unconscious biases and unintentional mistreatment. Brennan writes that blaming individuals in such cases “is unlikely to be effective even if one thinks it is warranted. It is certainly not the case that only male surgeons, staff and patients are to blame [for instance, as] research on implicit bias [indicates] that both men and women undervalue the work of women and overvalue the work of men.”

Brennan’s analysis seems right as far as it goes. But, as Brennan would no doubt agree, institutions do not reform themselves. Rather, individuals, both within and without unjust institutions, must work together to make concrete changes to relevant policies, while staying mindful of their individual-level moral responsibilities. And insofar as Real Men have disproportionate power and authority within an institution like surgery, they may have disproportionate responsibility to initiate changes at the institutional level—in collaboration with, and centering the perspectives of, those with less power—while also ensuring respectful, unbiased interactions with (inter alia) their female colleagues. As Gupta has argued in another context, addressing injustice is not an either-or proposition: individual-level and social-structural factors are often co-constitutive and synergistic.⁹ In other words, one can both lobby for systemic change where appropriate and take responsibility for one’s own behaviour.¹⁰

In their article on medical cannabis prescribing, Glickman and Sisti (*see pages 227–230*) make a similar point. Decrying

the current political situation in which medical cannabis policy is driven more by moralization and wishful thinking than by a sound appraisal of the evidence concerning benefits and risks of cannabis use, they are clear that systemic change is needed. For example, they suggest that the training pipeline needs to be reformed so that physicians receive an adequate (or indeed any) education about why and when to prescribe medical marijuana. But given the messy reality of politics coupled with institutional inertia, they argue that individual primary care providers now have a personal and professional obligation to “develop a level of clinical and ethical competency to enable them to recommend cannabis to their patients when it is indicated.”

Systems thinking is also evident in the papers by Winters *et al.* (*see pages 259–264*), Semrau (*see pages 269–270*), and Decullier and Maisonneuve (*see pages 255–258*). Niall *et al* defend prioritarian principles for digital healthcare in low-resource settings, arguing that certain structural inequalities speak against utilitarian health policy and in favour of prioritising the needs of the worst off. Semrau responds to critics of an earlier paper on kidney markets, distinguishing pressure to sell one’s kidney, specifically, from a more general pressure to make money, with kidney vending as one viable option. And Decullier and Maisonneuve focus on abuse of authorship criteria, citing researchers’ claim that the publish-or-perish system of academia leaves them with no choice but to accept gift authorships and even ghost authorships. Although detailed philosophical analysis of discrete, often stylized cases undoubtedly has an important role to play in medical ethics, it is encouraging to see so many authors taking a more holistic approach that positions actors, practices, and behaviours within the wider systems of which they are a part.

Speaking of which: I am proud to be one small actor within the wider medical ethics system (or rather, community), working with all of you to investigate, and hopefully shed light on, difficult moral questions in healthcare and beyond. The

Journal of Medical Ethics (JME) is a major institution within this community, and it gives me great pleasure to join the team of associate editors with this issue. In this role, I shall try to be sensitive to issues of power and justice within the journal itself, and to hold myself to a high moral standard when evaluating papers, recommending publication, and interacting with authors and others in the *JME* family. I look forward to working with you in the months and years to come.

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