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Otherization and Healthcare: A Philosophical Analysis of Gender-Based Discrimination in Medicine

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OTHERIZATION AND HEALTHCARE: A PHILOSOPHICAL ANALYSIS OF GENDER-BASED DISCRIMINATION IN MEDICINE

by

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ABSTRACT

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Healthcare interactions are a core feature of medical practice and medicine cannot function without these relationships. Moreover, the physician-patient relationship within healthcare have revealed varying problems that arise within the interpersonal interactions. These problems were even more concerning when they showed gender discrimination occurring within medical interactions, such as workplace discrimination of female physicians, higher risk of misdiagnosing and mortality of female patients, and an overall medical culture that invalidated women. Understanding the extent of these problems was achieved through analyzing philosophical structures presented within the philosophical writings of G. W. F. Hegel and Simone de Beauvoir. Application of Hegel's master-slave dialectic revealed how viewing individuals as an "other" can result in a concept known as otherization. Otherization was analyzed within healthcare through gender-based stereotyping and dehumanization of individuals. Simone de Beauvoir took this general concept of how individuals are viewed as the other and specifically analyzed the structure in relation to gender. This application was achieved through applying the master-slave dialectic idea to the dialectic occurring between men and women, with women taking up the placement of the other. Women's placement within this dialectical structure was an answer to the problems of gender discrimination occurring in healthcare.

Keywords: Otherization, Healthcare, Gender Discrimination, Hegel, Beauvoir

The members of the Honors Thesis Committee appointed

to examine the thesis of OTHERIZATION AND HEALTHCARE: A PHILOSOPHICAL ANALYSIS OF GENDER-BASED DISCRIMINATION IN MEDICINE

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INTRODUCTION

It is the goal of a physician to ensure the highest quality of care to their patient and to treat whatever ailment they are facing to the best of their ability. When this patient interacts with their physician, it is the physician's call on whether the symptoms call for additional testing or if they do not bode any dangerous value. This care is especially essential in cases where mortality could be a resulting outcome if care is not administered correctly. To stress this importance, take the instance of a woman experiencing symptoms of chest tightness, discomfort in the neck and jaw, and epigastric symptoms. Within this particular scenario, the woman's chest pain reaches a level that she believes it would be best to go to a physician to alleviate the pain and her anxiety that the pain could be caused by an underlying heart problem. Upon examination, the physician concludes that these symptoms are most likely linked to a potential underlying gastrointestinal or mental health condition instead of an ischemic – or heart – problem. In this instance, the woman was experiencing symptoms that indicate acute coronary syndrome – or heart attack – and her misdiagnosis is one that is all too common for women in healthcare (Lichtman et al., 2018; Antipolis, 2021; Maserejian et al., 2009; O'Connor, 2022). In all these studies, it was indicated that the misdiagnosing of women is not something that is an anomaly in the system; women experience far higher rates of misdiagnosing compared to men.

Now, let's consider another scenario that focuses on the results of a misdiagnosis. In this case, a woman in her late fifties comes to the hospital after experiencing intense chest pain and tightness with presentation of ST-segment elevation myocardial infarction

(STEMI). Similar to the first case study, the woman is misdiagnosed and does not receive a treatment for acute coronary syndrome. With not receiving the correct treatment, the condition worsens, and the woman readmits herself from the reoccurrence of pain. It is then the woman receives the correct treatment of reperfusion therapy for acute coronary syndrome. However, the delay in therapy is detrimental to the woman's heart and leads to the outcome of mortality. When taking this experience and applying it to the "16,000 U.S. women [who are] 55 or younger" who die each year and how these women account for "40,000 hospitalizations for acute MI annually" it raises the concern of how common this outcome is (Garcia et al., 2017; Vaccarino et al., 2009; Vaccarino et al., 1999). In the case that this woman didn't have the outcome of mortality, she still would have had a significantly higher incidence of stroke (Ferrante et al., 2011; Mrdovic et al., 2013; Benamer et al., 2011; Mehilli et al., 2002; Berger & Brown, 2006; Yu et al., 2015; Kosuge et al., 2006; Zhang et al., 2010) and significantly higher incidence of bleeding complications (Toyota et al., 2013; Birkemeyer et al., 2014) when compared to men in the same group. With this phenomenon for female patients obviously not being an enigma, it raises the question of why women are being misdiagnosed and experiencing higher mortality rates than men.

Furthermore, it isn't just female patients who are experiencing impacts of this unequal gender treatment, as female physicians have also shown reverberations of this gender-based unequal treatment in their own practice. In general, within the active physician workforce, roughly 37% of physicians are women and in certain fields – orthopedic surgery, interventional radiology, cardiology, etc. – women make up an even smaller percentage (Boyle, 2023; Eshtehardi et al., 2022; Murphy, 2023). In the best

attempt to explain how this gender imbalance impacts interrelationships of physicians, let's consider the relationship between a female cardiologist and her colleagues. With entering cardiology as a career, this female physician is already facing a unique experience that her male colleagues will not undergo. The female physician will experience a negative culture that has instilled an ideology that cardiology is not a well-suited career for a woman. Reasons for this thought stem from a view that the long duration for post graduate training results in a competition for this woman's "career and reproductive biology" paired with the lack of female role models within cardiology as it is a male-dominated field (Eshtehardi et al., 2022). After breaking the first barrier of entering the field and the stereotypes surrounding that action alone, the female physician will then experience another barrier including pay disparities between female and male cardiologists and heightened experiences of sex discrimination (Yong et al., 2019; Jagsi et al., 2016). This woman will also experience first-hand comments such as "women don't belong in the cath lab" or "you marry a wife; you call a doctor" (Graham & Kells, 2005).

This scenario I have presented showcasing the devaluation of women's abilities in comparison to their male counterpart is not just a plausible theory, but has been witnessed first-hand by Dr. Catherine Kells – an interventional cardiologist – when entering cardiology in 1984, by Dr. Michelle Graham – former chair of the Canadian Cardiovascular Society's Scientific Program Committee and cardiologist – in the 1990s, and by Dr. Sharonne Hayes – a cardiologist who founded the Mayo Women's Heart Clinic and Professor of Cardiovascular Medicine with over 25 years of experience – in the present day. The impact of this culture is best defined by Dr. Hayes when she

expressed how she felt "de-skilled" when presenting on women's heart disease to an audience of her male colleagues even when she is "the expert in the room" on the topic (Hayes et al., 2020). The experiences of these various female physicians are not uncommon and develops the question of what structure facilitated the differential treatment between male and female physicians.

These case studies exemplify a prevalent theme that gender discrimination or bias is prevalent within healthcare relationships and medical treatment. Some would view this theme to be a paradox with the strides that have been made within the 21st century United States, as legal protections for women's rights have been achieved and no reputable person would openly make the claim that men and women are due unequal healthcare access or treatment. However, I view that these daily occurrences for women in medicine is not a paradox and is something that has gone un-addressed within the strides to provide equal protections for women and men. It is the origin of this problematic theme that spurred the question of what structure cultivated the foundation for the development and persistence of gender discrimination in healthcare. This overarching question is the main priority to answer within this thesis, as understanding the structure of a problem can help to answer the specific questions relating to the case studies above. These questions include why do women fall through the cracks for cardiovascular disease more often than men, why is being female a variable for high risk of mortality or surgical complications, and why are women not viewed as capable and treated differently than their male colleagues? However, it is only by answering the main question of what structure creates the foundation for the development and persistence of gender discrimination in healthcare where any further answers can be found.

When reviewing literature on public health to discover an answer to this question, there was assumptions that these gender disparities are caused by internalized gender stereotypes and a lack of patient centered care for women (Travis et al., 2012; Gagliardi et al., 2019; Ramlakhan et al., 2019; Alcalde-Rubio, 2020). However, I believe that these assumptions are lacking the ability to see the broader structural problem that underlies the context of these everyday instances of gender discrimination occurring in medicine. Moreover, I will argue that this overarching question is best answered when approaching the problem with a philosophical perspective. In supporting this claim, I will propose that the gender discrimination within medicine follows a structure similar to a philosophical phenomenon of "othering" or "otherization," which is best understood through the application of the philosophical structure founded by Georg Wilhelm Friedrich Hegel. As separate as healthcare and philosophy from the 1800s may seem, Hegel's structure that defines how the Self and the Other develop provides keen insight into how discrimination, or bias, towards an individual or group could potentially be developed in real life. Furthermore, after examining Hegel's philosophical structure, I will provide an explanation of the parallels between the structure presented by Hegel to the structure presented by philosopher Simone de Beauvoir. Beauvoir transforms Hegel's master-slave dialectic into a structure focusing specifically on the interactions between man and woman, ultimately creating a new concept known as the man-woman dialectic. Beauvoir's explanation of the relationship between men and women provides insight into how gender discrimination can develop. Finally, understanding how these structures develop and ingrain themselves into our day-to-day interactions can provide the answers needed for why the problems of gender discrimination in healthcare exist. Through

knowing the foundational structure that gender discrimination can take, it provides insight into how this problem can appear within healthcare, specifically within patient-physician or physician-physician relationships.

CHAPTER ONE

Theory of Otherization

Philosophical Foundations of "Othering"

When taking on the goal of finding the foundational structure that aids in the development of gender discrimination in healthcare, my initial thought was how a structure first becomes incorporated into society. It became apparent to me when thinking of how structures, like gender discrimination, begin that the structures themselves are inherently social and theoretical concepts that only begin to take on a physical form when individuals start to act on them. It is this thought that changed my perspective of a seemingly practical and medical oriented question into one that can be analyzed from a theoretical and humanistic perspective. It is from here where the philosophical phenomenon of otherization began to prove fruitful in answering the question posed by this thesis. Otherization is a topic that has taken the interest of many disciplines but has always been explained within a humanistic analysis. In anthropology, otherization is a term that refers to "the use of language to dehumanize a group seen as Other, whom it is then easier to persecute, kill, and attempt to exterminate" (Arendt, 1951; Kosicki, 2007). In sociology, otherization is a phenomenon of labeling certain individuals or groups into a category deemed as not fitting societal norms, and this placement attributes negative characteristics to the out-group. This concept can be seen as an "us vs. them" mindset between social groups and can have ramifications for the other group experiencing intolerance and exclusion in society (Cherry, 2023). Each explanation provides a potential answer for how a structure of thought towards a group

can develop devastating physical problems for the group, such as gender discrimination. However, I believe the philosophical writings of G.W. F. Hegel in the 1800s provide an illuminating explanation of the structure of otherization and how it could develop the problems outlined within the introduction of this thesis.

Although Hegel never specifically mentions the word otherization in his writings, he writes extensively on the idea of a group seen as the other. In this thesis, I take the terms "otherization" and "to other" as verbs to denote the action of perceiving and treating an individual poorly because they are deemed as separate and different than the perceiver. This concept can be drawn from Beauvoir and from Hegel in their writings, however the etymology of the word is complicated to trace across Hegel's German to Beauvoir's French and to then compose it into English. The English term "otherization" can be applicable to a variety of terms in Hegel's German, such as *Entäusserung* (disappointment), *Entfremdung* (alienation), *Entzweiung* (divisiveness), *Zweispalt* (two-split), *Zerrissenheit* (brokenness), or *Trennung* (separation). Similarly, Beauvoir applies terms or phrases such as *"deviennent des « autres» vaguement hostiles," altérité* or *à d'autres,* and *opposant* which translate into become vaguely hostile "others," otherness or to other, and opposing respectfully. Even though there is a variance in the terms and their exact translations, the underlying concept is relatively stable and common even across the various languages. For the purposes of this thesis, the words otherization, to other, othering, and alienation will all be understood as placing an individual into a category separate to oneself and treating them different based on this placement. Having a foundation of this language will help when analyzing the harms that arise within Hegel's

philosophical structure and the further application of these harms as they present themselves within medicine.

How the structure of otherization begins to develop can be explained with Hegel's philosophical perspective of the relationship between the self and the other. It is this relationship that provides the first step in answering the question posed in this thesis, as the dynamic between the self and the other can provide the foundation for the structure present in gender discrimination. However, to understand the full picture of Hegel's dynamic between the self and the other there must first be a dissection of Hegel's early fragment writings on "Love," specifically the three-part structure that exists within these early writings. The three-part structure is one that can be multi-applicable and is the structure Hegel uses to outline the development of the Self and the Other. It is in this way that the early writings on "Love" are instrumental to "unlock the mystery of Hegel's concept of Spirit," and for our purposes the term Spirit can be used interchangeably with the idea of self-consciousness (Beiser, 2006, p. 113; Hegel, 1977, pp. 263-266). The idea of self-consciousness will be focused on later within Chapter One, as the concept takes on importance when explaining how an individual may be placed into the role of the other. Nevertheless, each section of the three-part structure provided in the fragments on "Love" is important to individually unpack as they will set up the structure necessary to answer the problems presented in this thesis.

The three-part structure presents itself within the fragment writings on "Love" as an interaction between two lovers, with the first stage being an immature unity of lovers, the second being the alienation between lovers, and the third stage ending with a completely mature unity between the lovers. For Hegel, we cannot understand love

outside of the ever-changing relationship between lovers. In his vocabulary, love is a "dialectic." This term is one that is extremely important when navigating how the problems of gender discrimination develop in healthcare, and it can be best explained as a structure of seemingly two opposing or contradicting concepts that are ultimately defined in reference to one another. On the surface, these two concepts may be perceived as independent from one another, but after closer examination they are intrinsically related and cannot be defined without the other even if they are exact opposites. Therefore, it is important to explain all sections of this three-part structure in relation to before, during, and after the dialectic opposition in order to understand how the structure can be practically applied and the potential problems that may arise within it. Chapter Three will focus on how this dialectic structure can present itself within physician-physician and physician-patient interactions, but for now let us turn our attention back to how this dialectic structure is created within the fragments on "Love."

To start, let's first describe each step of the dialectic structure as it appears within the fragments on "Love." The first step of an immature unity would describe when two individuals are together and are not conscious of what makes them separate individuals outside of the unity. In this phase, the two lovers would not distinguish the differences between them as individuals and consequently would not be able to unite together in acceptance of those differences. This step for Hegel - the acknowledgment and acceptance of a partner's differences to their own - is essential for the movement of an immature unity to a mature reconciliation. To provide another way to view this immature unity, take for instance the relationship between parents and their child. When a child is first brought into the family, the immediate unity that forms between the parents and their

child is one that Hegel believes is mainly motivated by emotion. The parent holds a view of the child as an embodiment of the relationship between their partner and themselves, and the child views their parents as individuals "they derive their existence from" (Hegel, 1977, pp. 273-274). In this way, the parents and child both view each other as almost extensions of one another and don't recognize the other parties as independent from themselves. The only way for the lovers – or the parents and their child – to reach a mature unity is if some events catalyze separation between the groups.

This leads to the second stage in the cycle of Love's developmental process: separation. Hegel describes separation – or alienation - as someone viewing their life in "opposition" to the world and objectivity (Hegel, 1971). This opposition to objectivity is when an individual starts to view themselves as autonomous or independent of the world or lives around them. They have unique differences - personalities, ideologies, experiences, and/or values - that individualize them compared to others and start to believe themselves to be "authors of their own actions." (Ortiz et al., 2023; Williams & Wood, 2014). Going back to the relationship between the parents and their child, a separation in their relationship occurs once the child starts to form an independence and self-consciousness of their own (Hegel, 1977, p. 274). However, this separation is not inherently negative as it is a source of important development for an individual. The act of leaving the parental home and establishing an independent existence from the family is a marker of an individual transitioning into adulthood (Egondi et al., 2013; Goldscheider & Goldscheider, 1993; Mulder & Clark, 2000). Without having this stage of separation, it would be impossible for a child to move into this important developmental hallmark. It is a natural progression for an individual to move into this separation within their varying

relationships, although this cycle is not completed until the individual comes back to the original unity with their newly founded perspective.

In moving past this second stage of separation, Hegel states that "love completely destroys objectivity," which will allow for an individual to move to the next stage of mature reconciliation, or unity (Hegel, 1971, p. 305). When breaking down the quote from Hegel, objectivity – which can be defined as foreignness or thinking of something as existing independently of yourself – acts as a barrier for an individual to reach a mature unity. If an individual isn't able to perceive themselves as being connected to the people around them, or view these people as foreign to themselves, it would present a barrier to relate or view the importance of the relationships around them on their development or life. With objectivity's destruction, the barrier – that would have previously frozen individuals in a constant state of opposing themselves to the people around them – would be removed and individuals can reach the next stage of reconciliation. An individual in this stage – before removing this barrier – would develop a view of characteristics they don't possess to be foreign and opposite to themselves. In taking this perspective, an individual would ultimately come to a view that the group opposite to them and who did not share similarities are an "other" to themselves.

As previously mentioned, this formation of an "other" group due to separation is inherently neutral and being in this state of separation is neither positive nor negative. However, being in a state of separation can become negative when the separated individuals become unequally polarized and one group is deemed the "unessential" other (Hegel, 1977, p. 113). A real-world example of when separation can turn negative is if the other group is dehumanized – viewing and defining individuals as less human than

other people or placing them in the same category as objects – resulting in easier persecution of the group by the deemed "self's" culture (Hamby, 2018; Kosicki, 2007; Kelman, 1973). This negative state of separation, or alienation, can be a problem seen within the dialectic structure, as an individual is defining themselves in relation to being superior or inferior to another group and vice versa. This structure is important when analyzing the problems that occur within healthcare, and this application will be further examined within Chapter Three. For Hegel, the way to overcome these problems is through love, as not only is it removing a barrier for individuals to reach mature unity – as mentioned before – but it starts the process of reconciliation between individuals who were previously opposed to one another. Reconciliation brings clarity to both individuals to stop otherizing – or viewing a group as "other" and lesser – one another and opens their eyes to see what is separate to them as people who they can be united with and not something unessential (Hegel, 1971, p. 305). In summary, both individuals can recognize that they are the "self" within their own lives but also accept that they are the "other" in the view of the people around them. They simultaneously accept that they both can carry the classification of the self and the other, and there is nothing wrong with having this duality.

This is when the final stage of Love is found and a fully mature reconciliation occurs. Within this reconciliation there is a recognition by each partner that they are separate individuals, each with their unique differences, that can still come together to make a united force. Recognizing each other's differences and accepting them – i.e. not erasing and disregarding of the opposite lover's differences – is essential for Hegel's reconciliation of love. Both of the individuals in the relationship must acknowledge and

accept the other person for the individual that they are, and this for Hegel is a true unity of love. This is also why objectivity proves to be a barrier to reconciliation, because if an individual views the person opposite to them as foreign or completely independent from their life they would not be in a place to accept or respect the other person fully. For a full circle of the parents and child example, this would be if both the parent and child acknowledge and accept each other as their own independent people and respect the other party. This dynamic can be exhibited with children respecting their parent's knowledge for guidance while the parents respect their child's autonomous decisions, which creates a community power instead of an authoritarian power (Grotevant & Cooper, 1986). Beyond the example of a parent with their child, this mature unity can show itself in life such as a doctor providing guidance and respecting a patient autonomy while the patient acknowledges that the doctor is also a person who's goal is to provide help or a boss acknowledging that their staff is capable of making everyday decisions for the company while the staff respects the guidance of the boss. In this newly founded unity, both parties have their independence and differences being shown respect and acceptance. As we will see in more detail in Chapter Three, this idea is important when this unity is not being exhibited between a patient and physician or even physicians with their colleagues of the opposite gender.

In a similar aspect as the stage of separation having the capability of being both "positive" and "negative", the stage of reconciliation can be achieved in both "positive" and "negative" aspects. A "positive" path of reconciliation is exemplified in the idea of "Love" when two individuals both recognize and accept the differences each person possesses and brings to the relationship. There is not an attempt to control, change, or

exert dominance over the partner's differences as a foundation of mutual respect has been established. This leads to how the stage of reconciliation could form into something "negative," and the unity of individuals is not based on accepting differences or respecting one another. One way in which this bad reconciliation can show itself is through an over-dependence of one individual onto the other, which can result in the dependent individual not viewing themselves as capable or at the same authority as their partner (Bacon et al., 2020). To go back to the example of the patient and the doctor, there can be a bad form of reconciliation in an instance where a doctor – through the dissimilarity of their mastery of medicine between themselves and the patient – can develop a sense of authority over potential decisions of the patient and potentially start treating them "as a means to an end rather than an end in themselves" (Haque & Waytz, 2012; Gruenfield et al., 2008). In this instance, the patient may be over-dependent on the doctor due to their knowledge in medicine, but the unity is lacking the mutual respect of the patients autonomy. A negative unity can also form if one side tries to dominate their partner through guilt, fear, or intimidation, as this ultimately tries to control any independence that the other individual might have gained within the separation stage (Ni, 2014; Viezzer, 2023). When unity turns into a negative relationship between individuals, it can perpetuate an oppressive environment and is not embodying the mature reconciliation outlined within "Love." In other words, for a mature reconciliation of love, there is an inherent acknowledgment, acceptance, and respect of the other parties' self-consciousness.

This action of acknowledging and accepting the self-consciousness of another individual is one of the most important ideas of reconciliation. As mentioned earlier in

Chapter One, self-consciousness plays an important role with the creation of the other. To Hegel, the dialectic between the self and the other can be explained through the idea of self-consciousness, and this is where self-consciousness' importance is explained. Self-consciousness is the embodiment of "*being-for-self*." In other words, "being-for-self" is an individual that is aware of itself as an individual and recognizes themselves as the absolute "I" (Hegel, 1977, p. 113). To be self-conscious, an individual must become certain of themselves as the essential being concerning the objects around them (Hegel, 1977, p. 111). Both the self and the other are acknowledged to have self-consciousness and are certain that they are an individual in their own right. However, their consciousness is premature and has not been defined in relation to the people around them, and this is where the difference between the self and the other truly develops. For the self, they possess a *pure* consciousness – which is to say the consciousness exists *for itself* and not has its existence confirmed by the individuals it comes into contact with (Hegel, 1977, pp. 115 & 112). For the other, it only ever reaches an *immediate* consciousness – which is to say it acknowledges the individuals around it but never has its own existence reaffirmed by other individuals, ultimately existing for another individual (Hegel, 1977, pp. 114-115). In a sense, one consciousness is being fully *recognized* (i.e. pure consciousness) and the other consciousness is only *recognizing* and not being recognized themselves (i.e. immediate consciousness). The development of the self and the other does not occur in a vacuum and are inherently engaged in a dialectic structure, as both individuals are defined in reference to their opposition (i.e. when their self-consciousness come into contact with one another). Without this opposing

interaction, neither individual would be able to take on the role of the self or the other, which means these roles are dependent on one another.

After outlining the three-part structure as it appears within the writings on Love, we can now move forward in examining the first step towards answering the main problem presented within this thesis, and this step is understanding the dialectic relationship between the self and the other. Furthermore, it is important to apply the three-part structure to the formation of the self and the other and this can be done by examining the opposition of self-consciousnesses. Before the opposition, the self-consciousnesses of both individuals are stuck within a simple unity and can be viewed as only being an immature, immediate self-consciousness. This immediate self-consciousness has not yet experienced life and the interactions with other individuals that life brings about. This immature view of self-consciousness is satisfied with being the essential being in their world and viewing themselves as the absolute "I", as they have had no other past interaction to challenge their belief of themselves (Hegel, 1977, p. 115). The view of themselves – this absolute "I" – is immature as it is formed when the individual is in isolation and has not yet encountered social interactions to challenge the perception of oneself (Kojève, 1969, p. 15). The simple unity dissolves once an individual first interacts with another individual who also possesses immediate self-consciousness. When this interaction occurs, both of the individuals become engaged in a dialectic structure where both are opposed to one another. This opposition is innate to the interaction as both individuals are having their immediate conception of self-consciousness – their absolute "I" – being challenged. The interaction between these

individuals results in the development of the self and the other, and this phenomenon is best explained within Hegel's master-slave dialectic.

The master-slave dialectic is a structure outlined by Hegel within his book *Phenomenology of Spirit*, and its structure shares similarities to the dynamic between the two lovers within the fragments on "Love." Both structures outline dialectical relationships, however as the lovers move into a state of reconciliation the master and the slave remain stuck within a negative state of separation. Within this negative state, an extreme opposition develops between the two individuals which results in one individual ceding to the extreme of master whereas the other will cede to the extreme of slave. When using the verbiage master and slave, Hegel does not necessarily imply the same connotation to these words as we might apply to them today. When using the term master, Hegel is implying a position an individual may take of being viewed as more "superior" and who may take on a dominant role with other individuals who are engaged in the same dialectical structure as them. When using the term slave, Hegel is referencing a position an individual can take of being viewed "inferior" or subordinate to another individual in a dialectical structure. It is only possible to understand the background of these two categories when they are in opposition to one another, which is why it was essential for Hegel to develop this theory within a dialectic structure.

Within one extreme, the master becomes enlightened to *pure* consciousness. Pure consciousness is different from immediate consciousness as the individual still views themselves as the absolute "I" – exist *for itself* – but their existence is "mediated with itself by *another* Consciousness" (Kojève, 1969, p. 16; Hegel, 1977, pp. 112 & 115). What this entails is that the master acknowledges their own existence, as well as,

has an external individual also acknowledging and agreeing to their existence. On the other hand, the other extreme leaves the second individual who takes the position of a slave and doesn't move out of their *immediate* consciousness. The slave is unable to move into *pure* consciousness as their consciousness is not acknowledged and agreed – or mediated – upon by the master. In a sense, the slave is able to acknowledge both their consciousness and the master's, whereas the master is only able to acknowledge their own consciousness. Ultimately though, the slave comes into their position when they refuse to rise above or challenge the individual they are opposed to – or in the words of Hegel take on the "fight to the death" – and concede to take on a consciousness not purely for itself and accepts the master's view of themselves as being an "other" (Hegel, 1977, p. 115; Kojève, 1969, p. 16). Within this dialectic, there exists a disparity between the subject - i.e. master, self, or "I" - being perceived as an existing being and the object – i.e. slave – being only known as an object in relation to the subject (Hegel, 1977, p. 22). This concept that the object is defined in relation to the subject, is important to take note of for further discussion in Chapter Two as this relationship between the master and slave can show similarities to the relationship between man and woman.

The one-sided recognition and imbalance within the master and the slave's relationship is important to take a step back and examine, as it is the foundation for what can go wrong with the development the self and the other if negative separation were to occur. Even though this dialectic will be referenced as the master-slave dialectic within the thesis, the terms master and slave are actually an English adaption to the original dynamic Hegel wrote about. In the original German text, the dialectic relationship Hegel outlines is between a lord and a bondsman. While keeping the same structure of the

individuals, the master can be equivalent to the lord and the slave is the equivalent of the bondsman, the English adaption keeps the spirit of Hegel's original intention of explaining the positions of mastery/domination and servility/bondage while giving it an updated application of his structure. However, to best explain the dialectic structure that Hegel is trying to illuminate it can be beneficial to understand how the master-slave dialectic is outlined within the dynamic between a lord and a bondsman.

The bondsman is in a state of dread in relation to the lord, as the bondsman has experienced "the fear of death" from the lord and thus in an attempt to preserve their life abandons the desire to be recognized and to achieve *pure* "being-for-self" (Hegel, 1977, p. 117; Kojève, 1969, p. 42). "Being-for-self" previously was explained as a thing that is aware it is an individual and an absolute "I," and has some capacity of self-consciousness. However, in the case of the bondsman they recognize they are an individual, however in the position they have taken on they are not acting entirely for themselves but instead acting for another person. In this way, the bondsman comes to the same view of themselves that the lord has of them, which is that they are in debt and a slave to the lord and will not be acknowledged as an absolute "I" (Hegel, 1977, p. 118; Kojève, 1969, p. 18-19). In taking on this position, the bondsman accepts that they will not be acknowledged as a person in the same way they acknowledge the lord, which creates an important distinction between the lord and the bondsman. This distinction is that the lord does not view himself in the bondsman, even though they both are human being, and this view of the bondsman as more of a thing than an equal ultimately strips the bondsman of his dignity and autonomy. Being perceived as closer to a thing than a being is something that the bondsman also acknowledges and accepts when acting to

preserve his life from the lord (Hegel, 1977, pp. 116-117). In a sense, the lord only becomes a lord when the bondsman decides that they would not win a fight to the death and chooses a life of indebtedness over death.

The fight between the lord and the bondsman is synonymous to the opposition occurring in the master-slave dialectic – or the unequal relationship between two interacting individuals – and further explains the negative state of separation that is important to answer the overarching question within the thesis. Being stagnant in this negative state results in the slave being subjugated and deemed as the "Other." In winning this interaction and coming out as the only *pure* consciousness, the master would view themselves as holding the power in the relationship between themselves and the slave. This power comes from the fact that they are the only entity that acknowledges themselves and has another entity to mediate this acknowledgment. However, even though the slave is mediating the master's existence, the master views the slave as something that is "worth nothing to him except as a negative entity," and is it this denial of acknowledging the slave as they did for them that places the slave into the category of the "Other" (Kojève, 1969, p. 17). A reconciliation of these two extremes is each individual – the master and the slave - recognizing their different experiences, realizing another individual with a self-consciousness exists outside of themselves, and mutually acknowledge that they are the dependent on each other. As it currently stands, the master is not viewing the slave as an individual and instead as some "thing," whereas the slave is viewing the master as an individual with dignity. In an ideal world of overcoming this unequal balance, the master must recognize that the slave is not a "thing" but instead is an individual that possesses dignity along with themselves (Kojève, 1969, pp. 19-20).

When both individuals realize that each of them is for themselves, as well as, for the other – each individual is simultaneously the self and the other within the interaction – it can lead to *mutual recognition* of one another (Hegel, 1977, p. 112).

It is from this point that I depart from Hegel's structure within the *Phenomenology of Spirit*. For Hegel, his main concern lies in the idea that the master does not reach the same level of understanding as the slave and is ultimately a stagnant, idle being. Due to the master being unable to reach the same understanding as the slave in his position and the interdependence he has on those around him, Hegel views that the true victim in the master-slave dialectic is actually the master not the slave. As mentioned before, the slave already acknowledges that the master has dignity, thus acknowledging "the Other" in relation to themselves, and also cedes their autonomy and mutual acknowledgment of their dignity in order to preserve their life. The slave does not inherently want to be a slave but chooses the path as a way to avoid death. However, the master chooses to become a master and he cannot work his way any higher or go beyond his current position (Kojève, 1969, p. 21). Within the slave's work for the master, the slave can rediscover their autonomy and overcome their fear of death with "becoming a master of Nature by [their] work" (Kojève, 1969, p. 23). When making this realization through their work, the slave can reach the conclusion that they are a being that can be for itself and does not indefinitely need to be a slave to the master (Kojève, 1969, p. 23). The master never reaches this conclusion, and instead stays stagnant in a state of oblivion of his dependency on the slave and cannot see himself in the other. To define his dependency, the master does not do anything except rule over the slave; he does not work, he does not produce anything stable outside of himself, and he cannot be a master

without a slave (Kojève, 1969, pp. 24-25). This inability to acknowledge his placement in the relationship is why Hegel focuses on the master being the true victim in this power dynamic. It is this conclusion that Hegel reaches that I will be breaking away from, as my focus will be on how the slave in this dynamic is the one who is the true victim. In going forward, I will be taking from the *Phenomenology* the structure of separation, or alienation, that Hegel provides, and applying this structure to examine the harms individuals experience when in the position of the slave or other as seen in healthcare relationships.

Otherization, Stereotyping, and Power Imbalance

Before breaking completely away from Hegel, it is important to analyze the second stage within the fragments on "Love" to reach the second step in answering the question posed within this thesis. It is already understood how two individuals can be placed into a dialectic, as shown through the master-slave dialectic, and what roles they can take within this structure. However, this second step is taking this placement one step further and analyzing how otherization between the individuals can create widespread problems. When the group is classified as the Other begins to be viewed as something less than what they actually are, or as an outcast from the general population, it opens the gateways for these individuals to be treated negatively based on this categorization (Arendt, 1951, pp. 474-479). It can be argued that this otherization is not inherently negative, as the development of these categories can be viewed as inevitable in regard to human development. What I mean by this is that an individual will naturally view themselves as being similar to one group - based on potential factors of social

information, resource distribution, and empathy responses - and not being within the other, which can be seen as a form of otherizing the individuals around them (Liberman et al., 2017; Xu et al., 2009; Devine, 1989). To relate back to the example of the parents and their child, at some point, the child will start to relate themselves closer to peers of a similar age, similar experiences, or similar ideas that might be different than their parents. At this point, the child would view others of similar status to themselves as being in their category and view their parents as being a part of another.

From the problematic nature of otherization being something that cannot be naturally assumed, it is important to examine how the categories Hegel outlines—such as the master-slave dialectic—can develop into a negative structure. To achieve this next step, the master-slave dialectic can find a connection to the formation of stereotypes, specifically stereotypes that result in negative treatment towards the stereotyped group. Before delving deeper into the connection of stereotypes to otherization, it is important to note the qualities that make up a stereotype. In the same aspect that separation can be neutral, positive, or negative, stereotypes develop in a similar fashion. The history of the word stereotyping exemplifies this point, as the term originally described a printing process in the late eighteenth century. "Stereotyping" was a word that described the process of a metal plate of an image being pressed against paper, having a fast transfer of the image onto the paper, and allowing for mass production of said image. This process of being able to mass produce a repeated image is where stereotyping transitioned into a word referring to anything "continually repeated without change" (Beeghly, 2015). To apply the original view of stereotypes to today, it could be imagined that stereotypes are just imprinted "pictures inside the heads of human beings" that result in a repeated view

of a group (Lippman, 1922; Beeghly, 2015). With the change in the view of the word, stereotypes have developed to be categorized as either "descriptive" or "evaluative" (Blum, 2020). Evaluative stereotypes are most similar to the negative view of stereotypes commonly held as they view stereotypes as having normative – or moral – implications (Blum, 2020; Beeghly, 2015). However, descriptive stereotypes are "morally neutral" and focus specifically on the "generic view of groups associated with one's concepts or with their formation or use" (Beeghly, 2015). The descriptive view of stereotypes opens the door for a conversation on *why* stereotyping is wrong as it doesn't automatically assume that the action of stereotyping holds a moral implication.

Stereotyping and answering the question of "what's wrong with forming expectations of individuals based on group membership and structuring our interactions accordingly" can help to understand the problematic nature of otherization (Beeghly, 2015). Stereotyping can become negative when extremely disproportionate views of the outgroup are developed and there is no intentional effort to gain a non-prejudiced response. Independent of the content that forms the stereotype, the feature of stereotypes to overgeneralize characteristics of a group results in a false or misleading view of the group members (Blum, 2020). An example of this can be gender stereotypes – which take generalized perceptions of male and female characteristics and apply them to specific gender roles – seen when men and women perform different jobs, such as the stereotype men perform paid work outside the home while women do unpaid work within the home (Suter, 2006; Gleitman et al., 2000). The stereotyping can also be subliminal, with an individual associating certain characteristics to one gender, such as masculinity being associated with aggressiveness or confidence and femineity being associated with

kindness and cooperation, which can impact how they may treat the individual within that stereotype (Heilman, 2001; Houchens et al., 2020). These misleading overgeneralizations can be taken to an extreme point, and if that misleading overgeneralization places negative content – such as criminal, emotional, or violent traits – onto the outgroup and can foster the development of prejudice towards the outgroup (Blum, 2020). Prejudice develops from increased antipathy attached to the perceived social category that the outgroup is placed in (Allport, 1954; Harris & Fiske, 2006). This is seen clearly in the lord-bondsman dynamic, as the lord does not relate to the bondsman and views him as closer to a "thing" than an individual. In a way, "stereotyping constitutes a form of disrespect, a way of misrelating to the stereotyped other" and this failure to acknowledge the person reveals a moral fault as a result of stereotyping (Blum, 2004, pp. 272-273, 282). The result of these types of interactions can foster the development of otherization within a dynamic similar to the master-slave or the lord-bondsman, which presents the first problem of otherization being the fostering of a power-imbalanced relationship.

Power-imbalanced stereotyping can result in the development of a feeling of social superiority by one group towards the other, and this can result in negative actions being taken against the stereotyped group. In viewing individuals as less than human or associating them to a misleading negative trait, it makes it easier to incite violence against the other as they are not seen as a moral being and the actions being done against them will not be viewed as immoral (Kelman, 1973). Otherization fuels this power imbalance by perpetuating the feeling of apathy that the lord - or master - holds towards the other. One way this apathy is fostered is by increasing and intensifying the feeling of

moral distance between the two groups, achieved when there is an increased view of "otherness" from one group to another (Blum, 2020). Moral distance can lead to a significant impact on an individual not feeling a moral obligation to help others, as well as having an increased disregard for a moral boundary of when to act (Chatterjee, 2003). When this occurs, the group deemed as other is being morally excluded and this places them "outside the boundary in which moral values, rules, and considerations of fairness apply" (Opotow, 1990, p. 1). With the moral distance being increased between groups, the violent actions towards the other become normalized and a sense of passivity towards the violence done against the targeted group is developed (Nonini, 1992). Otherization creates the spark that can lead to this moral distance taking control, and it is one way that makes otherization a potential problem to be dealt with within medicine.

As much of a problem it is to have increasing moral distance between groups, the problem of otherization moves beyond just stereotyping and this distance when there are physical actions that can be traced as a result from otherization's dominating structure. One of these actions is the dehumanization and subsequent violence wrought on the group viewed as socially inferior. When power increases for an individual their ability to adopt the perspective of others is diminished, which further creates a divide that allows for otherization to occur (Lammers & Stapel, 2011; Gruenfeld et al., 2008). The increased divide in power between groups can factor into an idea called the social dominance orientation (SDO), which measures the degree to which people desire for one's in-group to be superior to an out-group (Pratto et al., 1994). Using the SDO, it has been found that when dehumanization occurs perpetrators have increased enjoyment in asserting their power over out-groups and support division efforts to keep their status

higher than the out-group (Markowitz & Slovic, 2020a). As shown within the master-slave dialectic, when individuals are placed into a structure where one group has superiority over another, it shows itself with the master, or group with the power, postulating domination over the inferior group, as seen with the slave being beaten until submission to then only be viewed as a thing and not human. It's in this way that dehumanization is a problem, as dehumanizing actions can be so common within society that they lead to dire consequences for the group being targeted (Haslam & Loughnan, 2014). Dehumanizing actions can encompass a wide range, however specific actions of dehumanization will be analyzed further within Chapter Three as they may appear within healthcare.

By analyzing the dialectic relationship presented within Hegel's three-part structure of development, it is possible to understand the full extent the problem of otherization can have within society. It is within this negative separation between individuals – this dialectic – where otherization occurs and is only able to be understood when having the philosophical perspective presented by Hegel. This structure and its application will be instrumental to answering the question of what kind of structure cultivated the foundation for gender discrimination to occur in healthcare, however it is only one part of the overall answer. With the structure and information currently described, it would be possible to see the problems of otherization but with too broad of an application. For the intent of clarity, it would be impossible to spell out every way in which otherization has negatively manifested itself within our society. The topic of otherization has shown impacts within many different spheres of society, with large-scale examples being colonization or imperialism of nations to the assimilation of a group into

a bigger society (Markowitz & Slovic, 2020a; Roth, 2022; Nonini, 1992). However, to take the next step in answering the question presented within this thesis is examining how otherization presents itself specifically within gender disparities.

CHAPTER TWO

Gender Discrimination

The Man-Woman Dialectic

Understanding the three-part structure provided in the fragments on "Love" can shine light on the negative state of separation within the master-slave dialectic and the problematic nature of otherization that arises from this structure, however it can leave a question of how Hegel's theory is applicable to the case of medicine. As far removed as this theory may seem to being practically applied in modern day, this three-part structure and the dialectic between the master and slave have a direct influence in understanding gender disparities occurring within healthcare interactions. The connecting of these two realms – philosophical theory and medical practice – is the next step in answering this overarching question of how a philosophical perspective can provide insight into problems occurring within healthcare, and it can be achieved through examining the written work of Simone de Beauvoir in *The Second Sex.* To apply Hegel's three-part structure to gender, Beauvoir (1956) first outlined a similar thought as Hegel when examining the stage of separation with saying "no group ever sets itself up as the One without at the same time setting up the Other over against itself" (p. 16). Beauvoir's statement immediately acknowledges that the dialectic Hegel refers to between the self and the other or the master and the slave is front and center within her writings. Furthermore, the stage of separation being referenced in *The Second Sex* is more closely related to the view of separation presented in the *Phenomenology*. Within the *Phenomenology*, Hegel describes how hostility and opposition innately arises out of one

self-consciousness coming into contact with another, such as the master and the slave, and the interaction results in the categories of the essential – or self – and the inessential – or other – forming (de Beauvoir, 1956, p. 17). The language used and this placement is not a coincidence, as Beauvoir (1956) believes that the "relation of master to slave appl[ies] much better to the relation of man to woman," and it is this application that stresses the importance of the philosophical structure's in explaining women's position in areas such as medicine (p. 90).

Simone de Beauvoir, in transforming Hegel's structure to apply to a conversation on gender, shines light on how men and women are engaged in a special type of dialectic, unique in that women experience complete otherization in relation to men. This dialectic relationship is one that has been applied to many dynamics in history – Beauvoir alone mentions this dialectic relationship within the proletariat-bourgeoise and Haitian slaves-slave owners – however the relationship between man and woman is unique as women's entire conception of themselves as a group is in relation to their "opposing" group (de Beauvoir, 1956). The comparison is one stated directly by Beauvoir (1956) when she gives the powerful statement that "he [man] is the Subject, he is the Absolute – she [woman] is the Other" (p. 16). In saying she is the Other, Beauvoir is not just claiming that women are merely taking on an idea of being the other but instead are viewed as their identity – physically and psychologically – being placed into a subordinated, othered group. This statement, as straight forward as it seems, unveils an entirely new application to Hegel's structure than previously discussed. It is important in moving forward that this connection between Hegel's structure and gender disparities is understood and importance explained, as it provides the other half of the answer to the

main question of how a philosophical structure can have importance in understanding healthcare problems.

The thought-provoking claim that Beauvoir is making, which is that women are perpetually placed into the role of the Other, is an important addition to the structure described by Hegel. This claim is one I will discuss in more detail later in the context of women's relationship with men as a patient and as a colleague in healthcare. For the time being, however, it is important to note that this category of the Other is not confined to one specific time period or group and is a "fundamental category of human thought" (de Beauvoir, 1956, p. 16). This idea that the formation of the Other is something natural to human progression is one that was previously touched on with the example of the parent and the child and it is the reason to why the idea of the Other can be applied to many different areas (i.e. between two lovers, master and slave, man and woman, etc.). The formation of the Other being neutral is shown explicitly within Hegel's writings, specifically the fragments on "Love" and the *Phenomenology of Spirit*. The fragments on "Love" shows the Other to be a lover that is separated from their relationship and the *Phenomenology of Spirit* provides a view that the Other can be embodied by the slave or bondsman. The placement of women into the role of the Other is unique compared to the slave and lovers and is Beauvoir's extension of Hegel's philosophical structure. It is important to note that with viewing the creation of the Other as fundamental to human development, it is also implied that the innate competition Hegel described when self-conscious beings come into contact with one another is something natural. There is a form of "fundamental hostility towards every other consciousness" that can be found within an individual self-consciousness, and this competition is what pits women into a

dialectic with men (de Beauvoir, 1956, p. 17). This competition was best explained by Hegel in his master-slave dialectic, but it is important to outline how this competition shows itself between men and women.

Furthermore, the thought-provoking claim Beauvoir makes, that women are placed into a unique role of the Other not previously experienced by other groups who have also been othered, is one that has significance in the application of the philosophical structure to healthcare. The similarities between Hegel's structure of the master and slave to that of Beauvoir's structure of man and woman can highlight Beauvoir's big idea. To start, Beauvoir claims that women are not defined on their own and instead defined in relation to men. This idea reveals a larger theme that men are determined as the group that set the standard for all definitions in society. Man is the essential, woman is the inessential. Man is Subject, woman is Object. Man is active, creating, extending out into the world, while woman is passive, maintaining, and keeping to the home and family. This idea can best be shown when Beauvoir explains "man represents both the positive and the neutral, as is indicated by the common use of *man* to designate human beings in general" (de Beauvoir, 1956, p. 13). In turn, anything that would fall out of this category of the norm would be relatively seen as abnormal. With men being the absolute standard for identity, women are by extension viewed as abnormal or as a category outside of the neutral.

Women's position in comparison to men is an important topic for Beauvoir and is an idea that can help to explain the problems embedded within medicine. The idea I am referring to is the effects of transcendence and immanence in relation to women and men. These two concepts are important for Beauvoir in explaining women's position to men

and are a unique addition to the dialectic relationship not previously focused on by Hegel. On the surface, transcendence and immanence appear to be opposites. One may assume that transcendence and immanence are opposites due to the fact transcendence is defined as active, creative projection into the world – i.e. an individual who is able to go beyond oneself and their current position – where immanence is defined in relation to passivity, internal maintenance, and an individual operating within their current conditions. As mentioned before, men setting this neutral standard and being viewed as the "essential" can be credited to men being granted transcendence to actively define themselves in the world, whereas women are stuck in a state of immanence and are being defined passively in relation to men (de Beauvoir, 1956, p. 27). Achieving a state of transcendence is what would equalize women's position to men, and this fight for transcendence can be seen in the actions of women voicing their need for equal liberties and for a future that is open to unlimited possibilities not based on their gender (de Beauvoir, 1956, p. 27). However, traditional gender stereotypes only aid in women and men being placed into this unique dialectic as they reinforce the gender roles – i.e. women tend to the family and take care of the house versus men who are the breadwinners for the household – that support their positions, making it that much harder for women to mobilize out of the category of the other (Day, 2016).

Furthermore, if a woman is stuck in a state of immanence, they ultimately have reached a stage where the freedom to actively pursue their own ends seems impossible to reach. This can be due to the constraints placed onto them in relation to their bodies, i.e. the women start to internalize the view that they are merely stagnant bodies and not autonomous persons, or internalizing the definition placed onto them in relation to men

and believing that the definition is all they can aspire to be. However, this state of complete opposition – men and women can be either transcendent or immanent and not both – is unnatural and instills a negative state of separation as described by Hegel within his master-slave dialectic. For Beauvoir (1956), "all human existence is transcendence and immanence at the same time; to go beyond itself, it must maintain itself; to thrust itself toward the future, it must integrate the past into itself" (p. 443). Thus, problems that are occurring due to these gender disparities can be credited in part to the state of complete separation occurring within the state of transcendence and immanence. This theme of how women have a hard time reaching transcendence when being defined by unchangeable facts – such as their bodies or biology – within society and how this lack of mobility impacts the way they are able to freely act upon their own will be examined further in Chapter Three.

The lack of mobility that women have faced in trying to transcend to the same level as men can be compared to other subjugated groups in history, and it can help highlight how and why women are still stuck in a state of immanence. It was previously mentioned how women hold a unique position in their placement of the other, and it can be seen in the way that women organize themselves compared to the other groups in history. A view of this can be described that "women lack concrete means for organizing themselves into a unit which can stand face to face with the correlative unit," or that it is hard for women to fight against their submission as a group (de Beauvoir, 1956, p. 18). In comparison to other groups that have been placed into a similar category as women – such as the proletariat in regard to the bourgeoise, black Haitians in regard to slave owners, etc. – they are able to unify based on their subordination occurring from a

historical event. Beauvoir (1956) explains this phenomenon in giving the example that "proletarians have not always existed, whereas there have always been women," and this creation of the subordinated classes based on some historical event is what allows for these groups to have a stronger unity in resisting their designated oppressor (p. 18). By historical event, it is meant some action that led to the creation of an otherwise equal group being transformed into a group viewed as the other and the group was not always placed within a dialectic structure (de Beauvoir, 1956, p. 19). These groups who became the Other based on some historical events are able to be defined and unified to one another based on this event and use the shared historical experience as a way to rally against their subordinators and define themselves in relation to their own stories (not in relation to their subordinators). Women do not have this historical moment to rally behind, they have always existed as women (de Beauvoir, 1956, p. 19). In this way, the bond between women to her oppressor is not comparable to the bond between other groups and their oppressors.

This point – that women's position of being the Other is a unique situation – is important to note as it is integral to why real-life problems of women being othered in healthcare still occur today. In the way that other subordinated groups had existed prior to their placement into this dialectic structure, women did not have a singular event that "*occurred"* for them to be placed into their subordinated position (de Beauvoir, 1956, p. 18). Due to this, women's otherness can seem to be viewed as an absolute placement, one that isn't able to be just abolished in the future as it there has never been a time in history before this placement. From this point, it makes it harder for women to view the possibility to move beyond their placement, and similar to Hegel's description of the

slave taking and continuing their position, women have not broken the mold of being the Other due to their lack of "definite resources" to claim to be the absolute (de Beauvoir, p. 20). In definite resources, it can be interpreted as the ability to unify as a group and use the strength in numbers to change their position (similar to the actions of the proletariats or the Haitian slaves) or to have the confidence to achieve transcendence. Furthermore, women do not refer to themselves as "we" like the Proletariats or the Haitian Slaves, they refer to themselves as women in the same way that "men say 'women'" (de Beauvoir, 1956, p. 18). They do not take a subjective attitude – forming a view of themselves outside of the group that they are othered to – and continue to embrace the attitude of themselves that is perpetuated by men. When this occurs, the bond that unites women to their oppressor is based on an immutable, "biological fact" that women are separate from men and makes abolishing their position or moving into a state of transcendence harder. Throughout time – past, present, and future – women will continuously be set into a "fundamental unity" with men, based on their position of being defined in relation and by men. Women's placement as the Other only comes about due to the "totality of which the two components [men and women] are necessary to one another," outlining the unique dialectic that men and women share (de Beauvoir, 1956, p. 19). Thus, similar to the slave, women have accepted that to change the dynamic of this fundamental unity – or challenging the dynamic and trying to claim to be an equal partnership to men – would be an extremely difficult undertaking and has led to the ulterior action of accepting or internalizing the placement instead of taking up the fight.

Along with the view that women and men cannot hold the same position and must stay within their separate spheres, there are also similarities in women's relation to men

to how Hegel views the slave's position to the master. Pitting women in a similar position as the slave is not just inferred but is directly stated by Beauvoir (1956) when she says, "woman has always been man's dependent, if not his slave; the two sexes have never shared the world in equality" (pp. 15 & 19). Along with restating how women haven't been granted the same status as men – i.e. unable to transcend to the same status as a man – there is also the language used by Beauvoir that directly parallels the structure presented by Hegel. Within this parallel, it can be situated that women are currently being viewed in the category of Other to men. However, the position that women are in is still unique even when compared to the position of the slave. The slave before entering into the competition with the master was at one point outside of this subordinated position and not inherently tied to position of the Other. This key difference mentioned before that a historical event was the precursor for subjugated groups being placed into the role of the other is still applicable to the slave that is mentioned within Hegel's dialectic. For example, the case of Haitian slaves mentioned in *The Second Sex* highlights how a societal event occurred that led to the slaves entering into the dialectic relationship with the slave owners. In contrast, women – from their biology and their family being tied to their identities – have never experienced a prior condition of the Subject; from their conception they have been stuck within this dialectic as the subordinated Other. Hegel's structure is adaptable to the dynamic of men and women and it proves useful in highlighting women's unique position, something that will be beneficial in showing how the philosophical structures can explain gender discrimination in healthcare.

Furthermore, these parallels between man-woman and master-slave can explain *how* woman came to be placed in the position of the Other. Beauvoir (1956) states that women are viewed by society as "the incidental, the inessential," which directly parallels the language used by Hegel (1977) in describing the slave, or other, as "an unessential, negatively characterized object" (p. 16; p. 113). Opposite this view is Beauvoir's description of man, who is viewed as "the essential" – similar to the master or self – and who hold the view of woman that "she is sex – absolute sex" (de Beauvoir, 1956, p. 16). However, this language is not used to describe men, and can be the first indicator of how women were placed into the role of the Other. This distinction that women are absolute in relation to their sex draws a parallel to men being the Absolute in relation to themselves as a whole. Women having their biological "sex" – to the point of being described as a "sexual being" – as core descriptors to their societal identity, whereas men's sex is not integral to their identity, can explain how women are sociologically put in their position.

When women are viewed in this way, it reveals how the dialectic structure can perpetuate a foundation of otherization between individuals and lay the groundwork for potential dehumanizing actions. As mentioned before, otherization can show itself in a wide range of actions, however one type that will have prevalence in showing these problems occurring in healthcare is gendered objectification. Objectification – or dehumanization – of an individual or group is an idea that not only appears within Beauvoir's writings, but also appears within the *Phenomenology.* Hegel discusses this phenomenon when describing how the lord views the bondsman as closer to a "thing" than a human, and when comparing him to a thing he is denying the individual the same

respect of dignity as they grant themselves (Luft, 2019; Hegel, 1977). When objectification occurs, it results in several features that are inflicted onto the group that is being objectified. Some of these features are a denial of autonomy, denial of subjectivity (not assessing the individual's feelings as worthy of consideration), and a reduction of the targeted person to just their appearance or body parts (Nussbaum, 1995, p. 257; Langton, 2009, pp. 228-229). Women face objectification in the way of being boiled down to just a body, thus when Beauvoir outlines how women are viewed as a "sexual being" or defined on their "sex" it is a form of gendered objectification taking place. When women are sexualized, they are seen as objects for pleasure rather than individuals with moral and mental agency, and when constantly being portrayed as sexual beings that do not have agency it results in an increased threat of violence being taken against them (Seabrook et al., 2018; Fredrickson & Roberts, 1997; Vaes et al., 2011; Loughnan et al., 2010; Kellie et al., 2019). This type of gendered objectification is not as prevalent towards men, and Beauvoir's description of how men are not defined in relation to their sex – ultimately highlighting the theme that men set the neutral standard in society – can be a reason as to why this is a problem primarily impacting women.

Along with being seen as a sexual being, women who are sexually objectified also experience a denial of their autonomy and are attributed as having lower mental agency, especially by their male counterparts. This objectification does not stop with just sexualization though, as women who are economically dependent on men are also viewed to have a lower mental and moral capacity than their independent female peers (Kellie et al., 2019). Going back to the conversations on transcendence and immanence, the complete separation between man and woman to only possess one or the other trait can

explain why some women are attributed higher mental capacity than others. For example, the association of women who are stuck in immanence – i.e. dependent on men and not actively making their own decisions – as being less mentally capable as women who are associated with achieving some transcendence – i.e. independently working and acting in the world – could be due to the fact that the women in transcendence are being associated as more capable to take care of themselves as they are within a more "masculine" category. This gendered stereotyping is rampant within the man-woman dialectic, so it is not a surprise that when a woman starts to exhibit masculine traits or walk the line of a masculine category, they will be taken more seriously than if they exhibit more naturally "feminine" traits (King, 2021). However, as will be explained later within Chapter Three, exhibiting these masculine traits turns into a type of paradox, as a masculine woman will still be taken less seriously when paired against a man even when they are viewed as more capable when paired against a more feminine woman. In this way, women are ultimately not viewed as autonomous beings in their own right, which is to say men are not acknowledging or respecting women's autonomy even when they reach a seemingly equal status (de Beauvoir, 1956 p. 15). With how ingrained this objectification is in women's daily life, it makes it so that even "the most sympathetic of men [can] never fully comprehend woman's concrete situation," as they have never had to question the fact that they are not anything except absolutely defined (de Beauvoir, 1956, p. 25). This view is one similar to Hegel's, however, he views that men have a double fault because although men cannot comprehend the women's situation, *they also* cannot comprehend fully their own situation. This objectification and the perception that

a woman possesses lower mental capability is one that will be examined further within Chapter Three when analyzing the dynamics between female and male physicians.

At this point in the thesis, it is important to note that as similar as Hegel and Beauvoir's structure may be, there is a strong distinction between the two philosophers on who they view is the truly harmed group within the master-slave or man-woman dialectic. The final stance of Hegel, which is previously a conclusion that I had departed from, is that the master is the one who is most injured in the dialectic as they are unable to fully grasp their position in not seeing the relativity of themselves to the slave. When considering that the even the most sympathetic of men are not able to comprehend women's position, the divide between Beauvoir and Hegel's view of the victim in the dialectic is stressed. For Hegel, the man is the one who is truly hurt within this dialectic as they do not have the self-awareness to see their situation for how it truly is due to being unable to sympathize and visualize the situation of the women around them. However, women can empathize and visualize the position of men due to the self-awareness gained through their position. Hegel's conclusion that men are the true victim of this structure is polar opposite to the conclusion that Beauvoir makes. Although Beauvoir acknowledges that men are unable to comprehend women's position, she believes that it is women who are the true victims in the structure, not the men. In this way, Beauvoir believes that women – in a position as the slave in Hegel's theory – are hurt by not having their opposite in the dialectic, or men, understand and perceive their experiences and from having to endure the problems of gender-based otherization that stem from their position as the Other. Going forward, I will be following Beauvoir's view that women are the ones hurt within the dialectic. Now, it is important to examine

how women are being placed as the inferior, or inessential, group in this man-woman dialectic.

It must be reasoned that there is more to women being placed into the category of the Other aside from being viewed as "absolute sex" or men's dependent. With the competitive structure between individuals always occurring, the idea of men being the victor every time raises questions of how this victory was decided. Furthermore, the placement of women as the perceived other to men is not something that happened spontaneously and instead can be seen as a constant hierarchical structure. In a similar way that the master "won" the fight against the slave and claimed to be absolute over the slave, it could be claimed that men "won" a fight over women and have entered their position of the absolute in response. However, this account may have underlying bias, as the reason why men are viewed as the absolute and not women can be because "men's interest" has created the history – and the modern world – that we currently know (de Beauvoir, 1956, p. 20). In this way, men have been "judge and party to the lawsuit" of any grievances brought against women and can write the history of women being the *Other*. This suspicion of men appointing women in this category can be seen in several historical writings that show the man-woman dialectic to be supported – such as Aristotle claiming females are "afflicted with a natural defectiveness," the story of Eve in the Bible and Pandora in Greek mythology is made by man, and even scientists who theorize biological distinctions as justifications for women's position (de Beauvoir, 1956, pp. 15, 21, & 25). The answer to the question of how men always come out to be victorious can be found in these instances, as the circumstances created by men have resulted in women being placed in a situation that "affords them fewer possibilities" and keeps them in a

"situation of inferiority" within the vicious cycle (de Beauvoir, 1956, p. 23). When already starting ten feet under their competition, women are placed at a disadvantage the minute they try to take up the fight for equality.

With all of this considered, the true harm of this categorization are the devastating impacts to women's daily life due to the formed view that the unequal life – seen within the man-woman dialectic Beauvoir explains – ought to continue. The main proponents of this life are men who benefit from the system, as they have set the normal standard for society. The pushback for going against the societal norm is very comparable to a master who would not want their slave to be freed as that would result in the loss of the benefits that the slave provides for them from their subjugation. The quote that Beauvoir (1956) uses in *The Second Sex* on a male student's view of women gaining equal standing in the professional world – "'Every woman student who goes into medicine or law robs us of a job'" – highlights how men take advantage of women's position and feel their rights threatened at the idea of equal standing (p. 23). However, it is important to note that although the subconscious view that women are not deserving or qualified to become doctors in comparison to men, research supports that "female physicians provide an overall better quality of care" and "patients treated by female physicians had lower 30-day mortality and readmission rates" compared to those treated by male physicians "at the same hospital" (Ali, 2023; Berthold et al., 2008; Tsugawa et al., 2017). Again, the larger theme that men are setting a neutral standard is shown, and when women – who have been viewed as inessential or as the other to the norm – start to be of equal standing to men it threatens the absolute position men have angled themselves in. Even when achieving a position equal to or surpassing the bar set by men, women are still viewed as

inferior subconsciously within society. This theme is extremely prevalent to answering the questions raised within the introduction of this thesis – i.e. why female physicians are treated differently than their male colleagues – and is necessary to make note of as it will appear again in later conversations. Now, Beauvoir (1956) concedes that men may not "*postulate"* women as inferior directly in conversation, and that they may even view women equal when in a conjugal, co-operative relationship, but when there is a challenge to men's position there will always arise a support of the existing inequal life (p. 24). This is where the paradox of women being concurrently viewed as equal and inequal begins, as a woman may be viewed man's equal up until she begins to start capitalizing on positions historically only held by men up to that point, such as when she begins to step out of the romantic relationship and into the workforce.

From this point, it may be wondered how a woman can be placed within this paradox. One potential explanation beyond the fact that men have set a standard in society that they intend to keep is that women are viewed as less capable beings compared to men. As mentioned before, the gendered stereotyping and objectification that women endure within the dialectic structure attribute a state of immanence and passivity onto women. This attribution will lead even the most masculine of women to still be seen as less capable and untrustworthy on acting with their own autonomy by men, as they are still associated as the Other. When women's autonomy is being ignored and disrespected by men, paired with the fact men refuse to acknowledge their own autonomy is achieved through women respecting them, it can have negative ramifications for women's ability to move out of their state of immanence and their health. Specifically, a woman's health can be severely impacted when this objectification occurs

and their mental agency is put into question, as it can result in their actions and experiences being dismissed. A prime example of this in real life can be seen in healthcare, when a woman's severe pain during a medical procedure – such as giving birth – is often dismissed or undermined by a physician and as a result they do not have their request for medication acknowledged (Bever, 2022). This phenomenon is one that will be examined further within Chapter Three and provides the steppingstone for how the philosophical structures' presented up to this point can help to answer the problems of gender discrimination occurring in healthcare.

CHAPTER THREE

Otherization in Healthcare

Medicine as a Social Construct

It is now where the question posed in the beginning of this thesis, what structure cultivated the foundation for the development and persistence of gender discrimination in healthcare, can start to see practical application. At this point, the first part of this question was answered within the master-slave dialectic. The dialectic proved to be the type of structure that, when negative separation between individuals occur, can create a power-imbalance between groups and cultivate the problem of otherization. When this problem occurs, it can lead to devastating impacts in the form of harmful stereotyping, dehumanization, and/or objectification. Furthermore, the second part of this question was answered through the application of the man-woman dialectic, which shares strong similarities to the master-slave dialectic and can provide an answer to why gender discrimination is still prevalent within society. As man and woman are placed into this negative state of opposition, it will impact the way that a woman is perceived, treated, and expected to act within a given context. This is where we can now shift our focus to the last half of this pressing question, with how this all relates to healthcare and the problems occurring within medical interactions.

With Beauvoir's deconstruction of gender within her philosophical theory it shows that the phenomenon of women being placed into the role of the Other and being treated accordingly does not happen within a vacuum. The placement of women into the role of the Other occurs consistently throughout society, and it is this practical aspect of

Beauvoir's theory that allows it to be applied within modern medicine, as medicine similarly cannot function in a social vacuum (Bhugra, 2014). With medical practice's main goal being an "imperative to care for patients and to alleviate suffering," it is apparent how interwoven medicine can be with the surrounding society (*Opinion,* n.d.). The practice of medicine can involve multiple actors, however, it normally consists of a dynamic between a caretaker - i.e. physicians, nurses, hospitalists, hospital administration, etc. - and a care receiver - normally viewed as the patient. In this way, the core aspect of medicine has "long been recognized as residing in the interpersonal aspects of patient-physician relationship[s]" (Hall et al., 1981). From how interwoven medicine is to social interactions and relationships, it is self-evident that medical progress has deep ties to the social and cultural changes occurring around it. The Industrial Revolution's impact on medicine is a stark example of this phenomenon, with the rapid increase in hospitals being fostered by the rapid urbanization and social changes that this new era created (Arlotto & Irby, 2020, p. 42; Shryock, 1936, p. 44). Medicine being viewed as *social* medicine can allow for a conversation beyond purely immutable or biological conversations, and instead focus on how medicine is a product of human convention shaped by cultural and historical contexts (Kang, 2012). With how closely tied medicine is to the norms set by society, certain socioeconomic, ethical, and cultural developments can be influencers within medical progress and impact the evolution of medical practices (Bârsu, 2017). In lieu of medical progress being tied to social norms, it is important to identify what norms are present in medicine to understand the harms that need to be addressed.

The historical events that occurred to form the medical practices we know today can be good starting points to understand the magnitude of the problems occurring within healthcare today. This concept is important as the only way to have a proper perspective of medicine is to view it in its entirety, which is to view it as it is in "the past, the present, [and] the changing unfinished future" (Udwadia, 2009). This perspective is aided when viewing medicine through the social determinants of health. The social determinants of health provide a multi-layered view of an individual based on socio-economic and political contexts, structural determinants – education, occupation, gender, race/ethnicity, etc. – and socioeconomic position, and intermediary determinants and how all these non-biological factors impact their overall health (Solar & Irwin, 2018). Gender, which is a structural determinant of health, has been a focus within medical research in the hopes of studying its impacts on individuals health, such as in the form of gender bias or discrimination. Gender norms and their involvement in societal structures have aided in the rise of gender inequities within society, and in the field of medicine these inequities could be the difference between life and death (Pederson et al., 2014; Miani et al., 2021; Mosca et al., 2011). Looking at medicine in this perspective is a beneficial step in identifying the problems that were outlined in the beginning of this thesis. However, even taking this approach still only scratches the surface of how these problems arise. Therefore, in order to comprehend the true depth of the problems that are occurring, it is essential to use this social view of medicine and analyze it through the philosophical perspective provided by Hegel and Beauvoir.

Gender Discrimination: A Physician's Perspective

The dialectical structure presented by Hegel and reimagined by Beauvoir is an essential starting point in analyzing the development and perseverance gender discrimination within healthcare. With understanding the structure that allows for the development of this form of gender bias, it can open the doors to start answering other questions also posed within the introduction of this thesis. To start, let's look to the first question of how and why this dominating, dialectical structure has impacted the way female physicians – when having the certification and accolades to be a medical doctor – are treated different than their male colleagues. To navigate this question, it is important to pull through the overarching theme provided by Beauvoir that men are viewed as normal, transcendent subjects, which means both that they are setting the norm in society and that their perspectives are treated with respect. Women, by contrast, are considered the exception and with being viewed as abnormal to the norm their decisions and perspective are questioned on extra, external factors, such as biological features. Having a societal norm that interactions or social standards are based on men can have reverberating impacts in medicine and medical care provided to patients.

Having this background knowledge can be beneficial to see how Beauvoir's theory of men setting a neutral standard can create a "boys club" culture in male dominated fields or studies. By "boys club" I mean a culture where men in leadership positions share a specific camaraderie and exclusive privileges that are not experienced by individuals who identify out of their group (Fuller, 2022). This culture can be seen as early as undergraduate or medical school classrooms, and with no action being done to change this cultural mindset it continues into the culture of healthcare dynamics. An example of this occurring in practice can be a group of male physicians within a certain

specialty having a camaraderie with one another and sharing privileges only to individuals within this group, such as higher referral of patients to another physician within the group or receiving more lucrative procedural referrals (Dossa et al., 2022; Basky, 2021). This "boys club" culture has been cited as a barrier for women entering into male-dominated specialties and has created a "glass-ceiling" – a non-physical barrier that is derived from the organizational culture of a job favoring men – that women must break in order to be at even footing to men (Longo, 2008). The obstacle of having to overcome a one-sided culture has resulted in fewer women entering these fields, as even if they do overcome the culture and join the field they still are underpaid – over a $2.5 million gap in a lifetime wage – and have to acclimate to the masculine culture through either downplaying their femininity or actively try to exhibit more "masculine" traits (Eshtehardi et al., 2022; Shah, 2018; Winkel et al., 2021). However, as seen before with Beauvoir, even when women take up more masculine traits, they are still at a disadvantage of being viewed as subordinate or lesser by their male colleagues, which only makes moving up the social ladder even more difficult. The culture of male-dominated medical fields has definitely impacted the level of female representation in medicine and feeds into the man-woman dialectic explained by Beauvoir.

To specify a male-dominated field where women may face this culture barrier, let's reexamine the field of cardiology and first-hand accounts of women practicing in this field. In the cases mentioned in the introduction of Dr. Hayes, Dr. Kells, and Dr. Graham, they each experienced comments or questions that stemmed from this culture that women were perceived as being outside the group who are allowed to practice medicine. This culture not only perceived them as less capable of making decisions, but

also second guessed their own capabilities as doctors. In the instance of Dr. Haynes, she felt under qualified in talking on a subject she has dedicated years of research on due to the fact her audience was composed of men (Hayes et al., 2020). Cardiology employment and structure of the occupation also exhibit qualities expressed by Beauvoir in the way that they are "formulated by men with androcentric approaches," which means any woman joining the field is already going to be disadvantaged in facing a "glass ceiling" from the structure as the field was organized to purely benefit men (Eshtehardi et al., 2022). Knowing how men are seen as the transcendent subject, the privileges experienced by men in this culture – such as men specific networking opportunities and promotion of male colleagues over women – further disadvantage female physicians (Mengel, 2020; Mohta, 2023). As a result of this unequal structure, female physicians "must work 3 times as hard and then wait twice as long for the same rewards" as men (Longo et al., 2008; Winkel et al., 2021). If future physicians are subconsciously internalizing the norm created by the dialectic structure of women being treated differently than their male colleagues, it can have drastic impacts on keeping these conditions living within the future of healthcare.

Furthermore, this culture is not unique to when a physician finally enters into healthcare to begin their practice and instead can be seen as early as the educational environment that future physicians are exposed to before receiving their doctorate. In particular, the exposure future physicians have in medical school – such as textbook content and faculty – can subtly reinforce the idea that "women, because they are women, are abnormal" (Phillips & Ferguson, 1999; Harrison, 1990; Lawrence & Bendixen, 1992; Giacomini et al., 1986). This concept has been one dating back to the Third Century

BCE of “male dominance–and with it the superiority of the male body– was cemented into medicine’s very foundations” (Cleghorn, 2021; Dickenson, 2022). The male body being seen as the superior body, and ultimately the one that medicine should be based upon, is an idea that Beauvoir (1956) mentions in her excerpts – i.e. the story of Adam and Eve, Aristotle, or St. Thomas – with how women’s bodies are viewed as being “relative” to men and not being defined as a subject in their own right (p. 15). The historical precedent of how women are referred to, whether their bodies are an inverse of men’s or the concept of them being abnormal, is influential beyond just medical school and is apparent when future physicians are just pre-medical undergraduate students. An example of this is the previously mentioned standard of female physicians having to work twice as hard to be at an equal footing to men, where this culture is one that is very much prevalent within undergraduate S.T.E.M classes. In these courses, men are consistently viewed as more knowledgeable by their male peers, to an extent that a female student would “need to be more than three-quarters of a GPA point higher than the males” in order to be recognized by the same male peers to be at the same level as a male student (Bach, 2016). With all this in mind, it is of no surprise that the philosophy and language used within medicine, such as the male body being the main model within anatomy textbooks, equates “men with normal” leaving women to be seen as the “other” within medicine (Harrison, 1990; Phillips, 1997; Lawrence & Bendixen, 1992). The culture surrounding the education of future physicians can breed deep gender bias, where when left untreated can impact the interpersonal relationships at all levels of healthcare.

It is here where the dialectical structure proves to have its most influence, as it is the foundation for the hierarchical structure found between male and female physicians.

The stereotypes placed on man and woman – highlighted with Beauvoir in describing the relationship between immanence and transcendence – can be an influence on the development of these "traditional" gender roles within healthcare. Women being seen as more emotional than men are gendered stereotypes, but this view of women has resulted in women being placed within roles that expect them to be more empathetic, family-oriented, and passive. Due to the societal expectation for women to take on a role of immanence, when women directly refute this placement by taking on a position as a physician – i.e. a position long held to be associated with transcendence of actively leaving the household to create or not be family maintenance centered – it is going against the assumed dialectical structure. Thus, female physicians, even when taking on a transcendent role, still have the expectations of immanence follow them into the workplace. This takes the form of female physicians being expected to have a more caring or empathetic communication style, expectations for them to have longer clinical visits with patients than expected, and to take on a less dominant approach – dominant being seen as "sit[ting] too close, speak[ing] more and/or loudly, look[ing] more often at their computer, ask[ing] too many questions, or disagree[ing] with patients" – when engaging with their patients (Mast et al., 2011; Linzer & Harwood, 2018). These expectations are not there for their male colleagues, and it's this paradox of moving outside of the dialectical structure but still being viewed as within it that cultivates female physicians still being treated differently by their male colleagues.

With the organization of healthcare continuing to facilitate this dialectical structure between man and woman, negative impacts for all individuals involved, both patients and physicians, have developed. For men, when placed into a gender role based

in transcendence there is an expectation for them to take up positions that align with more masculine traits – such as a physician who is associated with curing a disease and leading a surgery – and more technical or active leadership positions (Hay et al., 2019). For women, being expected to continue the role of immanence, even when trying to mutually practice transcendence, results in an expectation to go into a position that aligns with more feminine traits – such as nurses whose roles are more focused on providing and maintaining care for their patient instead of leading and directing a surgery – and increased resistance against going into more masculine positions (Hay et al., 2019; Morgan et al., 2016; Morgan, 2018). For female physicians, when a structure is based on these gendered norms – specifically how the dynamic between a patient and physician has shown to take on a paternal, authoritative dynamic – there are already expectations for the women to act in an opposite manner than what the traditional gender roles expect them to take on. This dynamic is not only conflicting for the female physician themselves with navigating an androcentric work environment, but also can lead to conflicting interactions with their potential patients. In a case study conducted of a female physician showcasing dominant, transcendent traits more associated with men, they experienced negative satisfaction from male patients post-visit, whereas they experienced more favorability with female patients (Linzer & Harwood, 2018). This difference in reaction between the different gendered patients could be that the female patients acknowledge the female physician's plight to take on the transcendent position and challenging the dialectic structure, whereas the male patients may feel threatened. With all this considered, it is evident that the gendered norms and roles placed onto women – specifically women trying to succeed in a male-dominated field such as

cardiology – are large factors in the way that women have been viewed or treated differently than their male peers.

To further unpack how these norms have impacted the differential treatment towards female physicians, let's go back and examine the ideas of objectification now that we understand how they could show themselves in relation to gender. In terms of objectification, the idea presented before of viewing an individual closer to a thing than a human being can still be applied in healthcare, and it shows itself when an individual – either a patient or physician – is viewed as incapable of making autonomous decisions. This idea is important to build upon my answer for why female physicians are treated differently than their male colleagues, and another aspect that supports why gender norms aid in the objectification of female physicians. This objectification can take many forms, and one way is having their decisions consistently undermined from the perception that women are being "emotional" and not "rational" in their decision-making. Perceptions like these result from stereotypes that these characteristics are fixed to women and men respectfully, and results in a lack of trust and respect for a female physician to make autonomous decisions (Broverman et al., 1970; Phillips, 2005). In everyday encounters, this type of objectification can take the form of male physicians disparaging the diagnosis or medical decisions made by their female colleagues. The potential impacts of this encounter are only heightened when such an encounter is made in front of patients, ultimately pinning the female physician in a situation where their credibility and position are questioned on both the personal and professional level (Adams, 2022). Even patients – without being prompted by external comments on the validity of the physicians' decisions – have shown a prejudice towards female providers and deny their authority or

legitimacy, going so far as to ask for a "different" doctor due to the strong-held stereotype that "the white male doctor was still the optimal and preferred provider" (Dellasega et al., 2022). This type of stereotyping demeans female physicians capabilities to being inferior to the capabilities of their male peers, which is concerning when this viewpoint has been directly contradicted when a study found that when there are a greater proportion of female physicians in the workplace there are reduced maternal and infant mortality and overall better treatment of cardiac patients (Maas, 2020; Baumhäkel et al., 2009). With women being placed into the role of the Other – or as Beauvoir would view it as women being denied the transcendence that men are granted – it can illuminate the answer for why there is a difference in treatment for female physicians compared to their peers.

Furthermore, beyond the psychological objectification of a female physician's capabilities, stereotyping based on traditional gender roles can have physical implications for female physicians within their work environment. From the research of multiple studies, it has been shown that female physicians experience heightened gender-based workplace sexual harassment, especially women who enter historically dominant male specialties such as cardiology (Frank et al., 1998; Smeds & Aulivola, 2020; Eshtehardi et al., 2022; Sharma et al., 2021). Objectification to this degree can have psychological impacts on female physicians, especially in the instance of heightened self-doubt if workplace sexual harassment is really that bad or if they are just being "over-sensitive," or in other words over-emotional (Hinze, 2004). To refer back to the idea from Beauvoir, that women are defined based on their sex and viewed as a "sexual being" in comparison to men, when women are consistently portrayed as sexual beings that do not have agency it can result in heightened violence against women (Seabrook et al., 2018; Fredrickson &

Roberts, 1997; Beauvoir, 1956, p. 25). The healthcare environment is not immune to this violence, as female physicians face harassment that includes both verbal and nonverbal behaviors, such as viewing or treating women as "inferior through hostility, objectification, disparagement, or exclusion" (Jagsi, 2018; Minkina, 2019; Sharma et al., 2021). This sexual harassment is not just unique to physician-physician interactions, as there have been reports of female physicians experiencing heightened sexual harassment from patients whose actions are routinely dismissed as "hazard[s] of the job," even when it creates damages to the assaulted physician (Viglianti et al., 2018). It is reasoned that when women are viewed similar to objects instead of subjects, there is less moral concern for damage inflicted upon them and a greater tolerance for sexual harassment as a cultural expectation develops for how women can be treated (Heflick & Goldenberg, 2009; Loughnan et al., 2013; Gervais & Eagan, 2017). Due to the fact that women, when placed into the dialectic structure, are viewed as the Other, which is viewed as closer to a thing than a being, that can explain how this problem is continuously being unaddressed or dismissed in present day. With how overarching the gender norms can impact the culture of healthcare, it is deeply concerning the extent to which female physicians are treated differently than their male peers.

Gender Discrimination: A Patient's Perspective

Along with the dialectic structure providing the foundation to answer why female physicians are treated differently than their male peers, this structure also provides the answer for the second question raised in this thesis of why women fall through the cracks for cardiovascular disease more often than men. A prime example is that Beauvoir's

theory on how men take the role of the essential – or in the view of Hegel the master or lord – can be applied to the interactions between physicians and their patients. To fully examine how this structure relates to the question at hand, it is important to apply the dominating structure to the physician-patient relationship and analyze how it has impacted the quality of care provided to patients, specifically women. The first place to start is examining how a dominating structure arises in medicine, and a good place to start would be examining the power difference between a physician and their patient. Physicians take an innately powered role in this dynamic due to their "greater knowledge, expertise, prestige, organizational support, and stability within medicine compared to patients", leading many physician-patient relationships to be founded on a hierarchical, authoritative structure (Foucault, 1972; O'Shea et al., 2019; Bates, 2010). The resulting impacts on patients from being in this dialectical structure have been shown as heightened patient loneliness, disempowerment, and feeling a lack of autonomy in the ultimate decision the patient would have for their health due to lack of communication or time constraints of a procedure (Ocloo et al., 2020). Knowing this, it is concerning when studies show male physicians have a higher prevalence of asserting their status differences between them and their patients, whereas female physicians take "greater pains" to equalize their status with their patients in an attempt to neutralize this dominating structure within their interactions (Eagly & Johnson, 1990; Roter et al., 2002). To apply Hegel's view in interpreting this dynamic, women – with being placed into a role as the other – can understand both their own perspective and that of the patient or male physicians (as they can take on the perspective of both the subject and the other) – and that has equipped them to understand the importance of viewing both sides of the

clinical interaction. Whereas men – with only being able to take on the view of the "essential" – are not able to see the perspective of the patient or women as easily due to the placement they have taken in societal norms.

These findings that male physicians have a higher prevalence of asserting an authoritative dynamic in their patient interactions are concerning when considering a field that is heavily male-dominated, such as cardiology. Specifically, let's examine how these findings relate to the misdiagnosing rate for women with cardiovascular disease being higher than their male counterparts. When "a gender-lopsided field" arises – which is when one gender is more heavily represented in medical care than others – there can be an "affect [on] patient care" in the form of a patient looking for care having their perspective underrepresented – or viewed as abnormal – by the dominant gender in the field (Yong et al., 2019). With men dominating the field of cardiology, a female cardiology patient may be at a higher risk of experiencing the impacts of an authoritative physician interaction. Within one study this problem is apparent, as it was revealed that female patients who are treated by a male physician for acute myocardial infarction (AMI) experience a higher mortality rate than if the female patient is treated by a female physician (Greenwood et al., 2018). In taking the stance of a devil's advocate, it could be wondered if gender is the main cause of this increased risk for mortality or if it was just based on the sample size selected. However, when it was further shown that male physicians have more effectiveness in treating female AMI patients when they have more exposure to female colleagues or after treating multiple female patients, it can be inferred that gender and a gender-lopsided field has devastating impacts in and on the patient-physician relationship (Greenwood et al., 2018). With this problem still

occurring even after a male physician has had interactions with both female patients and physicians brings back the quote from Beauvoir that "the most sympathetic of men [can] never fully comprehend woman's concrete situation" (Beauvoir, 1956, p. 25). The role gender plays in the physician-patient relationship has now moved from being one of a philosophical structure to impacting the level of care that a woman may receive, which begs the question of if this is unique to just male physicians treating female patients or a part of a larger picture.

The fact that cardiology is a predominately male-dominated field may be one answer to why women seemingly fall through the cracks within cardiology, however it is not the only explanation. Along with the presence of a highly authoritative and male dominated structure, the research being conducted for how future physicians ought to treat patients historically is founded on a lack of female representation within clinical trials. It was only in 1993 when the US National Institutes of Health (NIH) required that women be a part of clinical trials, which is to assume that all investigators conducting trials are following this 30-year-old policy (Geller et al., 2018; Mauvais-Jarvis et al., 2020). Specifically in cardiology, 740 cardiovascular trials were completed with a total of 862,652 adults in which "only 38.2% were women" (Jin et al., 2020). In another set of trials focusing on heart failure, where women are not adequately represented, similar results were shown (Reza et al., 2022; Vaduganathan et al., 2019). The lack of female representation in clinical trials has historically kept this androcentric – or being focused and centered on men – structure and only reinforced the lack of knowledge on women in medicine within education (Merone et al., 2021; Liu & Mager, 2016; Holdcroft, 2007; Merone et al., 2022). It can also be wondered that with how skewed the demographic

pool is between female and male participants, if the ideology of women being the abnormal or other is an impact on the pool being predominately men with little concern for the lack of female participants.

Along with the initial problem of women's lack of participation in medical trials being a low concern, there are also the reverberating impacts that result from the lack of research on how women present health problems in clinical care. When this education is not being geared to teaching how women exhibit symptoms for cardiovascular diseases, it results in "typical" angina – a type of chest pain due to reduced blood flow to the heart – symptoms being derived "from male cohorts," which ultimately sets men as the standard for what symptoms to look out for when making diagnoses (Douglas & Ginsberg, 1996; Keteepe-Arachi & Sharma, 2017). When typical symptoms are based on men, it would lead women – who present cardiovascular disease at different stages than men and with unique symptoms compared to men – to have their symptoms fall outside of the diagnostic checklist as their symptoms could be perceived as atypical and result in a misdiagnosis by the cardiologist. Having this checklist based on men has astounding consequences especially in cardiology, as women are "50% more likely to receive a wrong initial diagnosis" and when initial misdiagnosing occurs the risk of mortality rises by 70% (Harding, 2022). This can be seen directly with a study conducted by Roswell et al., where female STEMI patients showed significantly higher mortality of 4.1% in the index hospitalization when compared to male patients' 2.0% mortality and this morality only increased as C2D (contact-to-device) time was increased (2017). When women are shown to have higher misdiagnosing rates, this would lead to an increased C2D time and ultimately be a factor in women's increased risk of mortality. This risk of mortality may

seem heightened for women, however it isn't out of the ordinary when it has been shown within a meta-analysis study that the female sex has consistently been viewed as a variable associated with early death in patients (Conrotto et al., 2015). Furthermore, women are less likely to be referred to further diagnostic investigations than men based on this reason and have more often a diagnosis of their pain been related to mental health ailments "rather than a bodily or biological one" (Cleghorn, 2021; Dickenson, 2022; Lichtman et al., 2018). Misdiagnosing and invalidation of women's pain is one that shouldn't be occurring in healthcare, and the drastic implications on health are reason enough to reexamine the dialectic structure that is influencing the diagnosing standards.

Along with experiencing an invalidation of their pain, female patients also experience invalidation of their decisions and opinions on their treatment. This is a form of objectification similar to that experienced by female physicians, however for a patient there is the key difference that the outcome of this objectification can turn to life-threatening complications. Before explaining this distinction further, it can be helpful to explain how the experiences of a female physician are universal to one of a female patient. In the way that female physicians are seen as too "emotional" and have their decisions undermined, so too are female patients – especially women who experience chronic pain – perceived as "hysterical and emotional compared to men" (Samulowitz et al., 2018; Markowitz, 2022). This universal gender bias can have drastic impact on the care that patients may receive, for women are viewed more often by health care providers to be "exaggerate[ing] their pain" leading them to be less likely to receive "more aggressive analgesic treatment" for their pain (Schaefer et al., 2016; LeResche, 2011; Safdar et al., 2009; Wesolowicz et al., 2018). As previously mentioned, this form of

exaggeration can lead women to be treated for a mental health ailment rather than a physical ailment. The implications of the gender discrimination on women can be seen explicitly in the case of surgery, as it was found for men and women both undergoing coronary artery bypass graft that men "received narcotics more often than female patients" and women "received sedative agents more often, suggesting that female patients were more often perceived as anxious than in pain" (Hoffman & Tarzian, 2001; Calderone, 1990). To make matters more concerning, female patients will experience a form of objectification in the language physicians use in referring to women compared to men, with women being described with more impersonal pronouns compared to men leading to a perceived "psychological distance between a physician and their target" (Wilson, 1990; Markowitz & Slovic, 2020b; Weiner & Mehrabian, 1968; Markowitz, 2022). It is the moral and psychological impacts on women's health that makes this problem important to research and understand its implications.

CONCLUSION

At the outset of the thesis, I highlighted medical errors and professional discrimination that can occur in a clinical setting. After identifying these problems that persist in healthcare, it became apparent to me that there was some type of foundational problem occurring in healthcare that showed itself within unaddressed discriminatory actions. This sparked the main question for this thesis, which was what structure cultivated this foundation that allowed for the development and persistence of gender discrimination in healthcare? After careful consideration and examination, I believe that I found the answer to this question within the research of the philosophical framework of the master-slave dialectic and the man-woman dialectic. In Chapter One, I offered the initial steps that can be made in answering this question. These initial steps included outlining the importance and universality of the three-part structure presented in Hegel's fragment writings on "Love," how this structure shows the important development of the self and the other, and how this structure can become problematic. Although each stage within the three-part structure showed its importance in the developmental cycle of the self and the other, the second stage of separation (or alienation) proved to be of high importance when answering the main question of the thesis. It was within this stage where the problems of otherization originated, and where the connections to healthcare problems became apparent.

However, it was important to bridge the gap between a theoretical philosophical theory to the practical everyday experiences in healthcare, and to do that I took the next step of showing how this dialectic relationship can turn negative. This was shown within the master-slave, or lord-bondsman, dialectic in Chapter One and within the man-woman

dialectic in Chapter Two. Each structure shares their similarities and importance in answering the question, however the initial goal of Chapter One was to outline what the master-slave dialectic was and how the individuals within this structure were perceived and treated. Immediately, the master-slave dialectic structure presented a power dynamic between two individuals and how one group or individual was treated objectively worse than the other. The dialectic structure also proved to be useful in answering the question of this thesis as it outlined a much deeper progression of how an individual may be placed into a position of the master or the slave and the competing dynamic occurring between the two individuals within this structure. The importance of this dialectic was shown in its explanation of how otherization can begin to exist, as individuals who are viewed as the other are in a position of being treated negatively based on their placement. The negative impacts of otherization proved how this dialectical structure can become negative itself and perpetuate harms in the physical world. As such, otherization can lead to the problems of dehumanization, negative stereotyping, and objectification that are seen within physician-physician and physician-patient relationships.

After laying the foundation of the dialectic structure and how it perpetuates harms in the form of otherization to the subjugated group in Chapter One, the next step in answering the question was to apply this structure to gender. The application of the master-slave dialectic into the man-woman dialectic was the main goal accomplished by Chapter Two. Simone de Beauvoir's philosophical theory of the men-women dialectic was integral to bridging the gap in applying philosophical theory to practice. The case studies that outlined the main concerns and questions that I had for this thesis were based on a foundation of gender differences in medical care and treatment in healthcare

systems. In order to answer these questions, a theoretical bridge needed to be made between Hegel's master-slave dialectic and the problems of gender discrimination within medicine, which is accomplished through Beauvoir's theory. Simone de Beauvoir showed how women are placed into the role of the other, how that placement puts them at a disadvantage to men, and why it is difficult for that placement and perception of that placement to be changed. It was from here where I made the first connection that the experiences of women, and the gender discrimination that they face, can be strongly linked to the dialectic structure that they are placed within. After showing how women are placed into the role of the other, it became clear that the problems of gender discrimination women face are a form of otherization, which can explain the heightened sexual-objectification, gender stereotyping, and dehumanization experienced by women. After making the connection that the problems of gender discrimination are a form of otherization occurring against women, it was then possible to make the third and final movement of answering the question posed in this thesis of applying this philosophical framework to the very real problems occurring within healthcare.

One aspect that was applied to the practical problems within healthcare was how the dialectic structure bred an expectation that men and women can only exist in one space or the other, neither both at the same time. The traditional gender roles and stereotyping helped to keep women stuck in their specified role. Through this placement, women were expected to stay in a place of immanence compared to men who were placed into a role of transcendence, and this had monumental impacts in the treatment of female physicians in the workplace. Female physicians inherently a paradox to this expectation as they are still a woman and are viewed as the other in the dialectic

structure, but also take on the qualities of transcendence normally associated to a man within the dialectic structure. In going against the expectations of the structure, female physicians are then met with demoralizing, sexist, and potentially physically unsafe workplace conditions. The quality of their workplace is only worsened if they enter into a field that is male-dominated, as they are even more pressured to fit into the placement of the other even when they have made strides to climb out of that role.

The application of the philosophical framework is also relevant to the relationship seen between physicians and patients, as female patients also feel the impacts of otherization. Implications of otherization for women's health include misdiagnosing and higher mortality rates for female patients, as well as an undervaluation of female patients' concerns or pain. These problems only worsen when a female patient is paired with a male physician, as they are placed in a double bind as they are stuck in the man-woman dialectic relationship, which places them as lesser to their male physician, as well as stuck in the patient-physician dominating relationship, where the physician holds more power over the patient. When you pair both of these considerations together, it is of no surprise after analyzing the impacts of a negative dialectical structure that these patients will experience higher misdiagnosing and mortality rates than if they were to be treated by a female physician. With all areas being shown to have statistically significant impacts for women, especially women within male-dominated fields like cardiology as a patient and physician, there is an importance of understating that this structure described by Simone de Beauvoir and G. W. F. Hegel can have direct application to the interactions occurring within medicine.

Finally, the question presented in the beginning of this thesis of what structure cultivated the foundation for the development and persistence of gender discrimination in healthcare has now found its answer. After reviewing the philosophical structures presented by Simone de Beauvoir and G. W. F. Hegel, it is apparent how this seemingly practical and medical oriented question encompassed so much more. After answering how the dialectic structure between man and woman was the influence for the gender discrimination occurring in healthcare, it leads to the answers for the questions raised by the initial case studies. The impacts from the dialectic structure are seen in the way that women not viewed as capable and treated differently than their male colleagues, in the way women fall through the cracks for cardiovascular disease more often than men, and especially in the way that being a female is a variable for high risk of mortality or surgical complications. All these answers share the common theme that the structure present between man and woman aids in the development of gender discrimination within healthcare, and this structure can only be understood with having a philosophical perspective. For female physicians, their existence is directly opposite to the role they have been placed into and results in treatment that attempts to place them back into their designated placement. For female patients, the active acknowledgement that there is a problem with the way illnesses and women's health are addressed in medicine is directly opposing against the passivity and immanence that they have been placed in. It is acknowledging how this system is structured that can result in the changes needed to bring a more equal – or in the words of Hegel a reconciliation – environment for women and to challenge the otherization ongoing within medicine.

Further Research Areas

An area that wasn't explicitly focused on within this thesis was the perspective of groups that fall within the inessential or abnormal category when compared to cis-gendered men. These groups can include transgender women, transgender men, and non-binary individuals who would also feel the effects of being placed into the category of "other." As the focus of the paper and studies that were referenced throughout focus mainly on the experiences and perspective of cis-females, the individuals who fall outside of that category do not properly have their perspective or experiences quantified within this thesis. Given more time and potential future research, applying studies that focus on the experiences of individuals in the LGBTQ+ community would be beneficial in analyzing the depth of the problems of otherization in healthcare. As Beauvoir mentions what qualifies being a "woman," the philosophical theories provided in this thesis could be a starting point to further analyze how individuals in the LGBTQ+ community are otherized and identify the structure that permits this type of problem to continue in healthcare.

The other demographic that was not heavily addressed within my research was the perspectives of people of color, specifically women. A large majority of the studies that I used would use the term women as a general blanket term, however it did not account for the different experiences that a woman of color might have compared to a white woman in healthcare. Towards the end of my research, I had come across multiple studies that showed that women of color experienced heightened racism and invalidation of their pain compared to their white peers (Sabin, 2020; Johnson et al., 2020). These heightened experiences are not just unique to patient and female physicians of color also experience

racism, invalidation of their decisions, and microaggressions within their workplace environment (Sharp et al., 2022). Understanding these perspectives in future application of the philosophical dialectic structure can add more depth to answer found within this thesis and can provide a different insight with the philosophical theories already presented. If I had more time in approaching this thesis, I would have unpacked the view outlined in *The Second Sex* that women have a hard time unifying against their conditions due to the fact that women might be more inclined to unify with other aspects of their identity more than the aspect of being a woman (de Beauvoir, 1956). These other identity demographics could be race, socioeconomic status, disability, etc. and a woman may feel more inclined to relate to the experiences of those groups than of a woman who is outside of their personal identity. Applying this type of idea to the answer might change future approaches to the dialectic structure and include more perspectives of the otherization occurring in healthcare.

Furthermore, the application of these philosophical theories can not only help to identify the problems occurring within healthcare but could potentially be a starting point for how to rectify the problems. As mentioned before, the philosophical theories of Beauvoir and Hegel outline the problems that are currently being seen within healthcare. Due to these similarities, it can be reasoned that if the problems align with the structure of the theories than it could be possible to apply the reconciliation and shifting of the dynamic also laid out within the same theories. Especially in the case of Simone de Beauvoir, it was outlined that women are in a unique position compared to other subjugated groups and women in medicine are an even more specialized category. There have been significant steps made by women in medicine to equalize the scales in

healthcare, and further research can be done on how these steps can be more effectively or efficiently utilized to achieve this unity Beauvoir believes would be enough to mobilize out of women's current placement. Especially when it has been shown that female physicians provide better care for their patients, that they engage in more personal interactions within their practice, and ultimately because they should be viewed in the same capacity the men are. This type of medical progress to change the structure of how women are viewed in medicine is also impacting patients, as there have been strides made to improve the quality of care for patients by addressing the implicit bias of viewing women as the Other. One attempt at addressing this problem has been the incorporation of implicit bias training for health professionals, specifically targeting the implicit gender bias or stereotyping that physicians may hold (Cooper et al., 2022). It is encouraging to know that strides are being made to address this problem, however I still believe that to target the foundation of this problem in healthcare is to address the structure of the man-woman dialectic and rewire the view of women in society. The medical studies referred to within this thesis were conducted without having this type of philosophical framework in mind, so it could be beneficial to reanalyze how the studies were conducted and to make note of the themes present in both Hegel and Beauvoir when conducting further research.

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