

# **Examination of Healthcare Marginalization of Women**

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## **Abstract**

Marginalization of women is a widely researched social problem however, there are certain arenas where the marginalization has garnered increased attention in light of recent events. One such arena is the marginalization of women in healthcare. The intersectional nature of inequality causes a compounding phenomenon where a person's life experience is dependent on how many proverbial boxes they check out of an infinite number of qualities or social constructs that are used to maintain a power disparity. Given that there are a near-infinite number of factors used in marginalization this analysis looks at just three and how they intersect with gender; first examined was gender as a sole factor then race, economic standing, and efforts of control were examined as intersectional factors. Research methodology was that of a literature review intertwined with a critical analysis of the factors.

## **Keyword**

marginalization, women, healthcare, gender, microaggression, race, economic, discrimination

## **Introduction**

The amount of light brought to the topic of marginalization as a whole has increased exponentially in recent years, but there's an even brighter light being shone on marginalization of women in the wake of Roe V Wade's repeal. The repeal of Roe v Wade can be viewed as a concrete representation of four hundred years of otherization, patriarchy, and methods of control. Given that marginalization is an intersectional phenomenon, healthcare marginalization can be viewed as a central piece of the proverbial puzzle; that puzzle includes pieces from every imaginable

socioeconomic category and creates an environment where those factors effect care, representation, participation, and comfort levels.

As often stated, women are, as a whole, marginalized to a degree purely based on their gender- there exists, however, a number of factors that increase the negative experiences such as their race, economic standing, sexual orientation, among others. The unfortunate reality is that, in the United States, every individual factor that separates someone from an affluent-white-heteronormative-Christian male is used as a piece in the equation that determines, to a degree, life outcomes regardless of the ‘foot-work’ put into the journey. To best serve as an insight into healthcare marginalization we will look at race, economic standing, and efforts of control in concert with gender to highlight the disparities present across all identifiers with increased impact within some. This will work to answer the question posed; is marginalization of women in healthcare a universal issue across the gender or is it dependent on belonging to any number of already-marginalized groups?

## **Gender & Healthcare**

First we’ll take a look at how gender alone influences the healthcare experience. There exists some level of microaggressions that seem like innocuous slights, rather than true discrimination or marginalization, but in reality they serve as a continued reminder of how women are perceived in healthcare and society. The term ‘mansplaining’ is used with some regularity when discussing how women’s interactions with male physicians and other healthcare workers play out; this indicates a level of disrespect or the perception of some superiority complex possessed by the male-dominated healthcare community. The idea behind microaggressions being a universal phenomenon is important as 99.6% of participants in a 2019 study, all female with a diverse ethnic makeup, reported being exposed to at least one microaggression in the prior year (Midgette & Mulvey. 2021). The prevalence of ‘simple’ gender microaggressions paints a picture that highlights how widespread, and far-reaching, sexism is within healthcare; in a study involving a number of VAMC psychological trainees, 65% reported sexism in the institu-

tion on the provider side (Cencirulo et al. 2021). With this prejudice, gender/race microaggressions, being expressed on both ‘sides’ of the healthcare system it is important to realize that microaggressions are commonplace because they are the most socially acceptable symptom of a racist and patriarchal society.

## **Race & Gender: Intersectionality**

For the intersection of race and gender, we need to look no further than in remembrance of the Tuskegee Syphilis Experiment, uninformed sterilizations of women of color, and reduced access to healthcare as a result of the intersectional nature of race and wealth inequality. Although the first two events are historic in nature and forced sterilization occurs at a much lower rate than in the past, they both serve as a reminder of the depth of depravity people of color have been exposed to on behalf of a nation whose mantra ends with “[...] with liberty and justice for all”. An immensely important caveat to the ‘historic events’ categorization; forced sterilizations have been reported to have occurred on women immigrating to the United States from Latin American countries as recently as 2020 (Andersen et al. 2021). The implication here is that some of our most vulnerable population comes as immigrants- they are often impoverished or fearful of the repercussions for dissenting, one of the physicians named in a class action lawsuit against ICE in 2020 was reported to have been knowingly performing nonconsensual procedures on Latinx women for as many as three years (Andersen et al. 2021).

## **Marginalization & Microaggression**

As race is often the catalyst for exposure to any number of marginalizing situations or inequality as a whole, one can infer a correlation between race, wealth inequity, and any number of other inequalities created by those factors that will present themselves as negative health outcomes whether physical or psychological.

Again, the use of microaggressions is a widespread commonality for women and women of color, as found by Midgette and Mulvey (2021)

with 78% of Asian-American women reporting being targets of a racial microaggression in the previous two weeks. . Race (along with the intersectional relationship with gender) is shown to be a predictor of the prevalence of certain negative health outcomes such as hypertension, maternal mortality, diabetes, cancer (Andersen 2015). One starkly morbid statistic is that women of color, specifically Black women, are equally likely to die from breast cancer as white women; with the way this statistic is often represented it seems irrelevant until the additional piece of information is revealed- Black women are half as likely to be afflicted by breast cancer as white women. The idea that race can determine health outcomes is startling, but it also needs to be noted that exposure to race-related problems can be a factor in the development of negative health outcomes such as depression, anxiety, and alcohol abuse. This is, itself, a full-circle issue as negative health outcomes can be tied to race, just as race (in the context of racial discrimination or prejudice) can be tied to mental illnesses that increase the risk for the aforementioned negative health outcomes (Sher et al. 2010).

## **Add Economics**

As gender itself and race have been analyzed, in the context of the healthcare system, we can look to economic strata's impact on health outcomes and experiences. In an advanced capitalistic economy, like what is present in the United States and much of the 'first world countries', financial inequity is becoming another topic of study as it relates to other factors of marginalization. Given the importance of money, both true importance and perception derived from social norms, it stands to reason that poverty has negative health outcomes linked to it beyond the image commonly conjured that links poverty to obesity or oral hygiene (which are microaggressions as well but are, again, commonplace to the point of non-reactivity). One common, and 'silent', negative health outcome associated with poverty is depression; this is telling as it sheds light on the impact that circumstance has on someone's life trajectory (Groh. 2007). Although there aren't disease processes that are unique to impoverished individuals or communities, there exists a connection between poverty and rates of illness as well as

age of onset; impoverished individuals have higher instances of chronic illnesses, such as obesity or hypertension, as well as a decreased age of onset for diseases that are commonly deemed age-related (Groh. 2007). Given the connection between depression and comorbidities such as heart disease, alcohol abuse, sleep deprivation, et cetera it is, once again, important to note how influential socioeconomic standing is on health outcomes. This influence becomes exacerbated, just as the other individual factors of marginalization, given the intersectional nature of inequality, marginalization, and health outcomes.

## **Legislative Marginalization**

A potentially more polarizing topic of exploration, in healthcare marginalization of women, is the perceived, or unwritten, implication of legislation as it stands to place institutional control over women. As is the case with a patriarchal society such as the United States, women are disadvantaged by way of legislation, institution, and social control; from the glass-ceiling present in corporate America to the current court rulings restricting women's choice to the hegemonic masculinity that seems to rule American pop-culture and politics. "The fifty years of attempts to regain control over women's autonomy culminated in the repeal of Roe v Wade (2022), and the subsequent human rights loss, that marks a dangerous turning point in the direction of additional freedoms lost" (Traylor. 2022). The commonly cited statement, "Abortion is Healthcare", used by feminists and groups fighting for healthcare autonomy is integral to this belief that women are only as free as their bodies are. Just as the symbolic ripples from the 19th Amendment, the culmination of the Suffrage Movement, placed women in an 'equal' line with men- the inverse is also true, the repeal of Roe v Wade in 2022 has symbolic, and concrete, repercussions that reach beyond the topic of abortion.

## **Conclusion**

Given how each of the factors mentioned carry their own level of inequality in a scenario where they would be the sole differentiating factor, and given the intersectional relationship that inequality is built upon it stands to reason that all factors would compound one another. Just as race, alone, carries untold markers of inequality as does gender and income level; when any of the three [or other factors] meet together at an intersection it can increase the marginalization experienced on an exponential level.

Although there is research that exposes the marginalization of women within healthcare, it seems to be occurring in perpetuity. As Martin Luther King Jr. famously proclaimed, “We shall overcome because the arc of the moral universe is long but it bends towards justice” (King, 1968). Given the amount of data such as negative health outcomes and pervasive prejudicial treatment that reaches all women, albeit unequally, is a stark reminder that regardless of how far we’ve come, we have farther to go before inequality is erased.

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