Gender and Medicine

On the Need to Address Patriarchal Structures, Medical Gaslighting, and Glaring Gaps in Research

Barbara Wittmann & Alena Mathis

> I had been waiting for months. When I entered the room, the physician was sitting back with his feet up on the table. He looked at my previous findings and said that the case was clear: I had been thoroughly examined and was simply hysterical, which is what he had thought as soon as he saw me. It was so dismissive, really harsh. I felt like a stupid little blonde and couldn't say anything.[1]

Isabell, as we anonymize the interviewee here, describes her experience with ME/CFS (Myalgic Encephalomyelitis/Chronic Fatigue Syndrome), which took over ten years to diagnose. Both during this time and afterwards, she had numerous encounters with a patriarchal medical system. The quote used here as an introductory vignette is not an exception—similar accounts of medical gaslighting, i.e., medical staff not taking patients' complaints seriously (Sebring 2021), are found repeatedly in qualitative studies on doctor-patient relationships and form a common thread throughout this special issue. They not only point to a lack of interpersonal sensitivity and thus to a deficit in the social training of medical personnel, but also reflect historically grown and still powerful gender-related imbalances within medical structures. This affects subjective interactions in doctor's offices and clinics, but it starts much earlier: The devaluation of so-called 'women's complaints' shaped by medical history, long-term exclusion of non-male test persons in pharmaceutical studies, the neglect of people who do not fit into binary gender categories, or the continuing dominance of men in senior medical positions are just a few of the many examples that can be mentioned here. To stick with ME/CFS: Although the illness has been recognized as a neurological disease by the WHO since 1969, it has been largely ignored by medical research and training. Since the symptoms show strong parallels to Long COVID, it was not until the pandemic that the lack of care for ME/CFS-patients achieved public attention. In light of the development of new testing methods for multisystemic effects, as well as recent findings on autoimmune processes and circulatory disorders,[2] decades of misdiagnosis and misguidance of ME/CFS-patients within the medical system are becoming increasingly evident. According to the German Federal Ministry of Health, estimates of the number of people affected in Germany alone vary between 140,000 and 310,000 (Bundesministerium für Gesundheit/Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen 2023). However, there is no clear data available because of the associated high number of undiagnosed cases. ME/CFS-symptoms differ greatly from patient to patient and can include, among many others, "muscle and headaches, intestinal complaints, dizziness, stress and irritability, palpitations, or blood pressure fluctuations" (Charité Berlin 2022).

Although there is this diversity of complaints, ME/CFS is not referred to as the "disease with many faces" like multiple sclerosis, but rather as the "disease with many names" (Bell 1991). Some researchers assume that part of the patients collectively diagnosed with 'neurasthenia' in the 19th century—at that time also culturally interpreted as the result of an increasingly 'nervous' society in the face of urbanization and industrialization processes —probably suffered from ME/CFS (Wessely 1990). In a medical treatise published in 1957 on the endemic extent of severe long-term consequences following the onset of infection within the Royal Free Hospital Group in London, in which the name Myalgic Encephalomyelitis was also used for the first time, RAMSAY *et al.* describe a threefold higher prevalence in women compared to men[3]—a ratio that is still evident today in papers on both Long COVID and ME/CFS. More and more studies highlight that this is related to the specificity of the female immune system—women are generally much more likely to be affected by autoimmune diseases than men (TOOGOOD *et al.* 2021). The culturally and medically constructed image of the 'hysterical' woman, characterized by an exaggerated perception of symptoms that are essentially non-existent, continued to appear in 20th-century descriptions of ME/CFS. Medical gaslighting experiences of those affected stemming from the 'invisibility' of the disease to others as well as the inadequacies of common medical tests continue to persist today (AU *et al.* 2022). HABERMANN-HORSTMEIER & HORSTMEIER, for example, note striking gender differences in the psychosomatization of ME/CFS-sufferers and write that medical gaslighting is not primarily a problem of interpersonal exchange, but rather the result of deeply rooted and largely unchallenged ideologies in the medical field (2024). 'Typically female' diseases such as irritable bowel syndrome, fibromyalgia, or endometriosis have been underestimated for decades, little researched, and in the worst cases denied by doctors and classified as purely psychological problems of 'hypochondriac' and 'stressed' women, while on the other hand psychological problems in men are often not taken seriously due to ideals of masculinity and normative expectations (MÖLLER-LEIMKÜHLER 2008).

At the same time, those power imbalances point to further structural problems—discrimination and downgrading of patient groups within the medical system is not only based on gender differences, but also on skin color, social class, origin, etc. These facts are closely related to fundamental structural dynamics and are always indicative of certain historical periods: The numerous discourses on 'hysteria' in the 19th century interpreted those affected by 'neurasthenia'—and thus by symptoms that could not be clearly attributed to neurological causes—as an expression of an increasingly 'nervous' and 'feminized' society (SCHMERSAHL 1998: 206 ff.). In the 1980s/90s, due to the leading symptom of exhaustion, ME/CFS was discredited as 'yuppie flu' and was therefore considered a self-inflicted disorder of an overworked urban middle class society, especially of 'career women' (WITTMANN 2025). Those affected therefore not only struggle with their individual symptoms, but must also bear the collective diagnoses projected onto them depending on time and place.

This special issue on gender and medicine attempts to explore historically, spatially, and socially conditioned inequalities and to examine them from different perspectives. The high response to the call for papers, which transformed the planned single issue into a double issue, is certainly related to the current attention on feminist issues and, given the present political situation, the new battles that need to be fought in this area: The right to self-determination over one's own body—a central motif of the women's health movement since the 1960s and 1970s—must be defended anew or still defended in numerous countries at the beginning of the 21st century (ANDAYA & MISHTAL 2017; RIVKIN-FISH 2023). The rights of transgender people have become a central starting point for right-wing political agitation (EVJE *et al.* 2024), and the funding of gender-related research is being curtailed in many cases (HEIDT 2025), even though it is often still in its infancy, as is particularly the case in the field of gender-sensitive medicine (OERTELT-PRIGIONE & HILTNER 2019).

Emerging from critical feminist initiatives and the women's health movement, central questions about whether, how, and why genders become ill differently have gained more and more recognition since the last third of the 20th century. Under the term 'gender medicine,' corresponding perspectives have come into focus and with them the shift away from viewing the cis-male body as the medical-pharmaceutical norm (REGITZ-ZAGROSEK 2023). Simultaneously, however, one could get the impression that media attention—e.g. the high-circulation German *Spiegel*-magazine provocatively titled a special edition "The End of Macho Medicine?" (2024)—is higher than internal medical attention when it comes to the topic of gender: A report of the German DEUTSCHER ÄRZTINNENBUND E.V. found that gender medicine still is a niche subject at most medical schools. At 70 percent of these institutions, the teaching of gender-sensitive knowledge remains “inadequate” and is not part of the curriculum (2021: 25).

Meanwhile, the conceptual definition of gender medicine requires consideration from not only a medical perspective, but also from a humanities and social sciences perspective. As Anne Hammarström & Ellen Annandale already pointed out when examining the unclear use of ‘sex’ and ‘gender’ in medical journals, the homogenization of corresponding perspectives under gender medicine can also be understood as a “conceptual muddle” (2012). Particularly contributions from the humanities are therefore critically highlighting the essentialist perpetuations of deterministically categorised men’s and women’s bodies and biologistic-binary perspectives that are associated with this relatively young medical field. The development of gender-sensitive medicine has begun to challenge patriarchal relationships and male-dominated perspectives strongly anchored within the discipline—a process that is far from complete, but is still striving for institutional establishment and recognition (Oertelt-Prigione & Hiltner 2019). A central challenge of gender- and medicine-related research both within and outside of medicine itself therefore lies in addressing gender-related inequalities without falling back into those same biologistic and/or binary simplifications that we seek to overcome.

The contributions to this special issue deal with a kaleidoscope of different gender- and medicine-related topics, ranging from historical developments, categorical attributions and the associated norms and hierarchies, medical (non-)knowledge regimes, power relations and, above all, the effects on and perspectives of the patients concerned. From our point of view, it was therefore essential to represent and bring together interdisciplinary perspectives. The first part of the issue in particular deals with what we consider an indispensable examination of the historical development of medically constructed gender relations and links contributions from medieval studies, modern and contemporary history, literature, and art history. A central concern in this context was to at least partially shift from Eurocentric perspectives and to critically examine the (post-)colonial effects of ‘medical expansion,’ which have hardly been addressed to date.

Carmen Canchen sets the first stone of the kaleidoscope: She immerses us in the records of two female healers practising in the Middle Ages on irregular menstruation (*Menorrhagia*). Reflecting about the approaches of Trota (Italy) and Tan Yunxian (China), she draws attention to two remarkably systemic treatment approaches. Other than that, the women’s herbal knowledge serves as a magnifying glass that makes the situational interplays of culture, history and medicine visible.

With Zoe Copeman we then switch to a somewhat more recent, US-American historical perspective. Using an iconographic approach, Copeman vividly analyses the development of the visual rhetoric of early anti-cancer campaigns in the US, which not only seem to manage without any cancer at all, but, subtly on the side, also stylise a narrow image of what a ‘healthy woman’ looks like.

Alvin Cabalquinto examines the biomedical construction of the body of Filipino mothers during the American colonial period. He shows not only the tensions that arose between indigenous knowledge and the colonial ideas of ‘healthy’ and ‘intelligent’ mothers, but also how racism and classism endured in American-trained Filipino obstetricians.

Anne Peiter sheds light on a dark chapter in Rwandan history, which also brings feminist issues into focus: Because of the mass rapes during the genocide against the Tutsi, many women had been infected with HIV and, because more men had fallen victim to the violence, the organization of the ‘aftermath’ had to be carried out primarily by female survivors. Based on autobiographies of victims, the paper promotes a holistic understanding of healing that includes spatio-material lifeworld dimensions. At the same time, Peiter shows the limits of medical healing efforts in the context of the genocide.

Based on gender inequality within medical leadership positions, Johanna Meyer-Lenz examines the history of paediatric cardiology and cardiac surgery in the USA. In particular, she uses the figure of Helen Taussig to unfold the picture of a male-dominated professional culture, which has long been radiating into knowledge production, teaching, research, clinical practice as well as the distribution of professional positions.

Completing the first part of the issue, in their artistic-scientific contribution, Anna von Vil-

LIEZ and CHRISTINE ACHTERMANN-JONES follow in the tracks of medical eponyms. As a part of standard anatomical language, eponyms such as the 'Achilles' tendon' or the 'G spot' reflect gender inequalities in the realm of medicine in a way that is particularly visible in everyday life. This is especially striking in the gynaecological field where eponyms continue to carry male hierarchies into the future.

The art project also serves as a bridge to the contemporary section of the special issue: Here, AWA NAGHIPOUR & LUCIA MAIR begin with an essayistic perspective on 'undone science.' Experienced as practicing physicians themselves, they emphasize the need for increased discussion and visibility of gender-related blind spots. By examining interviews with eight health activists across four countries—conducted as part of a teaching project at the Medical University of Vienna—they analyze three examples: endometriosis, ME/CFS, and 'male' contraception. This reveals significant conceptual gaps in current medical education.

JENNIFER FALTERMEIER then approaches the topic of pregnancy and birth from a cultural studies perspective, utilizing qualitative interviews as well. She focuses on the body of the pregnant woman and woman in labor and the status changes associated with these liminal phases. The article highlights key cultural challenges and conflicts, including regulations for protecting the developing life, reductionist views of the 'pregnant woman,' and criteria for assessing 'good births.'

A major focus of the contemporary section lies on the disease endometriosis. According to the WHO, around 190 million people of childbearing age are affected by endometriosis (WORLD HEALTH ORGANIZATION 2023). On average, however, the German Association for Endometriosis states that it takes almost eight years before a diagnosis is made (ENDOMETRIOSE VEREINIGUNG DEUTSCHLAND E.V. 2025). The chronic disease is one of those truly grotesque examples of medicine centering on the 'cis male': there is still no cure for endometriosis because it does not affect cis men. As a result, myths, misinformation and the normalisation of the life-limiting consequences of the disease can still have their appeal.

In view of this situation and the high number of people affected, we considered it all the more important that three submitted abstracts dealt with the disease and decided to give endometriosis broad visibility within the special issue. It is precisely in their reference to each other that the three contributions by CAROLINE MEIER ZU BIESEN, ANN-SOPHIE KNITTEL, and NIKITA TRÄDER *et al.* make the parallels between patients' experiences particularly clear and concurrently demonstrate the benefit of different methodological approaches.

CAROLINE MEIER ZU BIESEN chooses the approach of autoethnography, which reveals her own experiences and challenges with endometriosis for the first time. The oscillation between the role of researcher and the role of an affected person is sensitively explored here, making the effects of the non-recognition of chronic pain, on the part of both medical professionals and the affected persons themselves, incredibly tangible.

ANN-SOPHIE KNITTEL also incorporates autoethnographic elements into her paper, which deals with the long road to diagnosis in endometriosis. Like within the contribution of JENNIFER FALTERMEIER, theoretical concepts of body perception play a central role here. The intertwining of the body as a discursively constructed phenomenon with the immediate experience of pain allows for a more comprehensive understanding of subjectivity. This interplay also shows how normative ideas about health and illness are performatively staged and gendered.

In KNITTEL's article, as well as in the concluding contribution by NIKITA TRÄDER, MURIEL GROSSHENNIG, ELIF TÜRELI & ANIKA KÖNIG based on a student project, gendered emotions such as shame, guilt, and perceptual distortions emerge prominently. This is particularly evident regarding sexuality, a topic the authors explore in light of the significant research gap surrounding endometriosis and sexuality. The sexual experiences and practices of the surveyed endometriosis sufferers are deeply affected by medical gaslighting, period shame, and fear of deviating from gendered norms.

Certain gaps remain in the special issue that could not be covered by the submitted contributions: for example, none of the papers explores queer perspectives, particularly trans- or intersexuality, in depth, and the contemporary section primarily focuses on German-speaking countries. We view these and other gaps as areas that require further research and hope this issue highlights the importance of integrating social, cultural, and historical perspectives, as well as fostering interdisciplinary collaboration, and may stimulate broader research on gender and medicine.

Notes

1 This quote is taken from interviews and conversations with ME/CFS patients conducted between 2020 and 2022. More detailed information on the background and methodology can be found in Wittmann 2022.

2 Different international studies are now showing changes in the blood-brain barrier, which could be causing the brain fog that patients experience, as well as autoimmune abnormalities that have been found in lots of studies. See e.g. Doherty & Campbell 2024.

3 See The Medical Staff Of The Royal Free Hospital 1957. The head of the Infectious Diseases Department, A. Melvin Ramsay, was responsible for writing the article, see also Ramsay 1965.

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