Chapter 10
The Future of Healthcare is Feminist: Philosophical Feminism in Health Professions Education

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10.1 Introduction

Gender bias in healthcare is rife. In 2020, the United Nations reported that nearly 90% of both men and women across the world's population harbour some form of gender bias against women (UNDP 2020). Within medicine, gender bias is associated with poorer outcomes for women in many domains, including regarding pain management, and diagnostic delays for gynaecological conditions (Perez 2019; Verdonk et al. 2009; Winchester 2021). Gender inequality is an ongoing issue within society and, more specifically, within medicine and health including in medical and health professions education. Global and national policies often fail to consider gender-related health risks for people of all genders (WHO 2019). It is clear we need health systems that consider the intersections of gender with other inequalities, addressing how "gender norms, unequal power relations and discrimination based on sexual and gender orientation impede access to health services" (WHO 2019), including in the delivery of health education.

Philosophical feminism employs philosophical methods to feminist topics and questions, and so holds the potential to illuminate ongoing issues within health professions education, such as gender bias, in new and critical ways. Philosophical feminist inquiry is motivated by desire for social justice and so, through scrutinising

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social, cultural, political, and economic phenomena within medical and health professions education using feminist thought, recommendations may be made regarding confronting structural inequalities within healthcare.

This chapter considers philosophical feminism broadly, considering the ways in which gender combines with issues of race, class, disability, sexuality, and gender identity and examining contributions which have been overlooked in reference to the field of health professions education. Intersectionality as a concept and practice is introduced to understand ways in which gendered and related oppressions and privileges combine to create a need for more complex understanding of philosophical feminist inquiry in health professions education, and feminist theories of agency in relation to healthcare are explored. Addressing the structure and dynamics of gender bias within health professions education, the chapter opens new fields of enquiry and ways of working. Finally, we offer practical considerations for those in the sector to consider how philosophical feminism informs their practice.

10.2 Philosophical Feminism: Feminist Thought and Practice

What has been called philosophical feminism, or feminist philosophy, specifically examines the role of gender in traditional philosophical concepts, sexist bias in traditional philosophy, and proposes philosophical feminist theories (Vogler 1995; Alcoff and Kittay 2007; Garry et al. 2017). However, feminist thought is an interdisciplinary subject found across academic disciplines, creative practices, and social movements, from the sciences to the arts.

Feminist theories and practices describe several different interlinked approaches, all emphasising the role of gender and gendered structures in society. Feminist theory is often referred to as an umbrella term (Disch and Hawkesworth 2018; Finn and Brown, In Press). While scholars have emphasised the need to address gender bias from a localised context, taking into account specificities of local structures and cultures (Mohanty 2003), feminist approaches share a focus on interrogating concepts of gender, fighting gender injustice, and analysing the ways in which gender shapes our lives. Feminism is not just interdisciplinary, but practical, aiming to change the way we think and order society: feminism is about *doing* just as it is about thinking; 'deeds not words', as the old Suffragette motto noted. Feminist theorist bell hooks (1984) similarly notes that one cannot simply 'be' a feminist, one has to *do* or advocate feminism. This chapter uses a broad interchanging and interdisciplinary definition of philosophical feminism, feminist thought and practice, as terms signifying the questioning and fight against gendered and intersected oppressive ideologies, practices, and structures.

Feminist thought reaches back millennia, and feminist historiography[1] usually uses the metaphor of 'waves' to describe different trends and shifts in feminist movements throughout the years. Despite being a contested metaphor (van der Tuin 2009; Hemmings 2011; Reger 2017; Grady 2018), it continues to be used both temporally, as pertaining to a specific historical period, and also as demarcating certain broader issues occupying feminists during the associated period. The starting point of the 'First Wave' of feminism is often located either with the publication of UK writer and philosopher Mary Wollstonecraft's (1759–1797) *Vindication of the Rights of Woman* in 1792, or with organised women's movements in the nineteenth century (demonstrated in milestone events such as the 1848 US Seneca Falls Convention and the Conference of Badasht in Persia), following intellectual women's societies that sprung up in the mid-eighteenth century such as the Blue Stockings Society in Britain. Located in the late eighteenth, the nineteenth, and the early twentieth centuries, first-wave feminism took different forms for different women and in different locations but is usually defined as involving the fight for civil rights such as suffrage, marriage and property legal reforms, and women's access to education (including the right to practice as doctors).

Definitions and interpretations of feminist 'waves' differ, however: while Wollstonecraft's *Vindication of the Rights of Woman* is often seen as the mark of the birth of modern feminism, with its call for gender justice and criticising of gender bias, history recalls earlier feminist works such as Christine de Pizan's medieval *The Book of the City of Ladies* (1492) which questions gender bias in literature and history. Further, figures such as Sojourner Truth in 1850 already questioned not only gender, but racist thoughts and practices. Due to a white European and US dominance in feminist historiography, scholars have, until recently, defined the movement as one primarily concerning middle-class or liberal white feminists' concerns (such as the right to own property) in the global North, a perspective which has been proven incomplete by postcolonial and transnational feminists noting concerns not only regarding women's right to education and suffrage, but also labour conditions, the abolition of slavery, anti-colonial struggles, and peace building (see e.g. Jayawardena 1986; Wånggren 2018). Within health professions education, the fight for women's access to higher education is crucial, as early female doctors such as Elizabeth Blackwell, Elizabeth Garrett Anderson, and Sophie Jex-Blake in the nineteenth century fought for women's right to study for and obtain medical degrees. Although women now constitute a huge proportion of health professionals, they remain under-represented in some specialties and leadership roles (Skinner and Bhatti 2019, Gilmartin et al. 2020).

The Second Wave, usually timed as 1949–1990, highlighted issues of equal pay, sexual freedom, representation, reproductive justice; this is when feminism entered knowledge-producing institutions such as universities. Simone de Beauvoir's *The Second Sex* (1949) questioned the notion of gender itself, showing its socially and historically constructed nature: "one is not born but becomes a woman" (283). Martha

[1] Historiography is defined by the Oxford English Dictionary as "the study of the writing of history, and of written histories".

Weinman Lear first officially documented the term 'wave' in a 1968 article, as a historical benchmark to position current 'second wave' feminist struggles against those of earlier generations, although the term had been in use prior to this publication (Chamberlain 2017). These are the years in which feminist activists started engaging most fully with gendered inequalities in health and access to healthcare, highlighting gender bias and the lack of women's perspectives within care, and in which feminists question the perceived objectivity of scientific knowledge—see a fuller examination of this period below.

The Third Wave, from around 1990 onwards—with Judith Butler's groundbreaking book *Gender Trouble* seen as a milestone—involved a questioning of the singularity of woman, and a further questioning of the relation between gender and sex: the multiplicity of women's experiences is highlighted, noting intersectional and transnational perspectives, and interlinking gendered with other related issues. In healthcare professions education this is seen through an increased focus on not only gendered but other intersecting inequalities, across the globe.

There is currently a self-identified Fourth Wave, from the early 2000s, which highlights the use of social media and humour to address everyday sexism, street/workplace harassment, and rape culture (Cochrane 2013; Chamberlain 2017), seen in the growth of grassroots online campaigns for gender-sensitive healthcare—for example for trans persons, and for under-researched conditions such as endometriosis and questions of reproductive health (see e.g. Davey 2020; Cysters 2021; and UK campaigns around Period Poverty).

As a result of feminist and antiracist activism across centuries, especially through the work of Black and anti-imperialist feminists, intersectional theories and practices have gained ground, bringing a valuing and accepting, rather than denying of, what Audre Lorde (1984; see also Hill Collins 2000) terms 'difference':

> Certainly there are very real differences between us of race, age, and sex. But it is not those differences between us that are separating us. It is rather our refusal to recognize those differences, and to examine the distortions which result from our misnaming them and their effects upon human behavior and expectation. (Lorde 1984, 1–2)

Within healthcare professions education, this embracing of intersectional difference means an increased awareness of shifting perspectives of gender, race, class, religion, age, disability, sexuality, and gender identity within pedagogy and practice. Recently, intersectional identities have grown in prominence within the undergraduate curriculum, particularly within basic sciences such as anatomy (Lazarus 2021). Student cohorts are demanding the redefining of anatomical language in order to create safer spaces to acknowledge all genders (Lazarus 2021), racial identities and ethnicities (Finn et al., In Press).

Feminist philosophy broadly means linking theory and practice. In the sciences, we must specifically trouble the assumptions we have about what is considered 'knowledge' by questioning the perceived impartiality of knowledge, and who is in a position to be seen as a knowledge producer. What is crucial is highlighting the validity of subjective experiences, especially of marginalised groups, as central to knowledge production, something which demands reflexivity from those positioned

as 'experts' (Harding 1986; Haraway 1988; Rooney 2017). Feminist perspectives in healthcare professions education thus require a questioning of the kinds of knowledge produced in a healthcare setting, who produces knowledge, how this knowledge is captured, and what kind of power relations govern the roles attributed to patient and health professional. It means centring the feminist notions of reflexivity and positionality as key tools (Erikainen et al. 2021) in designing and delivering programmes. Embedding reflexivity allows for a critical interrogation into power relations and our situated places within them, while feminist notions of positionality means recognising that all knowledge, including scientific knowledge, is "situated, plural and partial", shaped by the knowledge producers' social location—this fact enables us to ask critical questions about who is seen as a knowledge producer (Erikainen et al. 2021, 9). For example, a young male nurse or doctor and a female patient in her 60s may have different knowledges about the experience of menopause; one being clinical 'expert' knowledge, the other being personal and experiential. These differences need to be reckoned with in order to provide a contextualised healthcare understanding the complexity of the situation.

10.3 Key Terms: Gender and Intersectionality

Gender is one of the key terms within feminist thought and practice, used to examine and address gender inequality and bias within patriarchal structures. Joan W. Scott's (1999) definition of gender links the concept with power, and as working on different overlapping levels of society:

> [G]ender is a constitutive element of social relationships based on perceived differences between the sexes, and gender is a primary way of signifying relationships of power. (1067)

Scott (1999) maps out the different levels at which gender operates: *symbolic and representational* (assumptions about gender difference); *normative concepts and statements* (e.g. religious, scientific, and legal doctrines); *social institutions and organisations* (organisational); and as *subjective identity* (how one sees/presents oneself).

Gender is not, however, the only social category intertwined with health. As such, health is more fruitfully understood through the lens of intersectionality, that is to say, alongside other axes of power such as those linked to class, sexuality, race, disability, sexuality, or gender identity. Intersectionality (Crenshaw 1989) is the notion that various social and cultural categories such as gender, race, and class, interact and overlap on multiple levels in the formation of identities and social relations (Cooper 2016). The term started as a main tenet of Black feminism to describe the intersecting oppressions facing Black women and has now gained influence in contemporary feminist activism as well as mainstream policymaking. Feminism, in an intersectional definition, signifies then not only a struggle for gender equality, but "a struggle to end sexist oppression" which harbours in it "a struggle to eradicate the ideology

of domination", realising the "inter-relatedness of sex, race, and class oppression" (hooks 1984, 24–31) alongside other structures of inequality.

10.4 Gender Inequality and Bias in Healthcare and Professions

In every society, what is considered health or illness, and how the health professions deal with these terms, are shaped by social, historical, and economic contexts—contexts that are all gendered. As Angela Davis (1990) declares:

> Politics do not stand in polar opposition to our lives. Whether we desire it or not, they permeate our existence, insinuating themselves into the most private spaces of our lives. (53)

A key tenet of feminism is, thus, the interlinking of individual with structure—the personal is political. Gender, that social categorisation of behaviours and beings, permeates the ways in which health and medicine are structured and how we understand ourselves within it. As part of the 1960s and 1970s women's movements, feminist scholars and women's health activists started addressing issues of gender within medicine and healthcare—often starting with the issue of 'women's health' as a focus and connected to social movements for women's health. Since then, the field has broadened and now encompasses multiple areas including Science and Technology Studies and the Humanities. We have moved from a focus on 'women's health' to gender inequalities in health (Hunt and Annandale 2011; Kuhlmann and Annandale 2012). Feminist critical attention to healthcare has revealed bias and oppression, as well as opened up new perspectives on health, caring, and knowledge. Not only does health science itself contain bias, but also practical understandings of medicine are biased along structures of race, gender, and certain forms of power and knowledge (Wyatt et al. 2020; Zaidi et al. 2021). For example, health professions education remains focussed on the white male as the archetypal representation within textbooks on clinical examination and anatomy (Plataforma SINC 2008; Finn et al. 2022; In Press).

With increased research into both men's and women's health, there is a new appreciation for the complexity of the 'paradoxical gender differences' (Bird and Rieker, 2008, 7) in health that challenges notions of the disadvantage or advantage of one single gender (MacIntyre et al. 1996). Antiracist and intersectional critiques of western clinical medicine have recently been brought into focus (Hankivsky 2012), with new approaches and interdisciplinary pathways to understand intersecting relations within health. While white women's experiences were (and probably still are) for long at the centre of the field of gender and health, there has been a growing body of work by women of colour and their experiences of health; Black feminists in particular have contributed much here, through works such as *The Black Women's Health Book: Speaking for Ourselves* (1990) and *Wings of Gauze: Women of Color and the Experience of Health and Illness* (1993). In recent years, activists such as Neelam

Hera have set up campaigns and networks to raise the voices of marginalised women and trans people within reproductive healthcare (Cysters 2021), or to address racism within healthcare (see Walcott and Linton 2018, for stories of racist mistreatment in mental health care, and a call for changes needed in health professions education). Alongside a continued struggle for gender-sensitive and antiracist training in healthcare, the end of the twentieth century saw more focus being given to the issues facing specifically trans and intersex individuals (for example: the Intersex Society of North America was formed in 1993). However, the health professions curricula have not kept pace—transgender health and largely also intersex healthcare remains undiscussed (Fausto-Sterling 2000b; Finn et al., 2021), while many students in healthcare professions have little understanding of the healthcare lexicon including 'cisgender' (Dubin et al. 2018; Brown et al. 2020). This leads to a healthcare system where patients rarely encounter trans- and intersex-inclusive healthcare (Bornstein 1994; Fausto-Sterling 2000a; Halberstam 2017).

Gender inequalities in health have been a major area of both activism and academic scholarship since the early 1970s. Since then, the search for an explanation for differences in male and female morbidity and mortality, alongside interest in the relationship between variations in women's social circumstances and their health, has been a crucial part of feminist enquiries into health care and professions (Hunt and Annandale 2011):

> Gender is known to be strongly associated with health status and to exert a significant influence upon help-seeking and the delivery of healthcare, but it has been a relatively low policy priority for many governments and also within the health professions until very recently. … [T]he current evidence base is scattered and fragmentary. Attempts to mainstream gender into healthcare often turn out to be simplified reports of sex differences without taking account of the complex life conditions of men and women and the gendered dimensions of the organization and delivery of healthcare. (Kuhlmann and Annandale 2012, 1)

The lack of a gender-sensitive approach in healthcare leads to women being "routinely silenced or erased as actors in the production of health, in both the provision and receipt of healthcare per se as well as in health politics and policy" (Clarke and Olesen 1999, 3). Even in 2018, so significant still are the gender inequities in medicine and healthcare that a lexicon of gender bias terms was published (Choo and DeMayo 2018). One frequently observed gender bias is the maternal wall bias, which pertains to the stereotyping and discrimination encountered by women (Williams 2004). Women are treated differently because they have children, may want children, or even just because they may potentially become mothers. Socialisation into gender roles, and expectations of stereotypical gender expression, has resulted in inflexible, archaic inflexible expectations of men and women. Recently, the maternal wall was documented within health professions education, with undergraduate students describing missed opportunities based upon perceptions of the present or future maternal status (Brown et al. 2020).

Feminist perspectives in health care involve not only a focus on substantive topics within women's health such as breast cancer, violence, or reproductive justice, but also highlighting gendered narratives within medicine, such as the positioning of the white male patient as norm of what is healthy, or the use of sexist language in

medical research and practice. As Longino (1990) shows, assumptions laden with social values affect the description, presentation, and interpretation of data; research on 'sex-differentiated behaviour' involves assumptions not only about gender relations but also about human action and agency. As Emily Martin (1991) has demonstrated, the ways in which we speak about health-related issues are not 'scientifically objective' but rather carry imprints of gendered, racialised, and other contexts; there is specific gender bias in scientific and medical discourse, particularly concerning human reproduction. Martin's *The Woman in the Body* (1987) questions the disparity between biomedical formulations of women's health and women's own experiences of, for example, menstruation, birth, and menopause. Querying the negative perception many have around menstruation, she examines the gendered language and metaphors in which menstruation has been described, in order to understand this negativity. As Martin describes in "The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotypical Male-Female Roles" (1991), seemingly 'neutral' scientific explanations such as "the sperm forcefully penetrates the egg" are presented with a sexist bias that places women's part in reproduction as passive. Black feminist and antiimperialist interrogations have furthermore noted racist, colonial and class bias within struggles for reproductive justice (Gould 1984; Kuumba 1999; Silliman et al. 2004).

Adding to Martin's work on gender bias in science and medicine, and on the role of women's own constructions of health outside of biomedical narratives, feminists have criticised the ways in which medical norms are often based on white, middle-class men's bodies, revealing a lack of diversity in health professions research and education (Lorber and Moore 2002). Until recently most health research focused on white male subjects, and less is therefore known about how to prevent and treat many illnesses in women (Bird and Rieker 2008). Because of this, there are still significant gaps in knowledge regarding health differences between the sexes in health (Marcelin et al. 2019). For example, men's and women's cardiovascular disease symptoms differ from each other, but since most research was carried out and information distributed with male patients in mind, women did not benefit equally from this research (Bassuk and Manson 2004). While gender and race usually are considered socially constructed, gender and intersecting biases have also worked to exclude physiological differences or ignored the biopsychosocial effects of sexism and racism (Sullivan 2015).

As feminist theory and methodology demonstrate, the ways in which we speak about health-related issues are not 'scientifically objective' but rather carry imprints of gendered, racialised, and other contexts—there is a significant gender bias in scientific and medical discourse. Understanding and addressing biases is a crucial way to improve health professions education. Introducing structural/unconscious bias or other Equality, Diversity, and Inclusion (EDI) training is a necessity within health professions curricula; without such work, health inequalities and differential treatment will continue. Furthermore, those working within the institutions, for example admissions teams, also need training to ensure diverse and inclusive workforces for the future. Similarly, an awareness of the hidden curriculum is of paramount importance (Hafferty and Franks 1994)—tacit messaging, role modelling and other aspects

impact learners, educators, and patients alike. For example, students may witness tutors (Finn and Hafferty 2020) or near-peers role modelling negative behaviours such as assumptions of cisgender identity or heteronormative patterns when taking a history (Laughey et al. 2018), or microaggressions based on gender or maternal status (Brown et al. 2020).

10.5 Reclaiming Health: Gender and Agency

The issue of patient agency and female agency has been crucial to women's health movements in the 1960s and onward in challenging male patriarchal control over women's health. Feminist theories of agency are thus crucial to considering ways of improving health professions education.

While modern biomedicine often comes to treat the patient as an object, infringing on the patient's agency over their health, this tendency has been critiqued, especially by feminist health activists who highlight the silencing of women's experiences in healthcare. Indeed, biomedical approaches can influence women's perceptions of themselves and their bodies, in ways which 'can ultimately undermine women' (Clarke and Olesen 1999, 33). In particular, reproductive justice has long been a central focus of feminist activism and scholarship (Correa and Petchesky 2003).

Certain groups (women, LGBTQIA+ people, people of color, working-class people) are more likely to be medicalised—treated as medical objects rather than subjects—and in different ways than others (Riska 2003), since aberrations from the white male norm is seen as individual biological problems rather than as affected by social structures. Feminist movements have thus sought to reclaim women's health and to focus on women's own experiences, to regain agency over such debates. In the late 1960s feminists challenged medical and male control over women's health, in movements ranging from local grassroots organisations and self-help groups to feminist health clinics, advocacy organisations, and scholarly research. In 1976 the now classic *Our Bodies, Ourselves* was produced by the Boston Women's Health Collective, one of the first in a wide range of writing through which women developed ways of understanding their own bodies and of challenging sexist bias in the medical profession.

Storytelling, and sharing stories of pain, have been crucial tools for reclaiming agency (Wånggren 2016). Two examples of feminist thinkers doing this are Audre Lorde (1996) and Johanna Hedva (2016, 2017). Lorde in *Cancer Journals* (1980) and *A Burst of Light: Living with Cancer* (1987) and Hedva in their "Sick Woman Theory" and "Letter to a Young Doctor" both address sexist biases in health professions, argue for a reclaiming of patient agency in the name of equality and social justice, and highlight the need for sharing stories of pain in order to heal. Hedva (2017) addresses a young woman studying to become a doctor, who has written to the author for advice:

> One of the problems with healing in this fucked-up world is that it's presumed that you, the doctor, have a set of knowledges that the patient doesn't, so for the patient to get better, to be cured, or to heal, they must submit themselves to Doctor's Orders. … I'm supposed to trust you simply because you are a doctor. To us patients, this dynamic feels like one in which we are helpless because it is. It feels one-sided, dangerously unequal. I have to give my trust to you, but not because you've earned it. It's because you work in the hospital, or the clinic, a place that is a metonym for medical expertise; it's because you speak in the coded language of medicine and wear the white lab coat, a rehearsed performance with its attendant costume. I don't feel like you trust me, because you are treating me, or parts of me, as enemies to be vanquished. … What if, instead, the presumption went both ways—that the patient was *also* a specialist, like you, in possession of a set of knowledges, a vision of a world we'd like to build, that is different from this one, and so by collaborating as equals, utilizing each person's skills, we might together build a world that contains multiple parts, a world that is not only one part—your part?

Writing about her struggle with cancer, Lorde declares that:

> Attending my own health, gaining enough information to help me understand and participate in the decisions made about my body by people who know more medicine than I do, are all crucial strategies in my battle for living. (1996, 321)

In a quest to reclaim agency over one's own body, writers, researchers and activists describe their experiences of pain and struggle: "I had known the pain, and survived it. It only remained for me to give it a voice, to share it for use, that the pain not be wasted" (Lorde, 1996, 9).

In health professions education, learning to centre the patient experience, providing them the right to formulate their own experiences about their bodies and to assert agency over their narrative, is crucial. Health professions education scholars have presented much research looking at contemporaneous examples of gender inequity and the troublesome perpetuation of negative behaviours towards women (Monrouxe, 2015). Examples from the ethical and professionalism dilemmas literature, as well as the popular press, include medical students being coerced into performing intimate examinations on anaesthetised women without consent and obstetric abuse against women (Carson-Stevens et al. 2013; Santhirakumaran et al. 2019; Shaw et al. 2020). Without open discussion with aspiring clinicians, such issues continue to manifest and present professional dilemmas for students who feel conflicted due to perceptions of relative power and hierarchy. Shaw and colleagues (2020) recently discussed concerns with regard to medical students' professionalism development, highlighting the extent to which gender bias is ingrained within medical systems. Their study reports the normalisation of disrespectful and abusive treatment of female patients poses immediate and future consequences to the wellbeing and safety of women.

10.6 Ethics of Care, Vulnerability, and Interdependence

Feminist thought has added much-needed new perspectives within health professions educations, encircling a feminist ethics of care which emphasises interdependency

and vulnerability (Gilligan 1982; Mackenzie et al. 2013; Hauskeller 2020). As Lorde writes in *A Burst of Light*, "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare" (1996, 332). Feminists have taken up this call for (collective) self-care to encompass experiences of living with chronic illness and disability. In a 2016 essay, the aforementioned Hedva proposes their "Sick Woman Theory", in which they propose sick bodies—those who, as Lorde puts it in *A Burst of Light*, were never meant to survive—as the twenty-first century's sites of resistance. In a society where one's health is defined in relation to whether one is able to go to work, Hedva (2016) writes, one of the most anti-capitalist protests is "to care for another and to care for yourself. To take on the historically feminized and therefore invisible practice of nursing, nurturing, caring".

Drawing resources from feminist academic research as well as activist groups, feminist thought and practice allow us to highlight gendered, racialised, classed, and other intersecting dimensions to health, and to centre not only epistemic justice and storytelling, but also empathy and an ethics of care.

Of course, promoting discourse on issues such as vulnerability and interdependency within the educational setting can be difficult and nuanced. Recent literature in the field of medical humanities advocates for the use of the arts and humanities as tools for broaching topics that may be sensitive or nuanced; indeed, much feminist literature and arts explore women's and gendered experiences of health and illness (Wånggren 2016; Foster and Funke 2018; Dudley 2021). Example activities could include: the creation of artworks on what it feels like to experience disease or illness as a woman; authoring love and breakup letters (Laughey et al. 2021) to the patriarchy or marginalisation based upon gender; or writing poetry on intersectionality. Key is the creation of a safer space for discussion.

10.7 Conclusion

Feminist thought and practice help us understand and address existing biases within health professions education, and to articulate new perspectives and practices that will serve us better. Alongside and intertwined with feminist activism, antiracist, LGBTQIA+, and disability activism allow us to counter bias in health professions practice and education. Feminist health and medicine scholars and activists have highlighted the sexist biases in science and medicine, questioned the medicalisation of women's bodies and minds, and highlighted health inequalities among women and other groups. Addressing the ways in which social, cultural, and political factors influence discourses and experiences of health, and understanding the historical roots of gendered inequalities in health, is crucial in improving health professions education (Table 10.1).

Table 10.1 Practice points

1	Embed reflexivity practices within programmes, allowing students and professionals to critically enquire and address their own and the patient's positionality and how this affects knowledge production
2	Include intersectional perspectives in handbooks, case studies, and examples, being sensitive to the different experiences and positionalities of diverse groups (for example: names in handbook examples should represent the diversity of educators, students, and patients). Awareness of intersectionality is of particular importance as we navigate efforts to decolonise the curriculum
3	Include compulsory structural/unconscious bias or Equality, Diversity, and Inclusion (EDI) training sessions for educators and students
4	Acknowledge and discuss competing discourses on sex, gender, and sexuality, including the perpetuation of bias and inequity. Embrace the arts and humanities as a tool for creating safer spaces and an informal approach to discussing gender and associated inequities
5	Remember that addressing equality, diversity and inclusion is a longitudinal process. We are training the future policy makers; taking the time to sow the seeds and allow understanding to develop is crucial

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