REDESCRIPTIONS
Political Thought, Conceptual History and Feminist Theory

Witnesses of Medical Sexism: Representations of Gender in Definitions of Gynaecology

RESEARCH

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HUP HELSINKI UNIVERSITY PRESS

ABSTRACT

This article presents a feminist critical analysis of institutional definitions of gynaecology in Quebec, Canada. By examining six official definitions, three problematic areas are uncovered: the essentialisation and vagueness of the subject 'woman'; the hierarchical appropriation of expertise by gynaecologists at the expense of patients; and the conflation of gynaecology with obstetrics, the latter of which entrenches the association between femininity and maternity. We argue that these definitions obscure the true diversity of patients' experiences and needs, thereby reinforcing existing oppressive power dynamics in medical practice. We advocate for an epistemological shift that values the situated knowledge of patients and promotes a more inclusive, feminist conceptualisation of gynaecology.

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KEYWORDS:
Gynaecology, obstetrics, feminism, gender, androcentrism, sexism

TO CITE THIS ARTICLE:
Toupin A, Brousseau R. Witnesses of Medical Sexism: Representations of Gender in Definitions of Gynaecology. *Redescriptions: Political Thought, Conceptual History and Feminist Theory*. 2025; 28(2): 140–159. DOI: https://doi.org/10.33134/rds.465

DOI: 10.33134/rds.465

Interested in the phenomenon of specialisation, knowledge and expertise in Western medicine in the late 19th century, Weisz (2006, xii) asks: 'Why did it take certain directions and not others?' While a few doctors had already established themselves as experts in specific fields before this era, such as birthing physicians or 'man-midwives', they were nevertheless more the exception than the rule. Weisz explains that the categories into which the medical workforce was distributed were primarily formed under the influence of medical stakeholders (doctors) and their habits of self-governance, much more than under the influence of patients' needs or the population's opinion, for example, thereby reflecting their beliefs, interests and moral values.

In 19th-century Western societies, where doctors faced challenges in gaining credibility and trust from a sceptical public (since quackery was legion), institutions aimed to limit the number of emerging medical specialities to prevent further fragmentation and weakening of the medical profession. Weisz (2006, xxv) asks: 'Did fields that treated specific populations, such as children, have as much justification to specialty status as those based on specific organs or hard-to-master technologies? And, what about those based on social needs, laboratory procedures, or specific therapeutic modalities?' In his view, certain specialities were created from professional categories that pre-dated the unification of medicine (surgery, for example). Others were born out of or grafted onto an existing speciality. Others, stresses the author, developed in singularly complex environments and in response to particularly hard-to-treat problems, which, he writes, is the case of gynaecology.

In Quebec, Canada, 60 medical specialities have been officially recognised to date by the Collège des médecins[1] (n.d.). Among these, gynaecology stands out as the sole speciality that came to define its expertise in relation to a sex/gender category: that of women. Medical specialities more commonly define their focus based on an organ (e.g. cardiology for the heart, dermatology for the skin), a function (e.g. anaesthesiology for pain management, immunology for the immune system), a situation (e.g. emergency medicine for urgent care, forensic pathology for autopsies and post-mortem analyses) or even an age group (e.g. paediatrics for children, geriatrics for the elderly). Although andrology or urology may be referenced to suggest that men are also the focus of a gender-specific medical speciality, the former, aside from emerging several decades after gynaecology (Oudshoorn 2000), is not recognised in Quebec, and the latter is concerned with all bodies, not exclusively those of men.

Several analogous definitions exist to delineate the scope of gynaecology. These definitions refer to a specialisation historically framed within the institutional category termed 'women's health'. In Quebec, for example, institutions sometimes refer to '*aspects féminins de la santé*' ('feminine aspects of health'; Université Laval 2021); to '*santé de la femme*' ('health of the woman'; Université de Montréal s. d.); to '*l'appareil génital de la femme*' ('genital apparatus of the woman'; Gouvernement du Québec 2021); or even simply to '*la femme*' ('the woman'), without further precision (Association des obstétriciens et gynécologues du Québec [AOGQ] 2021a).[2]

The historical reliance of gynaecology on gendered categories to define its field and focus on certain bodies raises important conceptual and practical questions. What does gynaecology consider a 'woman's' body, a 'feminine' health? Are we referring to sex rather than gender? Is there even a difference between the two? Are we referring to bodily characteristics, to organs? Can gynaecology provide healthcare to someone with a vagina but no uterus? What about trans men who haven't had genital gender-affirming surgeries?

DOI: 10.33134/rds.465

A feminist critique of the definitions of gynaecology would help clarify the scope of the speciality by acknowledging the legacy it inherits, the diversity of those it seeks to serve and the fact that its remit does not in practice encompass all medical conditions experienced by women.

Definitions provided by institutions influential in the societal regulation of medical practice have considerable weight in the representation of medical professions in that they determine, articulate and project a conceptualisation of their field of expertise to which few alternatives are opposed. In Canada, the regulation of medical practice is a provincial responsibility. For this reason, only institutions of the same province can provide contextually comparable definitions of gynaecology. Accordingly, for accuracy, this paper focuses on the institutional definitions from the province of Quebec.

The purpose is to answer the following question: what do Quebec's institutional definitions of gynaecology reveal about the epistemic foundations and political implications of the speciality in relation to gender?

HOW DOES GYNAECOLOGY DEFINE ITS PURPOSE IN QUEBEC?

A definition is, in short, 'a description of the features and limits of something' (Cambridge Dictionary 2024). 'A good definition captures the "real nature" of what is defined: "[it is] a phrase signifying a thing's essence"' (Antonelli 1998). Given that a definition endeavours to present the most fundamental elements of a concept, those indispensable characteristics without which the concept cannot exist, it follows that a definition delineates the conditions necessary for the existence of the concept it references, what justifies its existence, what gives it its *raison d'être*. In this perspective, 'gynaecology' is a concept that should refer to something that exists because it must, because it has come to be seen as necessary. Otherwise, the word 'gynaecology' would be useless.

Yet, it would be misguided to expect medical definitions to meet such a philosophical ideal. Their function is generally more pragmatic. They serve to delimit a field of practice, to assign authority or expertise and to stabilise categories for institutional, pedagogical and clinical purposes. What may be of greater interest here, then, is less about whether the definitions of gynaecology succeed in capturing its 'true nature' (a nearly impossible task for any definition), and more about what their form, language and omissions reveal about how the speciality justifies and intelligibilises its own existence. The words chosen, the boundaries drawn and the exclusions enacted all have epistemic and political effects.

Six Quebec institutions involved in the societal regulation of medical practice have defined gynaecology. The first is the Association of Obstetricians & Gynaecologists of Quebec (AOGQ 2021a), a union representing nearly 500 physicians practising this speciality. This institution presents its understanding of the expertise in the following manner:

> The name obstetrician comes from Latin (*Obstare*) meaning (to stand before) and the name gynaecologist is derived from the Greek words (*Gunaikos logos*) meaning (study of the woman). These two terms well define the role of this specialist physician.

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The AOGQ proceeds to state that 'the certified obstetrician-gynaecologist is [...] the physician best qualified to take care of the health of the woman during all the important stages of her life: from her birth to menopause, and through her adolescence, her maternity and her woman's life'. For conciseness, the AOGQ simply states that obstetrician-gynaecologists are 'specialists in the health and the reproductive system of the woman' (AOGQ 2021b). According to information on their website, obstetrician-gynaecologists have the power to act 'on several aspects of overall health' by treating and curing (or preventing) 'different pathologies affecting the feminine aspects of health and reproduction' or by promoting 'the feminine health' (AOGQ 2021b).

A more detailed definition from the Quebec government describes gynaecology as a 'branch of medicine that studies the anatomy, physiology and pathology of the genital apparatus of the woman, including the breasts'. It should be noted, however, that the precision of this definition pertains to the bodily processes studied (the anatomy, physiology and pathology of the genital apparatus) rather than to the subject of study (the person or population to whom this apparatus is attributed). This subject is designated, as in the previous definition, by the term 'woman'. This is also the case for the third and fourth definitions, offered respectively by Université Laval and the Université de Montréal.

The first of these two universities offers a residency program in 'obstetrics and gynaecology'. The definition it proposes for this medical speciality does not seek to distinguish the two areas of expertise. 'Obstetrics and gynaecology' is described as

> the surgical medical discipline interested in the health of the woman and her reproductive system. This speciality enables the development of the medical, surgical, obstetrical, and gynaecological knowledge and skills necessary to prevent, diagnose, treat, and take charge of a wide range of pathologies affecting the feminine aspects of health and reproduction. (Université Laval 2021, para. 1–2)

The Université de Montréal also provides a definition that links the two fields of expertise while maintaining the focus on 'woman' as the subject of study:

> Obstetrics-gynaecology is a medical speciality interested in the health of the woman, in all the stages of her life, from childhood to menopause. Pregnancy, contraception and all gynaecological health problems that may arise in the course of life depend upon gynaecology-obstetrics. (Université de Montréal s.d., para. 3–4)

Another definition, offered by Université de Sherbrooke, differs slightly from the previous ones in that it does not mention the subject 'woman' but instead refers to a 'feminine' subject. The definition it offers of 'obstetrics-gynaecology,' which almost exactly matches that of Université Laval, is as follows:

> This speciality develops the medical, surgical, obstetrical, and gynaecological knowledge and skills necessary to prevent, diagnose, treat, and take charge of a wide range of pathologies affecting the feminine aspects of health and reproduction. (Université de Sherbrooke s.d., para. 2)

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The sixth institution, McGill University, does not provide an explicit public definition of the speciality. However, its Department of Obstetrics and Gynaecology repeatedly refers to 'women's health' and 'women's issues' throughout its web page (McGill University 2021b). The Department's mission additionally indicates that students, residents, fellows and professional gynaecologists and obstetricians are encouraged to develop the professional skills and humane capacities to provide specialised care in women's health (McGill University 2021a). For the present purposes, these elements of information, while not constituting a definition, per se, will nevertheless be considered in the analysis, both because they are comparable to those of the preceding definitions and because they bear meaning.

GYNAECOLOGY AND THE FEMININE: GENDER, SEXISM, AND MEDICINE

A priori, three aspects common to all six institutional definitions of gynaecology emerge as problematic when subjected to a feminist critical analysis. The first aspect regards the construction of the subject upon which gynaecology claims expertise, the meaning attributed to that subject and the scope this confers upon gynaecology. The second aspect relates to the process by which this *subject* is positioned as the *object* of medical expertise and, from then on, of a necessarily hierarchical authority. The third aspect, finally, emerges when we try to understand what distinguishes gynaecology from obstetrics (from a medical point of view, is 'the woman' condemned to exist only if she is to experience pregnancy and childbirth?).

THE SUBJECT OF EXPERTISE: 'THE WOMAN'… AND BEYOND?

One thing that stands out when reading the definitions is the systematic use of the expression 'the woman' or analogous terms such as 'women' and 'feminine' to designate the subject of gynaecological expertise. This terminology, however, is insufficiently precise to capture the scope of a speciality (a delineated field of advanced knowledge and technique).

What do 'women', 'feminine' and 'the woman' designate precisely? According to whom? Based on what? Who (and what) do these semantic choices exclude? How do the answers to these questions reflect on people and their gynaecological health? In her book *Épistémologies féministes*, Elsa Dorlin (2008) draws on the work of philosopher Michel Foucault to highlight the importance of taking an interest in what forms of knowledge and experience are excluded when certain discourses are recognised as scientific. The latter writes:

> What types of knowledge do you want to disqualify the moment you claim to be a science? Which speaking subject, which discoursing subject, which subject of experience and knowledge, do you want to diminish the moment you say: I, who hold this discourse, I hold a scientific discourse and I am a savant? (Foucault 1997, 10)

Foucault's insightful reflection proves highly relevant to the ways in which gynaecology is discursively constituted. If gynaecology is interested in women, then who is included and excluded from this category? 'Woman/women' may refer to either sex or gender, provided we accept the idea that these two concepts do not represent the same

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single reality. And, even if they did, there would still be ambiguity in each of the terms' meaning.

According to Oudshoorn (2000), medico-scientific literature produced since the late 19th century, a time when the medical specialities emerged and settled (Weisz 2006), shows that femininity in medicine has been widely essentialised. From the uterus, the locus of femininity shifted to the ovaries, then to sexual hormones. She explains that the main gendered body categories we know today (the masculine body and feminine body) are social constructs that medical science and its discourse have strongly influenced, if not created. But, today, do we still think of sex as rooted in organs and bodily chemical substances?

The end of the 20th century witnessed a proliferation of critiques of the concept of sex. Consequently, the very pertinence of each of the previously mentioned sub-constructs of sex is debatable and debated, contestable and contested. For example, feminist sociologist Ann Oakley presented sex as a construct limited to biology and gender as a construct representing everything that is not sex and that is socially considered as belonging to women or men (social roles, behaviors, etc.; Oudshoorn 2000). Considering that medicine has been predominantly oriented towards the body (more than towards social and societal spheres), such a conception of sex and gender would suggest that the definitions of gynaecology invoke not the gender but the sex 'woman'.

However, Kessler and McKenna (1978) have argued that sex does not exist without gender, as no characteristic or group of characteristics can consistently and unfailingly allow the identification of a person's sex. Their assertion reveals its force when tested. The more we establish criteria for identification, the more these criteria raise questions and the less intelligible the answers become, leaving us perplexed and bewildered. What initially seemed a simple distinction between two sexes unfolds into a vast diversity of human bodies in which no single line can be drawn.

Chromosomal diversity, for example, exceeds the XX (female)/XY (male) binary. There are also XXY (Klinefelter syndrome), XXX (triple X syndrome), XYY (Jacobs syndrome), X (Turner syndrome) and 46,XX/46,XY (chimerism or mosaicism). Anatomically, there are bodies with strictly two testicles or strictly two ovaries, and also bodies with ovotestis (gonad containing both ovarian and testicular tissue), dysgenetic gonads (partially developed or atypical gonadal tissue), ambiguous or asymmetrical internal structures, micropenis or clitoromegaly (enlarged clitoris), partial fusion of tissues forming the scrotum or labia or yet vestigial uteri. The world is more complex than being one that includes strictly bodies that produce and use testosterone (considered a masculine hormone) and bodies that produce and use oestrogen and progesterone (considered feminine hormones). In fact, most bodies produce and use all three hormones, albeit in different quantities and proportions. Bodies also often challenge the assumption that chromosomal, gonadal, hormonal and phenotypical characteristics align. Bodies with an XY chromosome combination can develop a feminised phenotype due to different mechanisms affecting androgen activity, such as cellular insensitivity to testosterone (androgen insensitivity syndrome) or 5-alpha-reductase deficiency, which prevents the conversion of testosterone into dihydrotestosterone (crucial to the formation of male genitalia). Some develop a uterus and fallopian tubes due to anti-Müllerian hormone deficiency (necessary for the regression of embryonic female internal structures). There are individuals with an XX chromosome combination (female attribution) and a masculinised phenotype due to congenital adrenal hyperplasia (causing the adrenal

DOI: 10.33134/rds.465

glands to overproduce masculinising hormones). People assigned female at birth can have chest hair, a deep voice, a square jaw, android fat distribution, shoulders that are much wider than their hips or a completely flat chest. People assigned male at birth can have hairless bodies, high-pitched voices, gynoid fat distribution or gynaecomastia. Bodies can also experience no, delayed or incomplete puberty. These examples represent only a few among many known variations in sexual characteristics.

Some would say that these bodies are exceptions, anomalies or even aberrations of Nature and that it would be unreasonable to let their existence compromise the binary sex categorisation system. Yet, isn't it precisely Nature that creates these bodies? Furthermore, among the so-called male and female bodies, don't we find two pronounced spectrums of sexual morphology joined at their 'androgynous' ends? Why, then, within these two sex categories, is it the bodies that are most different from each other that are recognised as models of sexual naturalness and normality? And, if sexual dimorphism is justified on the grounds of reproductive complementarity, then why is reproduction, an episodic function representing at most a very small fraction of the human life, the unique criterion for assigning individuals to a sex category? One might just as well mobilise other logics of differentiation – for example, hormono-anatomical as is sometimes the case in regulatory frameworks of competitive sports (Handelsman and Bermon 2025).

Moreover, the fertility of certain androgynous bodies and the infertility of many bodies deemed 'typically sexed' expose the fragility of the binary model on which such reasoning relies. Bodies can be or become infertile for a wide variety of reasons: pre-pubescence, post-menopause, vasectomy, tubal ligation, hysterectomy, ovariectomy, contraceptive use, chemotherapy, radiotherapy, hormone therapy, endometriosis, polycystic ovary syndrome, uterine fibroids, adenomyosis, Müllerian agenesis, oligospermia, azoospermia, asthenozoospermia, retrograde ejaculation, varicocele, cryptorchidism, hypogonadism, hyperprolactinemia, pituitary insufficiency, chronic diseases or untreated conditions (diabetes, renal failure, autoimmune diseases, pelvic inflammatory disease, chlamydia or gonococcal infection, hepatitis, thyroid disorders), exposure to toxic agents (pesticides, solvents, heavy metals) or extreme or prolonged physiological stress (malnutrition, anorexia, overtraining), trauma, surgical altering of the reproductive organs… There are countless possible reasons. Fertility is not an intrinsic or stable property of 'male' and 'female' bodies but a contingent function that varies across time and circumstance. The fact that we continue to assign a sex to someone that is or becomes infertile exposes the incoherence of grounding sexual dimorphism in reproductive capacity.

It thus seems that what designates 'the woman' has yet to be specified in the definitions of gynaecology, even if we assume that sex is different from gender and that sex is the more objective basis on which the definitions rest. That said, according to Kessler and McKenna (1978), sex does not exist without gender; it is indissociable from it because gender must exist for sex to have meaning. They explain that the idea of two sexes is not given by Nature but rather produced through 'gender attribution': the everyday, socially organised process through which we assign a sex and gender to others based on our comprehension of what 'sex' is and our interpretation of their bodies and what we categorise as masculine or feminine. Similarly, Judith Butler has argued that sex *is* gender (Butler 1993). According to these perspectives, the definitions of gynaecology could thus not refer to sex as excluding gender.

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If 'the woman' in the definitions pertains to gender, then which gender are we talking about? As feminist philosopher Sandra Harding (1987, 7) puts it, 'there is no "woman" and no "woman's experience". Masculine and feminine are always categories within every class, race, and culture in the sense that women's and men's experiences [...] differ within every class, race, and culture'. Ollivier and Tremblay (2000) have a similar perspective. They argue that, even when women share a given experience, they experience it differently because they continue to be part of a heterogeneous group; they don't have the same culture, the same skin colour, the same social status, the same connection to parenthood, the same physical and mental health or the same age.

Building on this question of age, it is worth noting that both the AOGQ and the Université de Montréal exclude post-menopause individuals from the category 'woman' in their definitions. They imply that the important stages of the life of 'the woman' unfold from birth to menopause: 'the certified obstetrician-gynaecologist is [...] the physician best qualified to take care of the health of the woman during *all the important stages of her life: from her birth to menopause*, and through her adolescence, her maternity and *her woman's life*' (AOGQ 2021a, para. 4, italics added). The Université de Montréal's definition also suggests that the postmenopausal years are not part of the stages of a woman's life:

> Obstetrics-gynaecology is a medical speciality interested in the health of the woman, in all the stages of her life, *from childhood to menopause*. Pregnancy, contraception, and all gynaecological problems that may arise *in the course of life* depend upon gynaecology-obstetrics. (Université de Montréal s. d., para. 3–4, italics added)

Notably, the comma placed before 'from childhood to menopause' alters the meaning of the sentence. With a comma (as in the definition), 'from childhood to menopause' is an explanatory apposition that clarifies 'all the stages of her life' and makes it mean: 'in all the stages of her life, i.e. from childhood to menopause'. This implies that the stages of a woman's life are between childhood and menopause, and nothing beyond that, therefore limiting the whole of a woman's life to the reproductive years. Without a comma, the phrase would instead transform 'from childhood to menopause' into a restrictive complement that would only delimit part of the group 'all the stages of her life'. The meaning would then be that gynaecology is concerned with women's health during the specific stages of their lives from childhood to menopause (but not necessarily all the stages of their life). What appear as mere grammatical details reveal deeper ontological presuppositions.

If Ollivier and Tremblay (2000) have put forward the idea of a heterogeneity of experiences lived by a heterogeneous group, Butler (1995) had already suggested that identity categories were never solely descriptive, that they were always normative and, as such, that they inevitably carried with them the exclusion of what did not fit into norms. These conceptual debates do not suggest that medicine consciously enforces such exclusions, but rather that it can reproduce, intentionally or not, inherited cultural assumptions about sex and gender. Butler writes: 'This is not to say that the term "women" ought not to be used, or that we ought to announce the death of the category' (Butler 1995, 50). The proposal following their statement is interesting: if we postulate that 'women' designates something that cannot realistically be designated due to the differences that compose this identity category, if we thereby postulate

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that these differences cannot be totalised or summarised to form a purely descriptive identity category, then the term can only exist by remaining open and resignifiable and as a subversive category that we can politicise (Butler 1995).

Admittedly, the definitions are not limited to discussing 'the woman', 'women' or 'femininity'. They also contain elements of precision: the health of [the woman] (4)[3]; the reproductive system of [the woman] (2); several aspects of overall health (1); different pathologies affecting the [feminine] aspects of health and reproduction (3); the [feminine] health (1); the anatomy, physiology and pathology of the genital apparatus of [the woman] (1); pregnancy, contraception and all gynaecological problems (1); and [women's] issues (1).

However, these precisions still do not contribute with sufficient precision to circumscribing what constitutes the field of expertise defined as gynaecology. These elements cannot be interpreted unequivocally. Their meaning is ambiguous and calls for clarification. Most of the elements relate to and involve the body: health, anatomy, reproductive system, genital apparatus… But does something that could be classified under the category 'woman's body' even exist? Oudshoorn (2000, 34) provides an interesting answer to this question: 'there exists no natural truth about the body that is given directly and without intermediary. The body is always a signified body'. She adds that biomedical sciences are both dependent on language and actively involved in producing the realities that language designates. Oudshoorn (2000) concludes from this reasoning that scientists are not 'providers of objective knowledge about the "true nature" of the body' and that the scientific 'facts' they convey about the body are rather actively and collectively created. The importance of examining how gynaecology defines its subjects of expertise is therefore immense, especially as feminist approaches increasingly challenge claims of universal or purely technical knowledge by emphasising the social and subjective nature of health (Merone et al. 2022).

It is important to acknowledge that vagueness is not inherently problematic. In some contexts, it can serve a protective or inclusive function by enabling multiplicity and self-definition. In the case of gynaecology, however, vagueness operates differently. Here, the indeterminacy of 'the woman' does not broaden the category to encompass diverse experiences. Rather, it enables institutions to evade specifying whom gynaecology serves and on what grounds, thus maintaining an illusion of universality that conceals the diversity of patients' realities. Using 'women's health' as a convenient umbrella term to include trans, intersex and non-binary people without challenging the gendered structure of the category leaves biases intact and allows symbolic violence.

Instead of stretching a single, normatively gendered term to assimilate bodies of multiple gender identities, we could rethink the epistemic boundaries of the field. Concretely, this could translate into definitions where the object of expertise would be defined by organs and functions (e.g. 'Gynaecology is the branch of medicine concerned with the anatomy, physiology and pathology of the uterus, ovaries, vagina and vulva, and related hormonal and reproductive processes […]'), where the diversity of identities would be visible, (e.g. '[…], recognising that these may belong to persons of different gender identities […]') and where the historical entanglement of gynaecology with gender would be acknowledged (e.g. '[…] and that the traditional association of gynaecology with women reflects historical norms rather than biological necessity'.).

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WOMAN: *OBJECT* OR *SUBJECT* OF EXPERTISE?

In *Feminism and Methodology*, Harding (1987) explains that problematising a situation, in the scientific sense, means highlighting the need to explain that situation, a need that arises from the person or group of people directly or indirectly affected by this problem: 'a problem is always a problem for someone or other' (Harding 1987, 6). Although institutions might consider their definitions adequate, individuals using gynaecological health services may experience them differently and perceive issues.

The gap between the two standpoints calls for closer scrutiny of how gynaecological expertise is defined in practice, beginning with the choice of action verbs used in the definitions to describe the role assigned to gynaecologists in their relationships with their subject of expertise. For these professionals, it is a matter of studying [the woman; the anatomy, physiology and pathology of the genital apparatus of the woman]; taking charge of [the health of the woman]; having the power to act on [several aspects of overall health]; promoting [the feminine health]; taking an interest in [the health and reproductive system of the woman]; and developing [the medical, surgical, obstetrical and gynaecological knowledge and skills, as well as the professional abilities and humane capacities necessary to perform the following verbs:], diagnosing, treating, healing, preventing and taking charge of [different/a wide range of pathologies affecting the feminine aspects of health and reproduction] and providing [specialised care in women's health].

Studying and *taking an interest* do not delineate the speciality of gynaecologists. Patients regularly engage with knowledge of their own anatomy and physiology, yet such engagement does not equate to the specialist training and competencies associated with the profession.

Similarly, unless one implies that women do not share the *power to act* alongside gynaecologists on various aspects of their overall health, this action is also insufficient to specify the scope of these doctors' work or to distinguish their expertise from that of other specialities. In Quebec, *diagnosing* is, indeed, a professional act reserved for physicians but not solely for gynaecologists, according to the 2021 Medical Act. Nothing prevents a general practitioner, a paediatrician or an endocrinologist from diagnosing or managing polycystic ovary syndrome, for example. Therefore, the action verbs do not, on their own, unambiguously specify the scope of the field.

Definitions also use passive verbs to characterise gynaecologists. They are described as the most qualified among physicians to be the agents of the previously mentioned action verbs. Moreover, they are also certified specialists to be these active subjects, and the people upon whom pregnancies, contraception and (indeed, a tautological statement) all gynaecological issues depend ('*relèvent de*'). It is worth noting that, according to the definition provided by Larousse (n.d., para. 26), to '*relever*' (here, conjugated as '*relèvent*') as an indirect transitive verb means 'to be under authority, to be dependent on. Synonym: to depend on'. Thus, '*relever*' implies here that pregnancies, contraception and all gynaecological issues 'depend on' the gynaecologist. This is an eloquent example of the discursive expansion of the field (pregnancies are not contingent on the existence of the medical speciality).

In this regard, an instructive analogical parallel arises between what happens between a gynaecologist and a patient, on the one hand, and between a researcher

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and a research participant, on the other hand. In both cases, one individual (researcher or gynaecologist) is in a position of authority relative to the other, if only due to their association with socially valued, institutionally recognised knowledge (scientific or clinical) often presented as neutral and reliable. The other person holds knowledge as well, but theirs is composed of 'invisibilised and depreciated cognitive resources, determined by and developed from their material conditions of existence' (Dorlin 2008, 19). Valuing the knowledge developed from these situated cognitive resources is an epistemological project that Nancy Hartsock (1983) elaborates on in what she calls feminist standpoint theory. For Hartsock, this situated knowledge highlights what dominant knowledge keeps in the shadows and denies (Dorlin 2008). Consequently, if only by its capacity to reveal the arbitrary nature of the 'neutral' quality attributed to scientific knowledge (or clinical, in the case that concerns us), situated knowledge becomes a political tool. Scientific knowledge being equally situated in the material conditions in which scientists exist, it can only compete in partisanship with the situated knowledge of feminists. 'The so-called scientific neutrality is a political stance' (Dorlin 2008, 20). This is also the case for the knowledge held by physicians and patients. Delphy (1998, 277) emphasises the intimately historical aspect of power relations at work in the project of 'neutral' knowledge production: 'That there is no neutral knowledge is a common saying. [...] All knowledge is the product of a historical situation, whether it knows it or not. But whether it knows it or not makes a significant difference; if it does not know it, if it claims to be 'neutral,' it denies the history it purports to explain [...]. Any knowledge that does not recognise social oppression, that does not take it as a premise, denies it, and therefore serves it objectively.'

In the case of gynaecology, the knowledge considered scientific is typically that held by gynaecologists, whereas the knowledge of patients is more often devalued or rendered invisible. The former tends to be positioned as objective and universal, and the latter as partisan or subjective. Yet, both are situated and political; both are historical and subjective.

If medical–scientific knowledge is not neutral, Ollivier and Tremblay (2000) more precisely qualify the knowledge produced by science as androcentric. Like them, Harding (1987, 8) argues that, historically, the study of 'women' was conducted largely by men, thus from their standpoint and for their political projects: 'The questions about women that men have wanted answered all too often [have] arisen from desires to pacify, control, exploit or manipulate women'. Historical records provide relatively few examples of scientific knowledge produced by women studying women's standpoints and experiences with the aim of acquiring self-understanding (Harding 1987). The notion that racialised women feel less pain than white women, which James Marion Sims used to legitimise his experimental vaginal surgeries conducted without anaesthesia on enslaved women, did not arise from Black female researchers or physicians for the benefit of Black female patients; rather, it emerged within medical traditions led by white, slave-owning male practitioners, whose professional advancement was closely tied to such practices (Cooper Owens 2017). Similarly, the now widely discredited diagnosis of hysteria, portraying the uterus as a wandering organ responsible for women's ailments (Delcourt 2021) and which should be treated through orgasms 'prescribed and practiced by doctors on their patients' (Gardey and Hasdeu 2015, 77), developed within male-dominated medical traditions, not from women's research.

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To address the androcentric reality of science, Harding (1987) calls for intellectual democracy – namely, an epistemology that foregrounds the experiences and perspectives of women (we would add, in our case, of all individuals using gynaecological health services regardless of their gender), while identifying institutionalised sexism and racism, biases and 'social values and interests[4] that could affect research and its outcomes' (Dorlin 2008, 31). Moving toward a feminist *savoir-faire* (knowing how to do) and *savoir-être* (knowing how to be) would entail that researchers, as authority figures, first recognise themselves as biased individuals: 'We need to avoid the "objectivists" stance that attempts to make the researcher's cultural beliefs and practices invisible while simultaneously skewering the research objects beliefs and practices to the display board' (Harding 1987, 9). The same principle applies to the power dynamics occupied by gynaecologists. Harding (1987) further asserts that researchers must actively combat the injustices this hierarchy produces after recognising their privileged position within the hierarchy of authority. Similarly, gynaecologists can work to share power more equitably with patients, with the aim of building a more symmetrical epistemic relationship. The patient, both as the subject of the speciality and as a holder of situated knowledge, should be 'pictured as an actor and agent, not as a screen or a ground or a resource' (Haraway 1988, 592). As Elsa Dorlin (2008, 29) notes, such consideration is not merely 'a rule of respect towards the living subjects of the sciences [but] an epistemological prerequisite that establishes a vision, a way of seeing reality.'

In gynaecology, several conditions, such as endometriosis, vulvodynia or chronic pelvic pain, are diagnosed primarily through subjective symptoms like pain. The lived experience of pain then becomes clinically central, yet its epistemic status remains fragile within medical hierarchies of knowledge. As Temmes et al. (2025) show, physicians and patients often operate within different epistemic frames (pain as measure versus pain as lived). Pain, especially when expressed by young, racialised or otherwise marginalised patients, is frequently minimised or reframed as 'normal discomfort'. Reports describe, for example, cases where oocyte retrievals or intrauterine device insertions were carried out without anaesthesia despite cries of pain and trauma responses (Gillespie 2025). As Wiggleton-Little (2025) observes, even when clinicians believe women's pain, the normalisation of menstrual and reproductive suffering weakens their moral impulse to act. Patients report experiences of gaslighting and dismissal (Moss et al. 2025) and a continual need to negotiate their credibility in the face of the persistent minimisation of their pain (Robstad et al. 2025). In their autoethnographic study of vulvodynia, Taylor and Ridgway (2024) even show that diagnosis often serves to manage uncertainty rather than explain it. Pain is labelled, not understood, and suffering is acknowledged only within clinical categories. Drawing on Foucault, they argue that this translation of pain into diagnosis renders women docile bodies by shifting epistemic authority from patients to clinicians. Naming pain thus closes inquiry: 'you have vulvodynia' replaces 'you are in pain, and we do not understand why'. These studies reveal how clinical authority still owns the epistemic authority and power. When patients are not recognised as co-knowers of their own condition, the situation falls under epistemic injustice (Bayer and McWilliams 2025; Gillespie 2025). Re-centering patients' experience as a site of dialogue rather than suspicion is thus key to reimagining gynaecology as a practice *with* and *for* patients, rather than *upon* them.

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'GYNAECOLOGY AND OBSTETRICS' OR 'GYNAECOLOGY-OBSTETRICS': IS FEMININE HEALTH DISSOCIABLE FROM MATERNITY?

References to obstetrics are ubiquitous when discussing gynaecology, which makes it difficult to analyse the latter independently. For example, the AOGQ describes itself as representing 'obstetrician-gynaecologists'. The distinction between the coordinating conjunction 'and' (obstetricians and gynaecologists) and the hyphen (obstetrician-gynaecologists) is not merely grammatical but conceptual. 'And' links the two specialities but keeps them linguistically distinct. Thus, the phrasing 'obstetricians and gynaecologists' designates the heterogeneous group of obstetricians, gynaecologists and those qualified in both but practising only one speciality at a time. In contrast, the hyphen in 'obstetrician-gynaecologists' creates a new compound term that designates the professionals holding the specific expertise in situations where gynaecological and obstetrical factors are inextricable.

In Western medicine, the fields of gynaecology and obstetrics have often been jointly organised due to their overlapping clinical concerns and shared professional trajectories. The fusion created by the hyphen reflects that reality. But are obstetricians automatically gynaecologists, and vice versa? If obstetrics is the 'branch of medicine dedicated to the care that must be provided to the woman during pregnancy, childbirth and the post-partum period' (Usito 2021, para. 1), and gynaecology is the 'branch of medicine that studies the anatomy, physiology and pathology of the genital apparatus of the woman, including the breasts' (Gouvernement du Québec 2021, para. 2), then the two need not be inseparable. Obstetrics can be a part of gynaecological health, while gynaecological health may have no connection to obstetrics.

To illustrate how their boundaries are enacted in practice, consider how clinical services are organised in Quebec. At the Centre hospitalier universitaire (CHU) de Québec, affiliated with the Université Laval, the treatments offered in gynaecology include 'endometrial ablation', 'gynaecological surgery', 'treatment of Bartholin gland abscesses', 'various procedures to destroy condylomas or precancerous lesions' and 'laparoscopic hysterectomy' (CHU de Québec s.d., para. 1). At the CHU de Sainte-Justine, affiliated with the Université de Montréal, gynaecologists provide 'specialised care for children and women until menopause, [...] a consultation service for adolescents, planning, reproductive endocrinology, haemostasis, urogynaecology, colposcopy and vulvar disease [...] [, and] a consultation service for pelvic ultrasound and hysterosonography' (CHU de Sainte-Justine 2021, para. 2). The website of the CHU de Montréal, also affiliated with the Université de Montréal, offers a section on 'gynaecology', where the only detail is that gynaecologists 'evaluate, treat and follow up with women regarding general gynaecology and colposcopy' (CHU de Montréal 2021, para. 4). The CHU de Sherbrooke does not have a section strictly dedicated to gynaecology on its website; it only has a section titled 'gynaecology and obstetrics' that mentions services such as colposcopy, labour induction, management of complications related to spontaneous abortion, uterine curettage, treatment of ectopic pregnancies and vulvectomy (CHU de Sherbrooke 2021). The McGill University Centre, affiliated with McGill University, does not provide information regarding the services offered by its obstetrics and gynaecology department (CUSM 2021).

The persistent coupling of gynaecology and obstetrics encodes an epistemic assumption that feminine health is only intelligible through reproduction. When

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institutional discourse systematically fuses the two, it repositions gynaecology as reproductive care by default and narrows the field's subject to the *potential* mother. Variation across Quebec hospital services illustrates how organisational labelling 'does' boundary work that sustains this default. The point is not that femininity equals maternity, but that contemporary defining practices and service architectures still make it so.

An alternative mapping can be found on Gynéco Positive (2021a), a Quebec-based website compiling professionals identified by patients as practising feminist and anti-oppressive gynaecology. The website lists obstetrician-gynaecologists alongside oncologist-gynaecologists and gynaecologists who do not practise obstetrics. It also includes midwives, general practitioners, nurse practitioners, birthing physicians, osteopaths and physiotherapists specialising in pelvic rehabilitation. This alternative way of listing the gynaecological health services highlights that not all gynaecologists are necessarily obstetricians and that other professionals also provide services in gynaecological and obstetrical health. Moreover, Gynéco Positive explicitly promotes a gender-inclusive vision: 'We would like to see a practice of gynaecology, and more broadly, of medicine, that attends to all patients, regardless of their gender'. (Gynéco Positive 2021b, para. 13) This highlights a growing awareness that those experiencing conditions associated with 'women's health' are not necessarily women. For instance, some trans men are at risk of ovarian or vulvar cancer, while certain trans women may fall outside traditional definitions of the 'female genital apparatus'.

Other medical specialities outside gynaecology also treat conditions that affect women. When a woman has a collapsed lung, she has a health issue, but is it, by definition, a 'feminine health problem' simply because it occurs in a woman's body? If not, does this imply that women have both 'feminine' and 'non-feminine' health, depending on the organ concerned? And if so, do men also possess 'masculine health' when it comes to their gonads and 'non-gendered health' when it comes to their arteries? These questions, although intentionally rhetorical, expose the inconsistencies that arise when gendered terminology is applied unevenly across medical fields. They invite reflection on why certain organs and functions have been historically coded as 'feminine' and why only those have warranted a gender-specific speciality. The absence of an equivalent framework for 'masculine health' suggests that the gendered framing of gynaecology is less a reflection of biological necessity than of historical patterns of thought within medicine.

If 'women's health' remains organised around maternity, the consequences are epistemic and distributive. Non-reproductive gynaecological needs are perennially secondary, and patients who do not identify as women or who do not seek to experience pregnancy encounter categorical misfit. In a study conducted at Zagazig University (Egypt), the author reviewed 703 theses in the Department of Obstetrics & Gynaecology from 1975–2012. The most common gynaecological topics studied were infertility, in vitro fertilization, embryo transfers and polycystic ovary syndrome, while the most common obstetric topics were pre-eclampsia, high-risk pregnancy issues, foetal growth restriction and foetal well-being (Kassem 2014). Except for polycystic ovary syndrome, all these issues are directly related to reproduction.

Such disproportionate attention to reproductive issues reflects a broader epistemic hierarchy in which obstetric concerns set the parameters of 'women's health'. It is against this backdrop that the recurring debate over separating obstetrics

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and gynaecology must be understood. In a questionnaire-based study, Rani, Pandher and Tandon (2021) surveyed 167 obstetricians and gynaecologists (most practising both fields) and found that 55% favoured separation, citing improved care, expanded subspecialisation and enhanced expertise, while 39% opposed it on grounds of interdependence and continuity of care. However, in a critical analysis of subspecialisation in obstetrics and gynaecology, Ludwig (1991) argued that dividing obstetrics and gynaecology would weaken the internal coherence of the field and its position in relation to neighbouring disciplines. Fragmentation would affect continuity of care for patients. He maintained that excessive specialisation, often driven more by professional ambition than by genuine clinical necessity, risks narrowing perspectives and curbing innovation. Proponents of separation, by contrast, point to the rapid growth of knowledge as justification for a more focused training model. Yet, it is striking that these arguments remain confined to questions of professional organisation, credibility or yet efficiency. They do not engage with the deeper issue of how the very definition of the field continues to hinge on gendered assumptions that 'women's health' is primarily reproductive health. More recent analyses (Ewies 2023; Habiba 2023; Pandey and Lindow 2006) also approach the issue in managerial rather than epistemic terms, leaving unchallenged the gendered association between gynaecology and reproduction.

It is precisely this epistemic foundation that feminist scholars such as Nisha (2022) have sought to challenge by exposing how modern Western medicine was built on a masculinist model of scientific knowledge. Western medicine has historically reduced women's health to their reproductive function, naturalised and essentialised the link between femininity and motherhood, instrumentalised women's bodies, obscured their lived experience and transformed medicine into a device of power that serves to justify patriarchal domination. Female biology has been interpreted as destined for motherhood, and any irregularity in the menstrual cycle or reproductive function has been pathologised. According to Nisha, women's medicine should, in theory, empower women (by offering choices, opportunities and overall health). In practice, however, this is not the case. She therefore proposes to de-essentialise the body (no longer reduce it to reproductive biology); de-instrumentalise motherhood (no longer make it a biological destiny or an ideological tool); re-situate the female body in an existential, social and lived context; and integrate women's lived experiences into the definition of 'natural' and 'healthy'.

If Nisha unveils the historical construction of women's health as reproductive health, other authors emphasise how changing social realities now challenge that model. The diversification of women's experiences has destabilised the traditional alignment between femininity and maternity, and Joneja and Chopra (2012) build precisely on this shift. They explain that the 'modern woman' no longer lives as her predecessors did, and that these transformations have direct implications for health. As women's education, autonomy and longevity increase, their health priorities extend beyond reproduction to include sexual satisfaction, menopause, mental health and the embodied effects of social pressures. According to the authors, the role of the gynaecologist is no longer confined to pregnancy or pelvic pathology and expands to 'advise, educate and facilitate the lives of women' (Joneja and Chopra 2012, 3). However, this represents a functional expansion of gynaecology, not an epistemic redefinition of women's health.

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CONCLUSION

The purpose of this article was to answer the following question: What do Quebec's institutional definitions of gynaecology reveal about the epistemic foundations and political implications of the speciality in relation to gender? The feminist critical analysis highlighted three elements.

First, the definitions rely on an under-specified yet normatively charged category ('the woman', 'women' or 'feminine') that blurs sex and gender. They presuppose the model of sexual dimorphism and a biologised 'female body' understood as an alignment between feminised chromosomes, gonads, hormones and phenotypes, thus excluding trans, intersex and non-binary individuals. The essentialised framework neglects both the empirically documented diversity of human sexual bodies and the socially organised process of gender attribution that makes sex intelligible. To counter the normative vagueness that underpins current definitions, gynaecology should explicitly redefine its object of expertise in functional and anatomical terms rather than through gendered categories.

Second, the definitions position clinicians as primary knowers and agents, and patients as passive objects of expertise, which perpetuates epistemic injustice and power asymmetry. As per epistemic humility (Muyskens et al. 2025), patients should be treated as co-knowers of their health. To that end, institutions and clinicians must recognise the social and historical limits of their knowledge and engage critically and respectfully with patients' experiential knowledge as an epistemic source.

Third, 'women's health' is tacitly equated with genesic organs and reproductive functions. The body becomes intelligible primarily through its capacity for reproduction, a conception further entrenched by the quasi-systematic coupling (both linguistically and institutionally) of gynaecology with obstetrics and by the delimitation of 'women's life' from childhood to menopause. Separating the epistemic definitions of gynaecology from maternity could promote a more balanced health architecture, where reproduction remains one component rather than the organising principle of the field.

Although the empirical material analysed in this paper is limited, it offers a revealing entry point into the situated gendered norms that have structured medical knowledge and specialisation. Acknowledging the historical androcentrism of medicine does not diminish the value of gynaecological care today, but it highlights the importance of redefining the field in ways that better account for diverse bodies and experiences. Reimagining gynaecology could enhance its capacity to respond to the varied needs of patients and address enduring blind spots in research and practice unrelated to reproduction. In this sense, a reflexive and de-gendered gynaecology may be precisely what is needed to counter the forms of androcentrism that continue to shape medical science.

Future research could extend this analysis to other jurisdictions and linguistic contexts to examine how gendered assumptions are maintained, contested or reconfigured elsewhere. They might also explore gynaecological care delivered by non-gynaecologists (such as nurses, physiotherapists or other professionals) to understand how expertise is distributed across the healthcare system. Finally, comparative research could examine how analogous health realities in women and men are managed. For example, how and by whom are age-related androgen deficiency and menopause treated, or vasectomy and tubal ligation performed? These

inquiries would help to reveal the institutional logics through which bodily experiences become gendered medical specialities.

NOTES

1 The Collège des médecins is the professional order responsible for regulating the practice of medicine in the province of Quebec, Canada. Its role is to ensure that physicians meet high standards of practice and ethics to provide safe and quality care to the public.

2 In English, it would translate to 'Quebec Association of Obstetricians and Gynaecologists.'.

3 The numbers in parentheses represent the quantity of definitions that use these expressions among those analysed.

4 Here, those of gynaecology.

COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHORS' CONTRIBUTIONS

The first author led the conceptualisation and critical analysis, as well as drafted the manuscript in the original French. Both authors contributed to translating the manuscript into English, with the second author handling the majority of this work. The second author also played a key role in adapting the manuscript for an international audience and provided revisions to enhance its intellectual depth.

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TO CITE THIS ARTICLE:
Toupin A, Brousseau R. Witnesses of Medical Sexism: Representations of Gender in Definitions of Gynaecology. *Redescriptions: Political Thought, Conceptual History and Feminist Theory*. 2025; 28(2): 140–159. DOI: https://doi.org/10.33134/rds.465

Submitted: 24 September 2024
Accepted: 6 September 2025
Published: 2 December 2025

Redescriptions: Political Thought, Conceptual History and Feminist Theory is a peer-reviewed open access journal published by Helsinki University Press.

HUP HELSINKI UNIVERSITY PRESS
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