MJGH | Commentary

Medicine as a Tool of Gendered Colonial Violence

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Abstract

Introduction. Medicine in North America is widely perceived as a healing institution devoted to human welfare, yet this framing obscures its historical and ongoing role in perpetuating gendered colonial violence.

Methods. This commentary analyses the intersections of race, gender, and colonialism in Canadian and American health care systems, examining how colonial medical frameworks position racialized populations as the “Other”.

Results. Colonial medical frameworks systematically devalue racialized populations through intersecting mechanisms. Whiteness and heteropatriarchy establish the white male body as the normative standard, excluding women and racialized groups from research and clinical decision- making. For populations facing intersecting systems of oppression, these harms compound: Indigenous women’s access to regular healthcare providers declined from 75 percent (2015) to 48 percent (2020), while Black women face higher cardiovascular disease and cancer mortality alongside persistent undertreatment. The patriarchal and white-centred foundations of healthcare are structurally embedded and perpetuate gendered colonial violence.

Conclusion. Recognising medicine’s entanglement with systemic harm is essential to dismantling the colonial structures that continue to shape health systems. Confronting these legacies requires addressing the intersections of race, gender, and colonialism through sustained efforts to decolonize medicine and rebuild health systems rooted in equity and justice.

Keywords: medical colonialism; health inequities; intersectionality; racialized healthcare; gendered violence; women’s health

Introduction

Medicine, health research, and healthcare systems, especially in North America, are perceived by the settler-colonial majority as systems of healing and institutions devoted to human welfare [1]. This framing, while acknowledging medicine’s role in healing, obscures its complicity in perpetuating systemic human rights abuses [2]. From the colonial era of British and French settlement and land dispossession, through Canada’s development as a settler-colonial state, medicine has consistently functioned as a tool of gendered colonial violence [3].

Whiteness and Heteropatriarchy in Medical Systems

The concepts of ‘whiteness’ and heteropatriarchy are central to understanding systems of power and their reproduction in medicine. Central to colonialism is the creation of ‘Us’ versus ‘Them’, where white Europeans are depicted as rational, civilized and progressive, while non-white populations are seen as the ‘Other’ [4]. Empires relied on race theory to justify colonial conquest and naturalise white imperial rule [5]. While race is now understood as a social construct, colonial medicine reinforced colonialism by formalizing racial categories and portraying them as grounded in physical and social reality [5]. Medicine was wielded as a tool to pathologize racial and cultural differences, with Indigenous knowledge systems and healing practices often dismissed as inadequate or primitive in contrast to Western medicine [6]. Within this context, Bargallie defines whiteness as “a system of power relations that privileges non-Indigenous peoples over Indigenous peoples” in which the system constantly upholds white identities and interests as the natural, normal, and superior standards of existence [7]. This dynamic is entrenched in medicine, where the white

male body has historically been considered the standard for medical research and portrayed as typical, desirable, universally applicable, and superior [8].

Alongside whiteness, heteropatriarchy further structures medicine, resting on the assumption that heterosexuality and patriarchy are normal and natural [9]. Further, medicine operates as a site of heteropaternalism, where the father is both centre and leader, and should serve as the model for the social arrangement of the state [9]. Moreover, men have historically been the focus of health care and have predominated as doctors, researchers, and decision-makers, relegating women and racialized groups to the sidelines [10]. The exclusion of women from clinical research further highlights how medicine has perpetuated gendered violence by treating women's health as secondary and endangering lives through systemic neglect [11]. For decades until 1991, heart disease was labelled a "man's disease," with studies conducted almost exclusively on white, middle-aged men, leaving women underrepresented in research [12]. By failing to account for biological and physiological differences, the effect of gender bias in medical research and education results in delayed, inaccurate diagnoses, and higher mortality rates [13].

Othering and Racialized Health Inequities

The Tuskegee experiment exemplifies othering in medicine, where the construction of Black men as fundamentally different from White men (as 'Others') enabled researchers to violate basic ethical principles they would never have breached with white patients [14]. Moreover, research has shown that implicit racial bias in clinical settings results in Black patients receiving significantly less pain management than their white counterparts, as physicians often underestimate Black patients' pain, leading to lower analgesic doses [15,23]. By positioning Black bodies as suitable subjects for observation rather than deserving of treatment, the medical establishment revealed how othering strips individuals of their humanity and renders them objects of scientific curiosity rather than patients deserving care.

In the case of racialized minorities, this is clear when looking at the Black populations who face disproportionate disease burdens [16]. For instance, Black women are at a higher risk of developing cardiovascular diseases than Black men and receive substandard treatment compared to White women for similar conditions [17]. Further in cancer care, Black women are more likely to develop aggressive cancers at an earlier age and suffer higher mortality rates [18].

Intersecting Systems of Oppression

Indigenous women face multiple systems of oppression as they navigate settler colonialism and gender hierarchies. Currently, over one quarter of Indigenous people have unmet health care needs, while one in five Indigenous people report experiencing unfair treatment, racism, or discrimination from a healthcare professional [19]. Further, the healthcare gap for Indigenous women is increasing. For instance, in 2015, 75% of Indigenous mothers had a regular healthcare provider compared to 85% of non-Indigenous mothers [20], while in 2020, this gap grew substantially larger for Indigenous mothers, with only 48% of Indigenous mothers having a regular healthcare provider compared to 97% of non-Indigenous mothers [19]. The pattern of health inequities for non-white populations reveals a medical system that fundamentally devalues the lives of the 'Others' and perpetuates harm under the guise of care; representing systematic institutional failings rather than coincidental outcomes.

Colonialism is not a "historical point in time away from which our society has progressed" [9] but an enduring force that continues to uphold white patriarchal structures, particularly in healthcare. Colonial medical frameworks create a dichotomy between the colonizer and the 'Other'. The Coin Model of Privilege [21] illustrates how individuals can simultaneously experience both oppression and privilege. For instance, white women face gender-based discrimination but benefit from racial privilege that positions them above racialized populations. These hierarchies are further compounded by socioeconomic status, creating barriers to adequate healthcare for marginalized populations. Access to preventive care, specialist services, and timely interventions correlates strongly with economic resources, meaning that for racialized individuals, especially women, financial disadvantage frequently amplifies racial and gender discrimination [13,15,22]. Understanding these intersecting inequities through the Coin Model offers pathways for meaningful healthcare reform that addresses racial hierarchies, gender discrimination, and socioeconomic barriers simultaneously.

Toward Decolonizing Healthcare

Recognising medicine's entanglement with systemic harm is essential to dismantling the colonial structures that continue to shape health systems in Canada and beyond. The colonial healthcare system operates as a mechanism of domination, wielding Western medicine to invalidate Indigenous knowledge and to pathologize racial and cultural differences [23,24]. To dismantle this oppressive system, we must recognise the intersections of race, gender, and colonialism and how these manifest in disproportionate health outcomes for the 'Other'. While Canada has taken some steps to address these inequities, including efforts to integrate Indigenous knowledge and practices into healthcare, [25] confronting these legacies demands long-term, sustained commitment and concrete action to decolonise medicine and rebuild health systems rooted in equity and justice.

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AI Statement

The author declares that AI was not used in this article.