

# HORIZONS

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## MISOGYNY



In this issue of *Horizons*, we focus on misogyny, so it is fitting we release the publication on March 8 in recognition of International Women's Day.

Misogyny is defined as "hatred of, aversion to, or prejudice against women"<sup>1</sup> and/or as the form of sexism or social control that maintains the social structure of patriarchy, keeping women at a lower social status than men.<sup>2</sup>

While our authors in this issue likely recognize the importance of intersectionality in the forms and degrees of

violence and discrimination women face,<sup>3</sup> it continues to be the case that despite decades, even centuries, of hard work, in virtually all settings, women continue to face higher rates of discrimination and violence than men.

Women and girls face violence and discrimination from birth to death, although these experiences differ by geographic location, identity, and culture. Female fetuses are more likely to be aborted than male fetuses.<sup>4</sup> Female infants are more likely to be subject to infanticide (killed or left to die).<sup>5</sup>



In childhood and adolescence, girls are less likely to attend school, more likely to be victims of incest or sexual abuse, more likely to be subjected to child marriage, and more likely to be victims of child pornography or sex trafficking.<sup>5</sup> Throughout their life, in times of peace and conflict, women are more likely to experience rape and sexual violence, and more likely to experience physical violence at the hands of an intimate partner. Women are more likely to live in poverty, less likely to be employed in the formal sector, and persistently earn less money than their male counterparts with the same level of education.<sup>6</sup> Women face gender discrimination and sexual harassment in the private and public spheres: at home, in education, and in the workplace. These risks persist into old age.

This edition of *Horizons* explores some of the ways in which sexism and misogyny — the manifestation of social control of women by men — continue to play out in the daily lives and realities of women and girls in our own communities. All women know that their actions and choices are framed by their identity as women. Whether it is deciding to walk home at night with or without a headset on (as one resident recently told me), crossing the street to move away from someone following us, deciding where we can travel on our own, choosing the clothes we wear to the workplace, what comments we do or do not tolerate, or how forcefully we provide our opinions, our gender follows us everywhere.

Goal 5 of the UN's Sustainable Development Goals calls for gender equality by 2030. But the millennium development goals called for the same objective by

2015. In the words of the United Nations, "Fifty years ago, we landed on the moon; in the last decade, we discovered new human ancestors and photographed a black hole for the first time. In the meantime, legal restrictions have kept 2.7 billion women from accessing the same choice of jobs as men. Less than 25 per cent of parliamentarians were women, as of 2019. One in three women experience gender-based violence, still."<sup>7</sup>

Surely, we are done with this. Surely it is time to eliminate misogyny, and sexism, and to stand up for glorious, strong, and proud women everywhere.

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# Whose life is valued more?

## Systems of oppression and gender-based violence



By Maryam Pandi, Sexual Assault Centre Kingston

Reflecting on and entangling the concept of misogyny and its impacts is a challenging undertaking. Understanding misogyny and its various manifestations in our daily lives and its impacts on the health and well-being of the women in our communities can only be achieved by looking at the systems it thrives in, and the inequities it enforces.

For example, during the past couple of years, we have seen the disproportionate adverse toll this pandemic has had on the lives of women and gender-diverse people. Many reports have shown a sharp rise in gender-based violence (GBV) and sexual violence (SV) in Canada during the pandemic.<sup>1</sup> Those of us working in frontline organizations that serve GBV and SV survivors also saw firsthand an increase in demand for our services. The existing precarious housing and work environment quickly became more unsafe for many women. Cyber-violence and hate towards femme-identifying folks and activists continued to rise, especially for those who identified as BIPOC (Black, Indigenous, and people of colour) or queer.

On a more global scale, the UN reports that the pandemic and its economic fallout have a regressive effect on gender equality.<sup>2</sup> According to a report, women's jobs are 1.8 times more vulnerable to this crisis than men's.<sup>3</sup> One reason for this more significant effect on women is the fact that COVID is significantly increasing the burden of unpaid care, which has always been disproportionately carried by women. Economic insecurity, having to carry out higher rates of unpaid care labour, and experiencing higher rates of violence — in conjunction with precarious access to safe housing and food — have all come together to create the ultimate ill-fated recipe for hindering growth and threatening the well-being of billions.

When looking at all this data, it is important to note that they are averaged over a wide population group. And even the grimmest of these stats are far too optimistic for women living with intersecting identities. Very little research has focused on capturing the reality of the experiences of women who live in poverty or with a disability, or who belong to queer and BIPOC communities.

Acts of violence, particularly GBV and SV, though mostly



perpetuated on individual levels, have deep roots in patriarchal and colonial systems embedded within our communities. These acts can be predictable and dreadful byproducts of education, health care, and economic structures that are centred around protecting the health and well-being of wealthy, cisgender, abled, white men first, and move to disregard people based on how far away they are from the “ideal model” they were designed to serve.

So, the question of “Whose life is currently valued more?” — although a sad, unfair, and infuriating one — is a question we need to answer honestly if we want to imagine a path forward from where we are.

It is a reality that our capitalist and colonialist society creates the perfect stage for violence to thrive and devalue certain lives; it has allowed violence against women and girls to be normalized and only seen as existing and transpiring between individuals, while continuously disregarding the systems of violence until disastrous events (mass shootings, a pandemic, femicides, etc.) force a reactionary response.

When thinking about the path forward, any solution will need to be found in liberation and can only be achieved by implementing an intersectional lens that prioritizes those who have become most vulnerable through systematic oppression. As communities, we will need to ensure that any plan for change and progress will put the

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*Can we imagine a community free of misogyny without it being free from racism, transphobia, and gender inequity?*

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burden of action on those who have gained power and privilege, and minimize the harm to those who continue to be oppressed.

Further, we will also need to consider if the path to battling misogyny and the violence it creates can be imagined within the bounds of the systems that perpetuate it. This raises the question, “Is real reform possible and enough?” or “Do we need a revolution?”

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# Misogyny at Queen's: “The same old boys’ club”



Photo YGK News

*By students/teaching assistants Poppy Jackson, Annie Langford, and Kate Poehlmann, and Professor Margaret Little*

“LOCKDOWN YOUR DAUGHTERS NOT KINGSTON” screams one of the bedsheets hanging from the front porch of just another student house in October 2021.

Welcome to Queen’s Homecoming, where displays of misogyny are all just part of the white-hetero-privileged-boys-will-be-boys fun. This is how cultures are created and perpetuated; when a weekend designated to bring former and current Queen’s students together in celebration becomes an invitation to an alcohol-soaked rampage where those with privilege rape and pillage.

We live in a campus culture where at least one in three women and nearly one in six men are sexually assaulted by the time they leave university.<sup>1</sup> The 2018 Ontario Student Voices on Sexual Violence Climate Survey demonstrates that Queen’s has rates of sexual violence higher than

the Ontario average among all surveyed universities. According to this survey, 30.8 per cent of Queen’s students reported a non-consensual sexual experience and 71.4 per cent reported experiencing sexual harassment one or more times.<sup>2</sup> And racialized, Indigenous, lesbian, gay, bisexual, transgender, gender non-binary, and/or queer students experience far higher rates of assault than their white, heterosexual, cisgender peers.

The [@ConsentAtQueens](#) Instagram account details anonymous personal experiences of sexual violence at Queen’s. The sheer number of stories speaks volumes, but the central question is how can we transform this dangerous culture? How do we make it possible for Queen’s students to learn and to thrive in an environment that is respectful to all? First, we must take a hard look at the reality of Queen’s University culture. Only once we understand the problem can we begin to take steps to effectively address it.



queenspartylife Instagram

## The reality of Queen's campus

The prevalence of misogyny on Queen's campus is hardly a surprise when we examine its history. In October 1989, male students at a Queen's residence put up signs to mock the university's "No Means No" campaign, some of which read: "No means maybe," "No means have another beer," "No means tie me up," and "No means kick her in the teeth."<sup>3</sup> Popular football game chants at the time ("Lick it, slam it, suck it" or "I saw, I conquered, I came") and the slut-shaming publications of the student engineering newspaper, *Golden Words*, similarly echoed these sexist and dangerous messages.<sup>4</sup> These are not one-off incidents, but rather part of a larger institutional culture that is often unaddressed, and sometimes even facilitated, by the university.

An unfortunate commonality between these historical events and student parties during Queen's 2021 Homecoming is the insufficient ways in which the university addressed them.

Only two faculty members publicly criticized students and the administration over the 1989 event, while the university's principal at the time remained silent.<sup>5</sup> It wasn't until national media attention and alumni withholding donations threatened the university's reputation that the need to protect the "Queen's brand" encouraged the administration to take action.<sup>6</sup>

Following community outrage over the 2021 homecoming signs, Queen's Principal Patrick Deane

released a statement condemning the behaviour and indicating that disciplinary action would be pursued against those involved, although the university's specific actions and their outcomes remain unclear.<sup>7</sup> Just recently, Principal Deane released news of the formation of a task force, which will be the fifth task force on sexual violence in almost four decades.

Queen's has a long history of forming and reforming subcommittees, working groups, and task forces following an incident of negative press on sexual violence. In 1986 Queen's created the Sexual Assault Subcommittee, following negative national press on the issue. The subcommittee produced 11 recommendations, most of which still have not been met in 2022.<sup>8</sup> In 2013, when a report found that 11.4 per cent of Queen's students had been "sexually touched without their consent in the past year," Queen's established the Sexual Violence Prevention and Response Working Group, which took another two years to produce a set of 34 recommendations, echoing the 1989 recommendations still not met.<sup>9</sup> Queen's set up a working group on the issue in 2014 when the *Toronto Star* did a special investigative report revealing that Queen's did not have a sexual violence policy.<sup>10</sup> And another committee was struck in 2015 when the Ontario Public Interest Research Group released a report recommending that Queen's establish a sexual assault centre and a number of other important recommendations similar to the earlier ones.<sup>11</sup>

Will this new 2022 task force on sexual violence be different than the previous four? Will it take less than the historic three-year average to produce recommendations without results? Will it echo the combined 56 recommendations provided so far? It is hard not to see the pattern, that Queen's has yet again found a way to say "we have to do more" without doing more.<sup>12</sup>

This is not the only recent case of an inadequate institutional response to misogyny and sexual violence. In 2018, a professor at Smith School of Business invited a former Queen's student who had been convicted of assaulting a teen to speak in their course.<sup>13</sup> In 2020, the Instagram page @ConsentAtQueens emerged and students have questioned the university's seriousness in investigating these incidents after they've been reported.<sup>14</sup> Although Queen's has addressed these incidents through formal statements, the continued occurrence of these events shows that the university's responses have only been reactionary and have done little to prevent students from experiencing and/or engaging in misogynistic behaviour.

This culture of misogyny is tightly intertwined with cultures of "partying" and of white male privilege, which must be addressed together. White, cisgender, heterosexual students tend to disproportionately

participate in college drinking practices like those on display at events like homecoming — which often play a big role in students' sexual experiences.<sup>15</sup> Toxic drinking and sexual cultures thus create a perfect storm in which sexual assault and harassment are more likely to occur.<sup>16</sup> It is therefore necessary to examine why students partake in these cultures and how the university reinforces them so that effective prevention strategies can be developed.

### The culture and shirking responsibility

The “boys’ club” culture at Queen’s breeds an epidemic of sexual violence and an unsafe learning environment for students. Spaces that privilege white-hetero-cis-male entitlement promote violence inflicted upon the bodies of those ascribed less power and privilege. Survivors face having to sit beside perpetrators in class, be taught by them, or be worried about sexual violence while walking on campus. This is the reality that Queen’s students live with — especially those who are female, 2SLGBTQIA+,<sup>17</sup> living with disabilities, racialized, or otherwise marginalized. In particular, the most recent student experience survey highlights that racialized and Indigenous students feel the most unsafe and are subjected to the most violence and harassment on Queen’s campus.<sup>18</sup>

As teaching assistants (TAs), we worry about our students. We want to protect them. We wish we could tell them everything we wish we knew as 18-year-old undergrads, and we know this is not enough to prevent the occurrence of sexual violence. Moreover, the onus should not solely be on students. Rather than focusing on strategies that tell our students they need to protect themselves, it is time for Queen’s to focus its efforts on changing the white-hetero-cis-male entitlement culture that promotes sexual violence.



queensupartylife Instagram

Sexual violence is one way the “boys’ club” tries to control gender and sexuality. In a culture that privileges masculinity and heterosexuality, those who do not fit within these norms are left highly vulnerable. For example, the US Centers for Disease Control and Prevention reports that three in four bisexual women are subjected to sexual violence.<sup>19</sup> Further, such a culture with rigid definitions of what it means to be “male” and “female” perpetuates transphobia. Those who report sexual violence often report being ostracized, particularly if the perpetrator is someone who is popular and well-respected, which only adds to the challenges 2SLGBTQISA+ students face on a predominantly white, cisgender, heterosexual campus.

### Recommendations to change Queen’s misogynist culture

How do we interrupt this cycle of sexual violence? Research has shown that targeted training can make participants more willing to intervene. Bystander intervention programs have effectively reduced campus sexual assault.<sup>20</sup> Studies report that a year later, previous participants from sexual violence-prevention training retained awareness about sexual violence, reported more intent to stop sexual violence, and reported fewer missed opportunities to support survivors.<sup>21</sup> Students who believed their peers support bystander interventions were also more likely to help stop sexual violence, thus changing the wider campus culture is crucial.<sup>22</sup>

Public Service Alliance of Canada Local 901<sup>23</sup> is currently demanding paid mandatory sexual violence and racism-prevention training for staff. The union has been bargaining with Queen’s for more than six months, while Queen’s has shown little interest in fulfilling its demands. A petition is circulating urging the Queen’s community to push the administration to pay PSAC 901 members for anti-racism and sexual violence-prevention training.

Numerous Canadian universities enforce mandatory sexual violence-prevention training for faculty, staff, and students, with some universities mandating students complete the training before being able to register for courses.<sup>24</sup> Queen’s students must return or pay for overdue library books before they can graduate. Yet Queen’s has repeatedly refused to commit to mandatory sexual violence-prevention training.

A team of graduate student researchers (including Tawakalitu Braimah, Poppy Jackson, Annie Langford, Danny McLaren and Kate Poehlmann) is currently co-ordinating with Sexual Violence Prevention and Response Services at Queen’s to create sexual violence-prevention training for TAs. The training will help TAs respond to disclosures of sexual violence, while acknowledging the specific gendered, raced, classed,



queensupartylife Instagram

and ableist components of sexual violence. However, any training will bypass the most important audiences if Queen's refuses to make participation mandatory.

Everyone, including administrators, faculty, staff, alumni, and donors, is responsible for changing the toxic culture of misogyny at Queen's. The Queen's community must insist on annual mandatory sexual violence-prevention training for all faculty, staff, and students to shift the misogynistic campus culture. We must all do our part to make Queen's a safe environment where students can learn and grow.

*Poppy Jackson and Kate Poehlmann are MA students in political studies; Annie Langford is an MA student in gender studies; Dr. Margaret Little, PhD, is a professor in gender studies and political studies. All are at Queen's University and are part of the research team collaborating with the Queen's Human Rights Office to create sexual violence-prevention training for teaching assistants.*

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# Where do women “fit” in STEM?



*By Dr. Claire Davies, PhD*

The number of women graduating in the predominantly male field of science, technology, engineering, and mathematics (STEM) continues to be a minority. In the past two decades, the ratio of Canadian women enrolled in master’s and doctoral engineering graduate programs has dropped (from 20 to 15 per cent and 28 to 22 per cent respectively).<sup>1</sup> While Queen’s boasts 28 per cent undergraduate enrolment, 27 per cent graduate enrolment, and 20 per cent female faculty, the effects of male dominance are still paramount with all but one (announced in January 2022) government and Canada Research Chairs being male.

Government funding is being withheld from institutions that don’t meet faculty “equity targets,” and it is believed that the promotion of equity hiring shows “a dedication to women’s rights.” But women in academia don’t achieve the same funding successes or get promoted into respected administrative positions. (For example, the Queen’s Faculty of Engineering and Applied Science Excellence in Research Award has never been awarded to a woman.) Women have lower tenure rates and higher risk of burnout.

I’ve been a token female faculty member in mechanical engineering at two institutions. I’m a licensed professional engineer but am told all too often that my research focus is not “real engineering;” it’s “just design.”

In department retreats I have been called an “equity hire,” and in another case “she was so persistent, we couldn’t get rid of her.”

For a recent grant application, I put together a team of women in electrical engineering, mechanical engineering, aerospace, and biomedical engineering with at least one representative from each of the following equity-seeking groups: persons with disabilities, persons of colour, and persons from Indigenous communities. One reviewer commented, “The lack of male mentors in the program raises questions as to the extent to which the program is open to or would be attractive to male students interested in the field.” Did the reviewer give any thought to how the “lack of female mentors in engineering” affects the attractiveness of engineering to female students? And there was no recognition for a team that included other equity-seeking groups?

The same is happening in STEM education. Universities bid for the most female students. When these innocent students arrive at the ivory tower, women are told their “designs just won’t work,” and besides they are “better report writers” than their male counterparts. Our recent research has shown that attitudes of male peers, teaching assistants, and professors lead to negative experiences that can limit female student success. Unsolicited student comments that identified gender disparities focused on stereotypes and the lack of role models,

which were determined to influence one's sense of belonging and feelings of imposter syndrome. Over half the female students who participated in our study felt discouragement due to the lack of gender diversity that has further impacted their experiences and education.

Lack of equitable access also prevents many women from effectively engaging. For example, women buy scuffed, second-hand, steel toe boots because that's how their experience level is judged. If they want to rent boots, the sizes are not available. In engineering exams, students have had to run between buildings to find a women's washroom. Universities must step up to provide supportive, equitable environments. Female students just don't feel as though they "have the right fit."

It is not only important for women to be a part of STEM education to "meet equity targets," but also to ensure that effective "fit" is achieved by designing for 50 per cent of the population. Smaller versions of designs made by men for men do not meet the needs of women. Let's explore how current medical devices increase the health-care risk to women.

When conducting laparoscopic surgery, women report hand and wrist repetitive strain injuries more than their male counterparts (odds ratio of 3.5).<sup>2</sup> When females and males are matched for glove size, women who use larger gloves (size 6.5-7.5) require more hand rehabilitation and for those who use smaller-sized gloves (5.5-6.5), women reported significantly more discomfort in the shoulder area (neck, shoulder, and upper back) than men. Not only do anthropometric measures differ, but other ergonomic factors prevent effective use.

From a patient perspective, in cardiothoracic surgery (open heart or lung procedures), surgeons use retractors to keep ribs and tissue away from the surgical site. However, the devices are not designed for female patients where the breast tissue poses a significant barrier. Male surgeons are further bewildered when women complain that after surgery, their breasts are lopsided.

To obtain FDA approval, a company must provide evidence of clinical trials OR evidence of "substantial equivalence" to one or more already approved devices (510K process). In 1976, PROLENE Propylene Suture was approved after being used in the repair of hernias since 1954.<sup>3</sup> As propylene tension-free vaginal tape slings or vaginal mesh implants could be shown to be substantially equivalent, they were approved without clinical trials that involved women. These implants were found to fail internally and cause significant pain. After complaints to the FDA from thousands of women, in 2011 a safety communication was issued identifying serious adverse reactions. Finally, in 2018 the FDA issued an order to stop selling these products — seven years after recognizing the need for change.

Metal-on-metal implants continue to evolve, but as minimal changes in design have occurred over the last

few decades, they also meet the "substantial equivalency" requirement for regulation. The approvals process has lacked recent clinical testing. Women have a higher rate and severity of metal sensitization as compared with males.<sup>4</sup> Failure of metal-on-metal implants puts more women at risk and occurs three times more often than failures using other types of implants (such as ceramic). Allergic skin reactions to metal are also reported as seven times greater for women than men. The pathophysiology of women is significantly different than men.

Any article written at this time would be remiss to neglect the identification of differences in personal protective equipment. The COVID-19 pandemic has brought to the forefront the difficulties with identifying women as "smaller men" in design. Health-care workers complain that gowns and gloves are too big, or that face shields interfere with their breasts while treating patients. Results from fitting tests show that N95 masks fail at significantly higher rates for women. Again, we must remember that women's anthropometric features differ and it is essential that ergonomic differences are considered in the design.

Evidence suggests that relying on men to design medical devices that can be used by women lacks foresight. Women are provided substandard health care as a result. Women are not just "small men." We need female students in STEM to design devices by women for women to account for differences between the male and female population. Students must be mentored by women to allow them to meet their full potential. Inclusive and intersectional research, design, and development are paramount for better access and better outcomes.

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*Dr. Claire Davies, PhD, is an associate professor at the Queen's Department of Mechanical and Materials Engineering. In addition to her research in this area at Queen's, her experiences are drawn from the University of Calgary, the University of Waterloo, and the University of Auckland.*

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# From invisible to uppity:

## A romp through women's place in medicine

*"You're a girl" said the youth "and you put great reliance  
On Men when you're frightened by mice.  
But to take up the study of Medical Science!  
Do you think, for a girl, it is nice?"*

McGill University publication (1902)

By Dr. Susan Phillips

When women's enrolment in Canadian medical schools finally equalled their proportion within the population (late in the 20th century) there was both jubilation and distain. Many assumed equity would bring equality. On the other hand, Dr. Brian Day, then president of the Canadian Medical Association, opined that female doctors "will not work the same hours or have the same lifespan of contributions to the medical system as males" and will exacerbate a doctor shortage. Neither was correct.

There is much research of a kind I find somewhat distasteful because it pits men against women, showing that women physicians are better for patients.<sup>1</sup> Men also form the vast majority of physicians who are disciplined by Ontario's regulatory body, the College of Physicians and Surgeons of Ontario.

Ideally, values are shaped by information, although even in "science" the reverse is often true; that is, information is selected and sometimes distorted to reinforce values. There is an enormous amount of information about women's marginalization in medicine. It spans decades

and is far too extensive to summarize here. But, for a taste of some more recent reports, in 2018, Japanese medical schools were found to have tampered with scores so as to limit admission to women.

There is continuing evidence that women face barriers to entering certain specialties, earn less for the same work, and do not advance to leadership positions. At present, in Canada, female physicians are clustered in lower-paying specialties and earn less than men in each specific specialty even when hours of work are equal. Women surgeons in Ontario earn 25 per cent less per hour than do their male counterparts (2019). Male physicians preferentially refer patients to male surgeons (US 2021). Female patients are 32 per cent more likely to die when their surgeon is male (Canada 2021).

Although Queen's University has become a positive outlier in this regard, there remains a dearth of women in medical leadership. Sexual harassment, almost exclusively of women by men, is alive and well in Canadian medical education, perpetrated by peers, staff, faculty, and patients. Over and over, female medical students tell me that in residency interviews, they are

asked how they will juggle children and work. I have never heard this from male students.

Gender bias extends beyond medicine to permeate science and society. In 2015, Nobel Laureate Tim Hunt talked about his “. . . trouble with girls. Three things happen when they are in the lab. You fall in love with them, they fall in love with you, and when you criticize them they cry.” Perhaps this explains surgery’s ongoing reticence to accept women trainees. As a surgeon told me recently, “we don’t do crying in surgery.”

At a contextual level, there have been musings — although these generally remain unwritten as they fly in the face of an egalitarian ethos — that an influx of women will erode medical power and prestige. For individual female doctors, the realities of disproportionate responsibility for family formation and obligations still shape specialty choice, pushing them towards programs with shorter training and more flexible work schedules.

During my 40 years in medicine I have read, researched, and written about equity and, particularly, gender equity in medical education, care, and power structures. Somehow, for most of that time I thought that information would change behaviour. Deliver robust data showing there’s a problem and sensible and fair people (and medicine has lots and lots of such people) will fix it. On Dec. 31, 2021, *The Globe and Mail* ran a lead article titled, “How medicine’s gender power gap set up women for unequal pay and less prestigious jobs.” Like hundreds of other such reports, it demonstrates the limits to information and polite discourse in medicine or anywhere else.

Yes, there have been changes, both in equity and equality of women and, more recently, racialized groups. But it’s a bit like whack-a-mole — one problem gets corrected and another pops up. Although universities are in the business of education and knowledge development, sometimes one has to ask whether either makes any difference to behaviours and policies.

What, then, is the source of resistance to equality? Or, put another way, who benefits from marginalizing women? I wish I knew. It is certainly not our students or patients. But who — is it that much-referred-to white male? Am I forced again to draw gender lines? Would it be harsh or counter-productive to say that our society and medicine as part of it have a fundamental distain for difference, and that women continue to be “different?” Is this same distain for and invisibility of women behind the ongoing marginalization of women as patients?

Some examples of this: despite funding agencies’ and journal editors’ attempts to ensure that study populations are inclusive, medical research continues to escape from

being gender inclusive. Women are consistently under-represented in clinical trials and, therefore, in guidelines. Invisibility of women pervades medical-device testing and approval as well, where device failure is assumed to be a unique, individual occurrence despite these failures being much more prevalent among women.

Some would say that gentle persuasion is a better tool for change than is vocal dissent and critique. You know, honey catches more flies . . . . But what I see is the opposite — that decades, even centuries, of honey; of being nice, compliant; and accumulating data have brought only gradual and partial changes. From a June 2021 commentary in *The New England Journal of Medicine*:

“Broken systems cannot be fixed when people who sit at decision-making tables perceive misogyny as a shocking aberration, rather than recognizing it as the infrastructure upholding their authority. The solution itself is a painful catch-22: exposing the regularity of gender discrimination and harassment relies on women telling their stories and being believed; yet women are often unwilling to share these stories for fear of censorship or retaliation from a system that is structurally motivated to disbelieve them.”

A few years of strident anger and exuberance embodied in the Me Too movement or Black Lives Matter has eclipsed this.

What makes me positive about a more egalitarian future? It is the refusal of younger medical women to “be quiet.” Patients and physicians who favour justice, equality, and humanity can be thankful that these women have become uppity.

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## NOTES

1. These are not my words but findings from, for example, the following:  
Wallis CJD, Jerath A, Coburn N, et al. Association of Surgeon-Patient Sex Concordance With Postoperative Outcomes. *JAMA Surg.* 2021 Dec 8:e216339. doi: 10.1001/jamasurg.2021.6339  
Roter DL, Hall JA. Physician gender and patient-centered communication: a critical review of empirical research. *Annu Rev Public Health.* 2004;25:497-519



The Hamilton Spectator photo illustration

# How sexism failed misogyny

*“Moralistic or not, misogyny is not about hating women. It is about controlling them.”*

Kate Manne<sup>1</sup>

By Professor Beverley Baines, JD

The sex discrimination case that Dr. Irene Cybulsky successfully fought against Hamilton Health Services (HHS) and its senior administrators<sup>2</sup> presents a challenge to the contrast between sexism and misogyny that philosopher Kate Manne made in her book *Down Girl: The Logic of Misogyny*. Manne described misogyny as “the law enforcement branch of a patriarchal order.” When women

challenge men’s power and authority or decline to serve, flatter or admire them, we disrupt the patriarchal order.

Misogyny’s essence is not its psychological nature; rather, it is its social function. It polices and enforces patriarchy’s gender norms and expectations about authority and deference by imposing social costs on noncompliant women. In contrast, Manne defined sexism as the branch of patriarchal ideology that justifies and rationalizes a patriarchal social order. She regarded sexism as a crime that requires a “juridical” approach whereas misogyny calls for an “epidemiological” approach to signify it is a public health problem.

I leave to epidemiologists and other experts to comment about misogyny’s public health features. Instead, I adopt Manne’s “juridical” approach because it invites us to expose the patriarchal gender norms — gender denialism, gender privilege and gender silence — that underlay the respondents’ justifications and rationalizations in Dr. Cybulsky’s case.

Gender denialism is sexism’s normative lodestar because it rejects the relevance of gender analysis, and hence consideration of any form of gender relations, without even a perfunctory investigation. Gender privilege and gender silence are enforcement norms in misogyny’s

toolbox for decision-makers who want to justify foreclosing women's access to information and/or voice. When these norms fail to justify and rationalize sexism, as happened in Dr. Cybulsky's case, they also fail to enforce misogyny.

From the perspective of sexism's victims, to be forewarned about respondents' reliance on these underlying norms is to be forearmed. These norms appear nowhere in Ontario's Human Rights Code,<sup>3</sup> nor are they mentioned in the Human Rights Tribunal of Ontario's (HRTO) decision in Dr. Cybulsky's case, which is now the precedent for female leaders in male-dominated workplaces, especially hospitals.

Nonetheless, these underlying norms are no less available to respondents who choose to justify and rationalize sexism and misogyny. In what follows, therefore, I explain where to read them into HRTO adjudicator Laurie Letheren's 172-paragraph decision that sets out Dr. Cybulsky's argument about the sex discrimination (aka sexism) that she experienced, as well as the respondents' justifications and rationalizations (of sexism).

## Who is Dr. Irene Cybulsky and what did she argue?

Dr. Cybulsky studied medicine at the University of Toronto in the 1980s and began her residency in 1986 at McMaster University, rotating through Hamilton's hospitals. She came on staff at HHS's department of surgery in 1996. In 2009, HHS appointed her division head, making her the first woman in Canada to head a cardiac surgery division. She remained in this position until 2016, seven years into what was expected to be a 10-year tenure.

Dr. Cybulsky argued that the hospital and senior administrators had discriminated against her with respect to employment because of sex, contrary to Ontario's Human Rights Code. She identified three instances of sex discrimination: 1) the conduct of a review of the cardiac surgery division that was in larger part a review of her leadership; 2) the hospital's decision to invite others to apply for the position of head of cardiac surgery while she was still in the role; and 3) the response of the hospital's human rights and inclusion (HR&I) specialist to the duty to investigate her allegation of gender discrimination. For each instance, Dr. Cybulsky provided

evidence that she directly or indirectly asked the relevant decision-makers to consider the role her gender played in her experiences of being a female leader in a male-dominated workplace.

There were four respondents who lost this case: The hospital (HHS) and HHS administrators Dr. Richard McLean, Executive Vice-President and Chief Medical Executive; Dr. Michael Stacey, Surgeon-in-Chief; and Dr. Helene Flageole, Chief of Paediatric Surgery, who was appointed to lead the review. When they opted to fight back, they argued their decisions were justified and they rationalized them as unrelated to gender in each of the instances Dr. Cybulsky had identified as causing her to experience sex discrimination.

Tribunal adjudicator Letheren decided the respondents' justifications and rationalizations discriminated. Simply put, they were sexist. If their sexism represents a failure of misogyny's policing function, what do misogynists and sexists learn from their mistakes?

## Events of this case

Upon learning that her leadership as head of cardiac surgery was under review in 2014, Dr. Cybulsky suggested to the relevant decision-makers — Dr. McLean along with Dr. Kesava Reddy, interim Surgeon-in-Chief, and Dr. Flageole — that the stereotypes and bias women in leadership roles experience could be impacting her situation as a female leader to entirely male colleagues.

Dr. Cybulsky provided Dr. Flageole with information from her own experience as well as from social science literature about stereotypes and bias women in leadership roles experience. However, in her report of the review, Dr. Flageole made no recommendations about stereotyping and bias or about the challenges of a woman being a leader, even though a confidential portion of her report included descriptors shared about Dr. Cybulsky such as "rude," "bully," "like a mother telling her children what to do," and "they are afraid of her." Dr. Flageole based her only recommendation to Dr. Cybulsky, that she improve her communication style, on these and other descriptors instead of ascribing them to misogyny's stereotypes and bias.

When asked about this lacuna at the tribunal hearing, Dr. Flageole testified that leadership is not a "gender



Photo by Barry Gray, The Hamilton Spectator

thing” and “I do not believe that there is a male leadership style.” She also testified that “[gender] never came up” in the review. Her explicit denial of the relevance of gender, what I label gender denialism, led to attempts toward damage control from hospital lawyer Raj Anand, a formidable and very experienced senior civil litigation administrative and human rights lawyer who is also a former chief commissioner of the Ontario Human Rights Commission. To salvage Dr. Flageole’s testimony, he argued Dr. Cybulsky provided no evidence in the review (or to the division leadership) that she experienced differential treatment because of her gender. A curious response, given Dr. Cybulsky had the foresight to audio record all of the meetings that concerned the leadership review, and she made these recordings available at the tribunal.

The tribunal decided the evidence clearly supported Dr. Cybulsky; that Dr. Flageole failed to consider Dr. Cybulsky’s context of being a female leader in a male-dominated workplace; and that Dr. McLean did not acknowledge that Dr. Flageole should have considered that context. These failures constituted sex/gender discrimination under Ontario’s Human Rights Code. In the words of the tribunal:

“It is an act of discrimination to fail to take seriously the applicant’s allegations about the relationship between gender and perceptions about her leadership. Her dignity and self-worth were undermined, and those consequences are directly connected to the fact the applicant is a woman.”

(Surgeon-in-Chief) Dr. Stacey compounded the effect of the gender denialism when he declined to reappoint Dr. Cybulsky without holding a single meeting to discuss her leadership skills. Instead, he relied on “concerns raised during Dr. Flageole’s review,” putting it at the top of a list of eight “significant reasons.” Since Dr. Flageole’s review adversely treated Dr. Cybulsky, the HRTO found that Dr. Stacey’s reliance on it meant Dr. Cybulsky experienced “further” adverse treatment connected to her gender.

Hospital lawyer Anand tried to downplay Dr. Stacey’s reliance on Dr. Flageole’s review by submitting that there were other reasons on the list, but the tribunal ruled that gender “need only be a factor in the decision, not the only factor.” He also submitted that Dr. Stacey had performed his own leadership evaluation but the tribunal noted that there was scant evidence to support this submission.

Put simply, the HHS lawyer cast Dr. Stacey’s decision as “legitimate performance management” rather than owning it as an exercise of a privilege that is all-but inevitably exercised only by men, i.e., a gender privilege. The HRTO adjudicator rejected his justifications and rationalizations and ruled that Dr. Stacey had breached Ontario’s Human Rights Code when he failed to properly consider the role that gender might have played in Dr. Flageole’s review, and he breached it again when he relied on the review’s findings.

The third and final breach of the Human Rights Code occurred when the evidence showed the hospital’s HR&I specialist had no discussion with Dr. Cybulsky about the challenges in leadership for women and how the bias against female leaders had played a role in what she had experienced (which Dr. Cybulsky had raised in an email). HHS lawyer Anand argued unsuccessfully that the email did not trigger HHS’s duty to investigate because Dr. Cybulsky did not file a formal complaint. Tribunal adjudicator Letheren held that failing to discuss and investigate, what I label gender silence, was a breach of Dr. Cybulsky’s rights under the Human Rights Code for which HHS, not the HR&I specialist, was liable.

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*Her dignity and self-worth were undermined, and those consequences are directly connected to the fact the applicant is a woman.*

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### **The “juridical” approach — two perspectives**

Dr. Cybulsky’s case offers many lessons about the “juridical” approach to sex discrimination. I suggest two lessons — one pro and one con.

**In favour is its structure:** There is a law (the provincial Human Rights Code), an adjudicator (the HRTO), and a process. An individual can avail themselves of this structure, as Dr. Cybulsky did when she filed her application in 2016. She had no precedent case to follow, nor did she have a lawyer, and even after she left her medical practice and went on to become a law student at Queen’s in 2017 (she graduated in 2020), she had to teach herself to assemble evidence, choose witnesses, and formulate arguments about the challenges women in leadership face in an all-male work environment. She also had to survive the gruelling 26 days of hearings spread over more than two years, not only drafting her own arguments but also being prepared to respond to HHS lawyer Anand’s legal strategies. Moreover, at the time I write this, her case is not over, five-and-a-half years after she began, because winning on the liability issue left the issue of remedies still to be argued.



After leaving her medical practice, Irene Cybulsky went on to become a Queen's Law student in 2017. She graduated in 2020. ©Jeffrey Smith

**The con is substantive:** It is one thing to accomplish what Dr. Cybulsky accomplished when she proved the existence of sex discrimination on the part of the respondents, but it is another thing entirely to stand ready to rebut the defences they relied on before they actually voiced them. Once Dr. Cybulsky's recordings and witnesses rebutted the hospital's "no evidence" response, then she was met by justifications and rationalizations that lacked transparency about their underlying patriarchal norms: gender denialism, gender privilege, and gender silence. While not impossible, it is undeniably difficult to counter the emptiness of gender silence, the power of gender privilege, and the extinguishment of gender denialism. That Dr. Cybulsky succeeded is exceptionally valuable for those who follow her footsteps.

One puzzle remains: when HRTO adjudicator Letheren decided the respondents neither justified nor rationalized their sex discrimination, why did she not address the misogyny that underlay their replies: the gender denialism, gender privilege, and gender silence? The answer: these norms were beyond her remit because neither Ontario's Human Rights Code nor any other Canadian law proscribes misogyny. Should this be?

I suggest these norms inform misogyny as well as sexism; they represent a connection that is not found in Ontario's Human Rights Code but was revealed in Dr. Cybulsky's case. This connection is important for those who follow Dr. Cybulsky's example because it exemplifies how sexism failed misogyny.

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\*Read a *Toronto Life* article about this case, *The Only Woman in the Room*, [here](#).

Read a five-part *Hamilton Spectator* series about this case [here](#). (Paywall applies.)

Read a related *Globe & Mail* article, *Investigating gender gap in health case proves to be extremely complicated*, [here](#). (Paywall applies.)

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## REFERENCES

1. Kate Manne, *The Logic of Misogyny*, *Boston Review*, July 11, 2016, and *Down Girl, The Logic of Misogyny*, New York: Oxford University Press, 2018
2. *Irene Cybulsky v Hamilton Health Sciences*, Rob MacIssac, Richard McLean, Michael Stacey, Helene Flageole, and Kesava Reddy 2021 HRTO 213 (The tribunal did not hold CEO Rob MacIssac or Dr. Reddy liable for breaching Dr. Cybulsky's Human Rights Code rights, unlike the other four respondents.)
3. *Human Rights Code*, RSO 1990, c H.19, s 5(1)





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