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PUBLIC SYSTEMS AND THE ARCHITECTURE OF NEGLECT

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“The women surgeons I know are unbelievably smart,” had said a good friend recently, herself a highly accomplished, wonderfully passionate senior doctor working within the public health system in India.

“Yet I often sense that they have learned to veil their brilliance slightly, to make themselves more acceptable in rooms that were never fully designed for them”, she had continued.

It is a calculated compromise: brilliance, mellowed for acceptance. Meanwhile, men are routinely granted the presumption of competence, as though confidence alone were credential enough. “And still”, she later added, “the same men—well-meaning and amongst my closest friends in the institution —will tell me to keep my mouth shut and not pick a fight. I have learned to survive, and perhaps that is what most women do: we adapt, we persist, we find our own spaces”.

This is not a story of individual resilience. What follows is not resignation but adaptation: a deliberate but relentless learning to survive, to persist, and to carve meaning within a world that remains, for all its progress, frustratingly uneven.

Her telling was laced with as much pride and fierce determination as there was an equal measure of anguish. And therein lies the tragedy.

Time, I have spent inside India's tertiary and secondary care public health institutions reveals a paradox.

Institutions staffed by some of the finest clinical talent anywhere, operating within physical and administrative environments that seem almost indifferent to the people who sustain them. The dissonance is definitely not in the clinical competence, but in the incremental but steady erosion of the scaffolding of inclusion, respect and dignity that is needed to sustain it.

THE ~~MISSING~~ LOUNGE

The signage outside the lounge said “Surgery Department Lounge”.

Doctors and nurses work through relentless queues in our public hospitals, stand through hours-long surgeries, complete ward rounds, and do hand-overs that stretch well beyond any reasonable shift, yet the physical spaces designed for them to simply pause are either absent or an afterthought.

“Why aren’t you using this space?” – I ask my friend.

She – and her other women colleagues - have tiny, almost makeshift cubicle spaces a few meters away. So, when she says the question is not whether she *can* use *that ‘surgery lounge’* but whether she *wants* to, she is describing a subtler exclusion than a locked door — one built from years of spaces conceived without her in mind: poor lighting, lack of privacy, absence of basic amenities like clean washrooms near duty stations, or simply a culture where the space's informal "ownership" skews male. It reveals how institutional design encodes deeply ingrained assumptions rather than specific principles and intentionality.

The Gendered Clinic: Hidden Curriculum Influencing Professional Trajectories

Despite rising female enrolment in medical and nursing programs, the “hidden curriculum” of gendered expectations continues to shape aspirations, specialty choices, and pathways into leadership, often in ways that remain invisible to formal policy.

Yes, more and more women are entering higher education.

Yes, more and more women are formally present in premier public institutions.

Yet they work constrained by norms that define what kinds of ambition, speech, physical presence, and authority are acceptable when performed by female professionals.

The consequence is a paradox. This dissonance between clinical excellence and institutional neglect erodes the scaffolding of respect and dignity necessary for long-term engagement, particularly for women who must navigate additional layers of scrutiny, moral judgment, and informal surveillance in common spaces.

Gender bias is not limited to attitudes. It is deeply – and sometimes imperceptibly - encoded in bricks, corridors, and systemic processes.

A 2024 survey on workplace safety and security in Indian health-care settings found that 78.1% of health professionals reported the absence of separate duty rooms for female staff, with many women doctors forced to share overcrowded rooms lacking privacy and basic amenities.

Nurses and community health workers (CHWs), often working long and irregular hours, frequently lack secure rest spaces, changing rooms, or safe accommodation, underscoring how infrastructural deficits intersect with gendered occupational roles.

Security concerns reinforce this architecture of neglect.

An Indian Medical Association study of 3,885 respondents reported that more than 36% of doctors—disproportionately women—felt “unsafe” or “very unsafe” during night shifts. In some facilities, security personnel are not assigned to maternity wings, while protection is prioritized for male administrative or clinical staff, leaving female workers and patients more vulnerable to aggression from attendants and family members, especially when care involves refusal of treatments or triaging in resource-constrained settings.

Violence and harassment are further normalised by weak reporting and grievance systems. A study on low reporting of violence against health-care workers in India observed that roughly three-quarters of respondents felt there was no formal procedure for reporting verbal abuse or physical assaults within their workplaces. While India's Prevention of Sexual Harassment (POSH) Act mandates Internal Complaints Committees in all workplaces, including hospitals, many facilities lack functional grievance redressal mechanisms, effectively silencing those who experience abuse. Additional channels exist in principle but are not widely used, reflecting a wider gap between legal architecture and lived practice.

So, formal access does not translate into substantive access when women face discomfort, scrutiny, gossip or an informal sense that a shared space belongs to men. And, this is further compounded by specific asymmetric practices that disproportionately affect women in the workforce:

- Night duty rosters and on-call schedules rarely account for safety concerns specific to women commuting or resting alone in hospital premises after dark.
- Maternity leave and childcare support remain patchy despite policy existing on paper, mirroring the same gap between stated rules and lived practice seen with Compensatory-Offs.
- Career progression structures for women in medicine and nursing often assume an uninterrupted, linear trajectory that ignores caregiving responsibilities disproportionately borne by women.
- Contract and outsourced staff — a category with high female representation in support and nursing roles — face the added burden of lower pay for identical work, layering economic precarity onto physical neglect.

The list goes on. Gender has proved – decade after decade - to be a structural blind spot.

And, it doesn't end there.

The institutional male default is embedded not only in physical spaces but also in schedules that presume unrestricted availability, mobility, and time. Hospital systems are often organized around an "ideal worker" imagined as free from pregnancy, menstruation, caregiving responsibilities, safety constraints, and other embodied realities. Women's safety is too often framed as a matter of personal caution rather than an institutional obligation to design safe working conditions.

All of this is not just a matter of legal or even ethical compliance but of institutional respect. And it is an ignorance of the fact that compliance measures only the presence of a policy document, not the accompaniment of dignity in daily practice.

POLICY, ACCOUNTABILITY, AND GENDER-TRANSFORMATIVE REFORM

Here is the kicker - none of this may necessarily be the product of deliberate exclusion.

It is more likely the residue of systems designed by defaults that were never actively examined. And if I was being charitable, I would say it is a failure of imagination rather than a failure of intent.

But the effect is the same: institutions that signal, through the absence of thoughtful design, whose comfort was considered and whose was not.

Taken together, these point to the need for gender-transformative approaches that move beyond symbolic inclusion toward examining and redesigning institutional defaults.

International experience shows that gender-sensitive policies can be integrated into health systems without prohibitive cost, but their impact depends on whether they are backed by robust accountability mechanisms. Regular gender audits, performance reviews, and compliance assessments focused on infrastructural adequacy, safety protocols, and usability of shared spaces can help track progress in implementing gender-responsive reforms.

Equally critical is the question of who occupies decision-making roles.

Increasing women's representation in health-care leadership enables gendered concerns about safety, infrastructure, and career progression to be articulated from within the system rather than treated as peripheral demands.

By making hospitals and clinics spaces that are explicitly designed with women in mind, and by enforcing gender-sensitive policies through accountable practice, health systems can begin to repair the architecture of neglect and align everyday working conditions with the ethical ambitions of equitable, high-quality care.

Resolving this does not primarily require capital investment. It requires sensitivity:

- Consulting the actual workforce — across gender, seniority, and employment status — before designing rest and support spaces, rather than defaulting to inherited layouts.
- Auditing existing "rest areas" for gendered usability rather than assuming their mere existence satisfies the need.
- Extending the same scrutiny given to compensatory-off compliance to informal norms around who feels entitled to use shared spaces.
- Treating contract staff — disproportionately women in many care roles — as part of the same dignity calculus as permanent staff, not a separate, lesser tier.

The point is not only equity; it is better care delivery. When staff feel safe and respected, retention improves, burnout falls, and teams function better, which strengthens patient care.

Any system that fails to include all genders and categories of employment by design—and instead tries to patch in inclusion later—has no legitimacy in calling itself "a great place of care."

That claim is not aspirational; it is simply unearned.