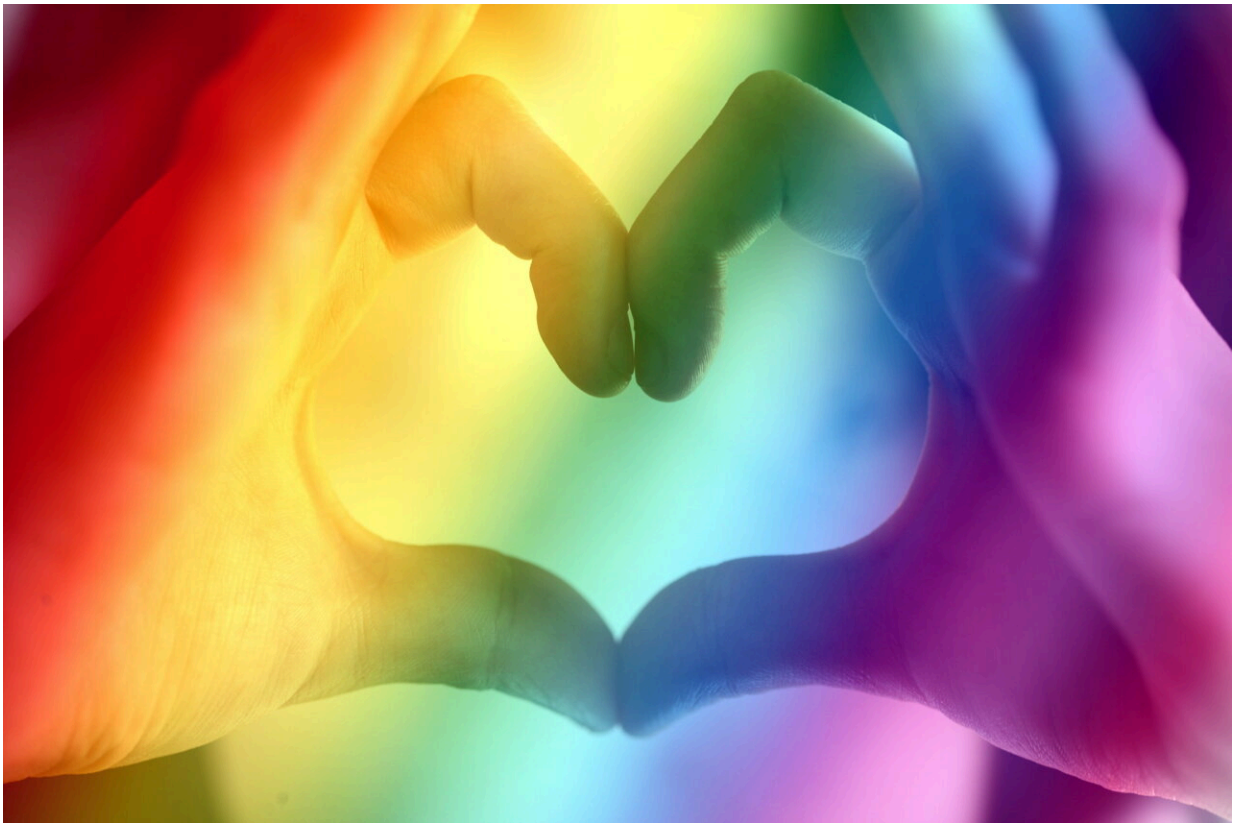


Medicine's gender revolution—how women stopped being treated as 'small men'

August 7 2017, by Deb Colville



Credit: Alexander Grey from Pexels

Men and women respond differently to diseases and treatments for biological, social and psychological reasons. This is the first article in our series on Gender Medicine, where experts explore these differences and

the importance of approaching treatment and diagnosis through a gender lens.

Until the turn of this century, there was little sense in Western medicine that gender mattered. Outside the niche of female reproductive medicine, [the male body](#) was the universal model for anatomy studies.

Clinical trials mainly involved males and the results became the evidence base for the diagnosis and treatment of both genders. [Medication dosages](#) were typically adjusted for patient size and women were simply ["small men"](#).

Medical academia has also been male-centred, with teachers, professors and researchers being mostly male. Twenty-five years ago, most college boards representing medical specialities around the world were almost [exclusively male](#).

But in the last 20 years, [mainstream medical research](#) has begun to seriously explore [gender differences](#) and bias in academic and clinical medicine. This explicit recognition of gender—along with factors such as ethnicity and socioeconomic status—helped determine how healthy all people's lives are likely to be.

And so, the discipline of ["gender medicine"](#) (also called sex-specific medicine) was born. [Gender medicine centres](#) opened in the early 2000s, textbooks followed and gender modules were introduced into [some medical training and curricula](#).

In 2008, the [World Health Organisation](#) issued guidelines on "teaching gender competence". This is the capacity for health professionals to identify where gender-based differences are significant, and how to ensure more equitable outcomes.

Gendered medicine is [not only about women](#). It is about identifying differences in clinical care and ensuring the [best health care](#) is provided for all. It is also about ensuring equity of health care access, and about gender equity in the composition and roles in the profession.

Does gender matter?

Gender is not the same as sex, which is about biological and physical male-female differences. Gender relates to the social and cultural behaviours we attach to the biological aspects of sex; it is [not binary](#) and exists on a spectrum.

In medicine, gender impacts how, when and why a person accesses medical care, and the outcomes of that access. For instance, women seeing their doctor for chronic pain often don't [feel adequately listened to](#) or supported.

In the area of heart health, women are less likely to seek help for a [heart attack](#) as their symptoms make it harder to identify. Studies have also found they [don't receive potentially beneficial treatments](#) for heart disease in the same way men do, and have [lower survival rates](#).

In mental health, [depression](#) is more common in women and [suicide rates](#) are higher in men. The nature of diseases such as [heart disease](#), [osteoporosis and lung cancer](#) are different between women and men too, as are their outcomes.

Less well known is that [two-thirds](#) of the [blind people](#) in the world are women, even when the data is adjusted for the fact women live longer. And as an example of sociological differences that need recognising, women who present with an eye socket fracture, a ruptured eyeball or eye bruise are at risk of dying, not from the injury, but from a further assault by a perpetrator of [family violence](#).

Improving the evidence

Clinical trials are the bedrock of medical research and evidence building. Until relatively recently, they were mainly conducted with males for a number of reasons, including availability to participate and concerns about the impact on [women's reproductive health](#), or the impact of [menstrual cycles](#) on the trials.

Restricting difference also makes trials cheaper by reducing the [required sample size](#) (even though it leads to inaccuracies for various important subgroups).

Women were excluded because they are different, but the results were applied to them because they are nearly the same. And when women and men are included in trials, the results are usually not published separated by sex, so the findings may be inaccurate for all participants.

Even in pre-clinical research using animals, [female animals](#) have been excluded to make management and costs simpler, and reduce measurement variation.

As a result, large scale [clinical trials](#) have yielded findings based on particular population groups. For example, a 1988 study into the use of aspirin to lower the risk of heart attack was based on a six-year [trial of 22,000 men](#).

But change is afoot in trial design. Australia's largest medical research grant body, the National Health & Medical Research Council, for example, has [introduced guidelines](#) that require applicants to address [gender equity](#) among research participants.

What are the next steps?

We need data from clinical trials and population data that is sorted by gender, so knowledge bases can be gradually improved. [Generalisations about gender](#) can be both useful and problematic, so careful analysis is needed.

We must account for gender in all [medical training](#), and clinical practice. This should apply to not only disciplines that relate to sex hormones such as gynaecology, but also for example orthopaedics and ophthalmology.

We need the profession itself to take the lead in encompassing [gender diversity](#) in our community. Following the lead of non-medical groups such as the [Australian Institute of Company Directors](#), the medical profession needs to introduce targets for diverse representation on all professional decision-making bodies.

Sarah, an Australian medical student in her final year, told me the biological perspective is taught well, but the psychological and social "not so much".

"There are broader social and cultural factors that might affect the way a male patient presents versus a female."

Medical training on diversity also needs to include people who are transgender or who identify as non-gender conforming. As Sarah said:

"We talk about inequalities in terms of males and females, but gender diversity isn't mentioned at all. I shudder to think of the barriers and obstacles you might face in training if you were transgender or non-[gender](#) conforming. I haven't heard anyone raise that."

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