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ORIGINAL ARTICLE

Gender in medicine – does it matter?

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Abstract

Aims: A broad range of socio-cultural issues have been recognized as determinants for health and disease. A notion of gender neutrality is still alive in the medical culture, suggesting that gender issues are not relevant within this field. *Methods:* We have explored the claim that doctors encounter their patients as human beings, not as men or women, and discuss causes and consequences of such a claim. *Results:* Empirical evidence does not support such a claim – gender seems to have a strong impact on medical knowledge and practice. The concept androcentrativity signifies a state of affairs where male values are regarded as normal to the extent that female values disappear or need to be blatantly highlighted in order to be recognized. We have applied this frame of reference to understand how the idea of gender neutrality has been established in medicine. The average medical practitioner, teacher, or researcher is a man. We suggest that notions of normality subtly construct gender in medicine in ways where men become normal, while women become deviant. Finally, we discuss strengths and pitfalls of three different strategies which have been used by gender researchers in health to challenge androcentrativity: demonstrating gender differences, revealing the consequences of gendered power inequalities, and deconstructing the meaning of gender. ***Conclusions:*** **We conclude that gender still matters in medicine.**

Key Words: *Gender, gender identity, medicine, men, prejudice, sex, women*

Introduction

A broad range of socio-cultural issues have been recognized as determinants for health and disease, among them sexuality [1,2]. Feminists have provided strong arguments for the influence of gender in the interrelationships between biological and socio-cultural determinants for health and disease [3]. Research on women's health has been accomplished in the Scandinavian countries during the last three decades. A Norwegian white paper presented in 1999 concluded that women's health was a neglected area deserving increased attention. The president (at that time) of the Norwegian Medical Association, Hans Petter Aarseth, responded that such unsubstantiated allegations would create unfounded distrust to the health care system, because "doctors encounter their patients as human beings, not as men or women" [4].

Hammarstrom describes how the theoretical developments have led to a change of concepts from women's health to gender research, where the impact of social and cultural relations between men and women is analyzed [5]. But in spite of an increasing drive towards implementation of gender issues in politics and education in Scandinavia, academic medicine has responded with different strategies, including resistance and redefining concepts, Hammarstrom concludes.

A Swedish interview study revealed varied opinions on the relevance of gender in medical education [6]. Course organizers were asked whether they felt that gender perspectives had contributed to their scientific field, and, if so, how they implemented them in their teaching.

Women faculty recognized the impact of gender perspective in science and clinical practice, while

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their male colleagues were more reluctant on the relevance of gender. Another Swedish study demonstrated an additional effect of medical specialty, with male surgeons assessing gender as significantly less important than their female colleagues [7]. Hence, the president Aarseth is not exceptional when he gives voice to a notion of gender neutrality in medicine, suggesting that gender issues are not relevant within this field. We therefore set up a study to explore the claim that medicine is gender neutral and to discuss the impact for medical theory and practice of such an argument.

Method, concepts, and theoretical framework

Our approach is a theoretical investigation of logical arguments and their meaning. Cases to illustrate out investigation were drawn from a literature search looking at recent empirical studies about gender in medicine. However, we did not intend to present a systematic literature review with unambiguous evidence, but to demonstrate the complexity of the questions we discuss. Articles in English and Scandinavian languages were identified through online database searches of MEDLINE, PsycInfo and Sociological Abstracts ($1/2002 \pm 12/2007$) from 2002 to 2007. We used the following search in overall searches: doctor-patient interaction, patient interaction, physician-patient interaction, physician gender, combined with female, gender effects, female physicians, female doctors, sex of doctor, gender effects and communication. Further studies were found by searching the reference sections of relevant papers identified. The search yielded 134 possibly relevant "hits", which were downloaded and reviewed. Of these, 28 were deemed relevant and the full paper obtained and reviewed. A review of the references contained within those papers obtained yielded five additional papers for review. Thus, in total, 33 peer-reviewed articles were reviewed.

Commenting and discussing the material, we use the concept gender instead of sex, since the former explicitly embraces the social and cultural construction of the matters discussed, while the latter is more limited and denotes the biological perspectives. During our explorations, we regard gender in the context of social and cultural interaction ("doing gender") [8], and as something beyond an inborn property [9].

Studies about men and women as patients and doctors

Gendered assumptions about patients which influence doctors' interpretation of medical symptoms and their management were demonstrated in several of the studies we identified. Doctors discussed substance use and addiction more often with male patients than with female patients [10]. In a large study including 3,205 internists and family physicians, the doctors use fewer resources to treat the genital-specific conditions of patients who share their gender [11]. A study of 105 primary care doctors proved no significant difference in the visit length or work intensity for female patients compared with male patients; however, women's visits had more discussions regarding the results of the therapeutic interventions, more preventive services, less physical examination, and fewer discussions about tobacco, alcohol, and other substance abuse [12]. A meta-analytic review demonstrated that patients spoke more to female doctors than to male doctors, disclosed more biomedical and psychosocial information, and made more positive statements when the doctor was a woman. Patients also were rated as more assertive toward female doctors and tended to interrupt them more [13].

Empathic communication and gender in the doctor-patient encounter was studied by coding 100 videotaped office visits between patients and general internists. Here, doctor communication behaviour showed that female doctors tended to communicate higher degrees of empathy in response to the empathic opportunities created by patients [14]. In a study of gender bias in doctors' management of neck pain, non-specific somatic diagnoses, psychosocial questions, drug prescriptions, and the expressed need of diagnostic support from a physiotherapist and an orthopaedist were more common with female patients. Laboratory tests were requested more often in males. Both male and female doctors contributed to the gender differences [15].

The gender of the doctor also makes a difference. In a study of referrals to a hospice a statistically significant difference was found; women doctors younger than 45 years of age were more likely to make referrals than male colleagues [16]. Outpatient visits by women doctors differ from those of male doctors [17]. Women doctors are more likely to counsel patients than men [18,19], engage in more communication that can be considered patient-centred and have longer visits than their male colleagues [20]. Women general practitioners seem to be more affective than their male colleagues, and they use gender-specific communication strategies to explore the patient's agenda [21]. It seems that both patients' and doctors' gendered expectations are mutually involved in creating gender differences in medicine.

How can the gap between beliefs and evidence on gender be understood?

These kinds of studies indicate that gender matters in medicine - doctors do actually encounter their patients as men or women. The overall pattern of these studies through time and location consistently refutes the idea that gender does not matter. There is a mismatch between the perceptions of gender held by influential spokespersons like the president Aarseth, compared to the empirical evidence presented above. We shall now explore this gap further by discussing possible explanations, consequences, and strategies for change. Our explorations will be supported by perspectives from queer theory and feminist theory.

Queer theory has been used to analyze social and cultural issues taken for granted, especially related to sexuality. The concept "heteronormativity" was for example presented to describe the practices and institutions "that legitimize and privilege heterosexuality and heterosexual relationships as fundamental and "natural" within society" [22]. Warner coined this term to suggest that society takes heterosexuality to be normative in terms of identity, practices and behaviour, implying that heterosexuality is the median point on the normal curve: that which is expected, demanded and always presupposed in society [23]. One example from medical institutions is the risk of general practitioners overlooking important knowledge concerning sexual orientation in their work with lesbian patients who may experience barriers in disclosing their sexual orientation to general practitioners [24].

The corresponding concept "andronormativity" signifies a state of affairs where male values are regarded as normal to the extent that female values disappear or need to be blatantly highlighted in order to be recognized. This frame of reference might help us understand how the idea of gender neutrality has been established in medicine [3]. Let us have a look at the conditions which shape the images of medical normality. Does the fact that gender issues are not recognized within this field, mean that male values on gender are taken for granted and equated with normality in medicine?

Andronormativity in the medical culture – a Scandinavian perspective

The average medical practitioner, teacher, or researcher is a man. In Denmark and Norway, although approximately 60% of medical students are women, only 40% of MDs in Norway and Denmark are women [25,26]. The proportion of women in academic positions is not increasing correspondingly with the increase of women students [27]. The large majority of academic teachers are men. Only 9% of full-time Norwegian medical professors in 2006 were women (personal communication, A. Taraldset, The Norwegian Medical Association), and similar proportions were found in Denmark [26]. Taking normality as a numerical issue, the normal doctor is a man.

However, normality is more than proportions. Questions of values and power are firmly embedded in what we regard as normal and what we take for granted. Although a female neurosurgeon would count as an exceptional case in Scandinavia, a woman doctor would not be labelled as abnormal in our culture. Normality is an issue which goes beyond majority. It is also about interpretation and meaning, values and power, which have an impact on what happens to be recognized and how it is interpreted. Gender may be subtly embedded in notions we take for granted. Below, we will look at some examples, drawing upon new as well as older references which together complement the argument and demonstrate the inertia within this field.

Medical textbooks and references still present the normal range of physiological and biochemical parameters irrespective of possible cyclical variations, as if human beings are not menstruating [3]. Fertile women have been systematically excluded as participants in pharmacological studies due to the risk of teratogenic side effects. This sounds reasonable, but the conclusions of these studies have yet been extrapolated to women, as if the results on men were unquestionably valid for women. Guidelines for prevention, diagnosis, and treatment of cardiovascular diseases have been drawn from studies of white, middle-aged men, but yet applied to patients of all ethnicities, ages, and genders [3,28]. Women often present symptoms of myocardial infarction different from those of men. Their symptoms do not match textbook standards, and diagnostic technology is better suited to identify disease in men than in women [29].

Examples like these indicate that notions of normality subtly construct gender in medicine in ways where man appears as the normal human being, while woman becomes a deviant phenotype, compared to the norm. Such a hypothesis could explain how a perception of medicine as gender neutral can be established, while also providing new questions about normality, deviance, and status.

The social construction of gender and normality in medicine

The Canadian philosopher Code defines rhetorical spaces as social locations whose tacit imperatives structure and limit the kinds of utterances that can be voiced with a reasonable expectation of being heard and taken seriously [30]. Code's analyses draw attention to gendered locations - structures and circumstances where women occupy positions of minimal epistemic authority and where questions of power and privilege figure centrally. She explores how we know one another, how knowledge of other people is constructed and circulated, how its deliverances are enacted in social practice. According to Code, knowledge is rather about intersubjectivity than about selves, persons or subjects. She challenges the objectivity of "a view from nowhere". The hidden subjectivity of the experienced from a privileged group of people is presented as paradigmatic for knowledge as such, presupposing a certain range of contexts – "standard or typical for whom"?

From what we have seen above, gender is not necessarily an issue which is welcomed within the medical discourse – sometimes rather the opposite. Normality is constructed as being gender neutral. We have presented evidence that doctors actually do encounter their patients differently according to gender. This does not mean that women (or men, for that matter) receive health care of lower quality due to their gender. Differences in themselves might indicate equality, in the sense that fair treatment requires adequate attention to significant differences. However, in other studies, a gradient on legitimacy has been demonstrated for different diagnoses with gender as an underlying dimension. Fibromyalgia, anxiety, and depressive disorders – health problems where the majority of patients are women – rank lowest in the medical status hierarchy [31]. A plausible hypothesis is that men's diseases have received the status of being more "normal" than women's diseases. If so - does this imply that gendering a phenomenon in medicine (which often means drawing attention to invisibility of women's matters) gives it the tag as deviant or inferior [32]?

Challenging andronormativity

Above, we have argued that medicine constructs, enacts, and perceives gender in many ways which potentially could have an impact on health and health care. We have put forward the proposal that andronormativity is at work when these mechanisms are denied or neglected. Below, we shall present and discuss the potential and pitfalls related to three different strategies which have been used by medical gender researchers to challenge andronormativity in health.

Differences between men and women – the pitfall of essentialism

Denying the impact of gender within certain social areas is a particularly powerful way of doing gender. Gender issues are simply eliminated. By dismissing matters related to men and women respectively, such issues do not have to be dealt with. The taken-for-granted neutrality is confirmed and not contested. In this respect, empirical studies where differences between men and women are examined, serve to confront the gap between empirical evidence compared to illusions of fairness and equality. Above, we have demonstrated this strategy by reviewing the claim of gender neutrality through the lens of empirical studies of gender differences in health. As we have seen, such studies may serve to challenge a preconceived gender blindness articulated as neutrality.

Studies like these do not prove that men and women are always treated differently. Yet, their findings argue convincingly that gender is at work. Sometimes, these kind of studies also provide elements for understanding causes and consequences of the dissimilarities revealed.

However, authors of these studies are also doing gender. They do not only put gender on the agenda, but also contribute to discourses where men and women are essentially different, in the sense that any man is different from any woman. An essentialist discourse is often extended to sociobiological explanations, representing determinist attitudes on "the nature" of these differences and their inevitable existence. Within this paradigm, gender is often understood as an independent variable, based on the biological sex, not from society. Differences between men and women are considered to be natural. Men are stronger, more rational, love sport and competition. Women are weaker, are intuitive and caring, and love needlework and co-operation. In a historic perspective this idea is related to the connection of the woman to nature and the man to culture, a connection where the two categories are ranked not equalized, giving culture high rank and control over nature [33]. A focus on gender difference hence implies the pitfalls of mediating binary opposites which consolidate the social construction of gender as inevitably determined. Although we welcome fragmentation of the foundation of gender blindness, we would therefore warn

against simplistic determinism where gender is enacted as a static stereotype.

Demonstrating inequality and disempowerment – the pitfall of misery?

Andronormativity has also been challenged by feminist researchers in medicine who have studied interactions between gender, body, and culture. Gendered conditions representing power inequalities have been demonstrated to represent significant determinants for health and disease, especially in women. The role of the health care system in mediating or counteracting such forces has also been explored. The common strategy for challenging andronormativity within this kind of research is to identify and make visible the gendered structures which legitimize the power differentials and their consequences.

Scandinavian contributions within this field have been dealing with medicalization of women [34,35], health consequences of violence and abuse [36–38], reproductive health and rights [39], work and health for women [40–42], and women's medically unexplained disorders [43,44]. These researchers are also doing gender, heading for change [45]. Asking these kinds of research questions have often led to exposure of disgraceful conditions which can explain the causes of certain serious health problems, and make the concrete health consequences of oppression evident.

Studies like these challenge andronormativity by focusing certain unfortunate effects of power inequality which have usually been taken for granted, and providing an opportunity to discuss the urgent need for change. However, the social construction of gender within this paradigm also represents certain pitfalls. First, the focus on misery could also function as self-fulfilling prophecies, in the sense of creating a common understanding that women are the oppressed and suffering victims of the masculine norms in culture. This kind of research might contribute to the neglect of images of women as resourceful and vigorous, with a broad range of strategies for coping and survival. Second, the dichotomized view of power and gender can lead to an understanding of men as the enemy of women, instead of pointing to the mechanisms of the gendered matters which are at stake on a structural level. At worst, this research tradition contributes to construct gender as something for women, while omitting the interplay of cultural femininity and masculinity.

The meaning of gender - discursive power

Within this paradigm, gender is recognized as a significant part of social life, no matter how visible it may or may not be. Researchers are concerned about finding connections, instead of differences.

Gender is often regarded as part of the redefinition of power and research questions often move from identification of differences to investigation as to whether the stereotypes are "true" or can be explained only by gender.

This approach belongs to the social constructivist tradition, where the medical discipline is studied as a cultural discourse and the medical profession as a system based on gendered conditions.

Medicine can be regarded as a discursive strategy where the ruling profession is presented in terms of masculinity. Andronormativity can be challenged by deconstructing the conceptual taken-for-granted-ness, by asking systematically for alternative ways of understanding of apparently clear-cut phenomena and the way they are performed and perceived. An example of the benefit of this approach is that it focuses on the status of women in the medical profession and points towards the need for unravelling the social and cultural practices that define and confirm the role of women in the distribution of work within medicine [46].

A Dutch study illustrates neatly how the implicit, taken-for-granted meaning of gender can be challenged by presenting alternative discourses in the medical curriculum, facilitated by different discursive approaches such as concrete and directly executable content-oriented proposals for adjustment; adequate translation of gender differences into actual patient care; motivated block co-ordinators; the presence of a "trigger person" in the faculty; incorporation into the existing education programme; the involvement of block co-ordinators in decision making, and the provision of practical support [47]. However, social constructions can also lead to a narrow cultural interpretation of the organization of the work of doctors and hereby risk overlooking some of the powerful structural influences also existing.

Conclusions

Gender matters in medicine. Gender is constructed, performed, and perceived every minute, more or less obviously, and the consequences of this dynamic deserve attention. Andronormativity has a strong foundation in the medical culture, counteracting a critical view on gendered knowledge and practices which are usually taken for granted. Strategies for

challenging andronormativity in the medical context therefore need to be developed, elaborated, and discussed, in order not to function as preservation of the conditions they seek to change.

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