

INSTITUTE ON GENDER AND HEALTH PROCEEDINGS

MCMASTER UNIVERSITY
HAMILTON, ONTARIO, CANADA
OCTOBER 12 - 17, 2009

IMPACT OF

burden, consequences, effect, influence, meaning, repercussions, significance,

GENDER ON

refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to two sexes on a differential basis. Gender is relational - gender roles and characteristics do not exist in isolation, but are defined in relation to one another (CIHR)

HEALTH

is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO)

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This report was compiled and edited by Margaret Shkimba.

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WELCOME

It is our privilege to present to you the proceedings of the Institute on Gender and Health: Impact of Gender on Health, which was held at McMaster University in Hamilton, Ontario on October 14 - 17, 2009.

The Institute on Gender and Health, a joint initiative undertaken by three Ontario universities, McMaster University, University of Ottawa and Queen's University, was designed to engage participants in dialogue and debate to discover best-practices for incorporating gender in health care research, education and practice.

There is no doubt that gender analysis has grown significantly over the last 30 years. Early research on gender was primarily focused on women and was largely carried out in social science and humanities disciplines. Over the years, these influences have migrated to science and health science disciplines, where the debate over sex differences and gender influences has a very real and tangible impact on the delivery of health care.

We decided it was time to take stock and provide guidance on the way forward.

We wanted to know the extent to which gender is being incorporated at medical schools around the world. We wanted to discuss strategies and techniques designed to influence the research environment toward incorporating gender-based analysis in health research projects. We wanted to uncover ways to effect practice, how to traverse the distance between what we know and what we have to do. And, finally, we wanted to connect with health science educators, researchers and clinicians around the world in order to create a network of individuals committed to a vision of health care that understands and promotes gender as a significant determinant of health.

This document is a record of our discussions; we offer it as both a record of our time spent together and as a reminder of how far we've come and, more importantly, where we still need to go. The final discussion section of this document highlights the key points and actions for moving forward.

In health,

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Funding support was generously provided by the **Gender and Health Education Initiative**, in the Faculty of Health Sciences at McMaster University.

Dr. Susan Denburg, Associate Vice-President, Academic and Associate Dean, Education, Faculty of Health Sciences for her ongoing support and guidance.

Ms. Louise Bruns, Louise Bruns Consulting for keeping us all together and moving in the same direction.

Dr. Jo Wainer, for passing along her excellent notes and **Dr. Susan Phillips** for the photographs.

SYNOPSIS

The **Gender and Health Education Initiative**, in the Faculty of Health Sciences, McMaster University, in conjunction with the **Office of Equity, Diversity, and Gender** in the Faculty of Medicine, University of Ottawa and the **Women's Health Program**, in the Department of Family Medicine, School of Medicine at Queen's University, held the first Gender and Health Institute in Hamilton, Ontario, on October 14 – 17, 2009.



Toine Lagro-Janssen, May Cohen, Katarina Hamberg

The event opened with the **May Cohen Lecture in Women's Health**, jointly presented in 2009 by **Dr. Antoine Lagro-Janssen**, professor in medicine at Radboud University, in Nijmegen, Netherlands and **Dr. Katarina Hamberg**, associate professor, Umeå University, Umeå, Sweden. Dr. Lagro-Janssen addressed the topic "From Same Bodies to Gender Matters" while Dr. Hamberg reviewed "Gender in Medical Education – More Than Sex Differences".

The audience included Institute participants as well as McMaster faculty, students and members of the Hamilton community at this public lecture in honour of the life and career of **Dr. May Cohen**. Both May and her

husband, Gerry, were in attendance and Dr. Cohen kindly added her vast knowledge and experience to the 3-day Institute by participating in all the sessions.

Just over 50 people attended the Institute. Participants came from around the world: Germany, The Netherlands, Japan, Taiwan, Australia, Mozambique, South Africa, and, of course, Canada.

The Institute was organized into three areas, with a day's discussion devoted each to: translating gender into medical research, education and practice. Guest speakers **Drs. Susan Philips** (Queen's), **Deborah Cook** (McMaster), **Joke Haafkens**

(University of Amsterdam), **Alan Neville** (McMaster) and **Wilfreda Thurston** (University of Calgary) brought their expertise to bear on various strategies, tactics and processes that insert gender into research projects and questions, education resources and medical practice.

Evening events included: dinner and a wine tour at Peller Estates in picturesque Niagara-on-the-Lake; dinner and a presentation by **Dr. Jackie Duffin** (Queen's) at the Art Gallery of Hamilton; and dinner at Hamilton's historic Dundurn Castle. These events provided opportunities for people to come together and encouraged conversation and networking. Participants were particularly pleased with these opportunities to engage with colleagues in a relaxed setting.



Beatrice Alvarado-Llano and Toine Lagro-Janssen at the Art Gallery of Hamilton

I got really inspired and left with lots of ideas and fresh energy

The overall quality of this program was excellent

*Excellent!
Stimulating!
Interdisciplinary!*

I was thrilled to learn that a community of like-minded scientists exists

From participant evaluations

SPEAKERS



Dr. Sonia Anand (Respondent, May Cohen Lecture) is Professor of Medicine and Clinical Epidemiology and Biostatistics at McMaster University, the Director of McMaster Population Genomics Program and a vascular medicine specialist. She holds both the new Heart and Stroke Foundation of Ontario/Michael G. DeGroot Chair in Population Health Research, and the Eli Lilly Canada – May Cohen Chair in Women’s Health Research at McMaster. Her present research focuses upon the environmental and genetic determinants of vascular disease in populations of varying ancestral origin, women and cardiovascular disease, and peripheral vascular disease.



Dr. Nahid Azad (Planning Committee), Associate Professor of Medicine, University of Ottawa, is an Internist and Geriatric Medicine specialist. She is Faculty Director and Provincial Chair of Equity, Diversity and Gender Issues of the Council of Ontario Faculties of Medicine. She has led curriculum integration of gender and health at U.O. and has been advisor and invited collaborator to many national and international schools. She received the AFMC’s May Cohen Gender Equity Award in 2007 and U.O.’s Excellence in Teaching Award in 2009. Her clinical research focuses on heart failure and CVD in women, and gender differences. She is co-investigator of the POWER study and has been a national advisor and editorial member to MOHLTC Strategic Planning for Older Women’s Health Priorities.



Dr. Deborah Cook (Respondent, Gender in Health Research) is a Professor in the Departments of Medicine and Clinical Epidemiology & Biostatistics and Academic Chair, Critical Care Medicine, McMaster University. Dr. Cook designs and conducts patient-centred research in the ICU. Her interests include: risk factors for serious illness, prevention of ICU-acquired complications, life support technology, end-of-life decisions for critically ill patients, and evidence-based practice and research uptake. She is an expert in the design and conduct of multi-centre randomized trials, minimizing bias in systematic reviews, and incorporation of diverse kinds of evidence into practice guidelines and clinical recommendations.



Dr. Jacalyn Duffin (Guest Lecture, Art Gallery of Hamilton) is Professor and Hannah Chair in the History of Medicine, Queen’s University and a practicing hematologist. Dr. Duffin has taught in medicine, philosophy, history and law for more than twenty years. She has served as President of both the American Association for the History of Medicine and the Canadian Society for the History of Medicine. The author of seven books and many research articles, she holds a number of awards and honours for research, writing, service, and teaching. Her most recent book is an analysis of the medical aspects of canonization: *Medical Miracles: Doctors, Saints, and Healing, 1588-1999*, Oxford University Press, 2009.



Dr. Joke Haafkens (Keynote, Gender in Practice) is an Assistant Professor, Department of General Medicine, University of Amsterdam. Dr. Haafkens has carried out several studies on patients’ experiences with mental health care. Since 1987, she has been working on the use of psychotropic prescription drugs by women.



Dr. Katarina Hamberg (May Cohen Lecturer, Respondent, Gender and Education) is an Associate Professor in the Department of Public Health and Clinical Medicine, and Family Medicine, at Umeå University and a General Practitioner. Using a gender perspective in medicine is a principal component in her research and education. Dr. Hamberg is one of the research leaders in the Centre of Gender Excellence at Umeå University. Dr. Hamberg is a member of the Expert Group on Gender at the Swedish Research Council.

“ Excellent international presence/perspective
Great speakers, knowledge and enthusiasm.

Excellent speakers
good discussions topics
diversity in attendees

From participant evaluations



Dr. Antoine Lagro-Janssen (May Cohen Lecturer, Respondent, Gender and Education) is Professor, Women's Studies in Medicine and General Practitioner, Radboud University, Nijmegen Medical Care Centre. Dr. Lagro-Janssen conducts research in gender in medical education, urogynecology, partner abuse, reproductive health issues such as pregnancy/delivery, female refugees and health care access. Current studies focus on gender awareness in medical students and teachers and on professional attitudes and careers in vocational training. She is a member of the Dutch Health Council and Chair, Dutch Association of GS's (HNG) Urogynecology for GP's; the Working Party NHG Women and General Practice and the Committee for Medical Education Radboud University Nijmegen Centre. She was appointed in 2009 as a Principal Lecturer. In 2003, Dr. Lagro-Janssen was awarded the Royal Honour as Officer of the Order of Oranje-Nassau. Dr. Lagro-Janssen is on the editorial board for the Dutch Scientific Journal in Medicine.



Dr. Alan J. Neville (Keynote, Gender in Education) is Assistant Dean, Undergraduate Medical Education Program, and Professor, Department of Medicine, Faculty of Health Sciences, McMaster University and a practicing oncologist at the Juravinski Cancer Clinic. As Assistant Dean, Dr. Neville spearheaded the successful revision of the MD curriculum which resulted in the current COMPASS Curriculum. Dr. Neville is an award-winning educator, having recently received the AFMC President's Award for Exemplary Leadership in Academic Medicine.



Dr. Anne Niéc (Planning Committee) is Professor, Department of Pediatrics, Faculty of Health Sciences, McMaster University. Dr. Niéc is the Director, of the Child Advocacy and Assessment Program and the Gender and Health Education Initiative and serves as a consultant with the Faculty's Ethics Consultation Service. Dr. Niéc is the Faculty Liaison to McMaster Human Rights and Equity Services regarding harassment and discrimination and is an expert consultant with respect to peer reviewing cases of sexual abuse/assault. Dr. Niéc is involved in education from a community, university and hospital perspective and has been involved in undergraduate, postgraduate and interdisciplinary education.



Dr. Susan Phillips (Planning Committee, Keynote, Gender and Research) is Professor, Family Medicine and Community Health and Epidemiology Queen's University. Dr. Phillips coordinates the integration of international medical graduates into family medicine residency and is the Director, Women's Health Program. Her scholarship on gender has been published in such journals as: JAMA, New England Journal of Medicine, Social Science and Medicine and the International Journal for Equity in Health. Dr. Phillips was the 2006 co-recipient of the AFMC's May Cohen Gender Equity Award and was awarded the College of Family Physicians of Canada's Equity and Diversity Award for 2009-10.



Dr. Wilfreda (Billie) Thurston (Respondent, Gender and Practice) is Professor, Department of Community Health Sciences, Faculty of Medicine and the Department of Ecosystems and Public Health, Faculty of Veterinary Medicine. Dr. Thurston is the Director of the University of Calgary, Institute of Gender Research. The focus of her research program is on the interplay of gender, culture and socioeconomic as determinants of health; health sector prevention strategies regarding gender-based interpersonal violence; public participation as a key tenet of population health; diabetes prevention and Aboriginal female youth; and the development of an urban Aboriginal health promotion primary health care research network.



Dr. Sandra Witelson (Respondent, May Cohen Lecture) is Professor, Department of Psychiatry and Behavioural Neurosciences and holds the Albert Einstein/Irving Zucker Chair in Neuroscience. Dr. Witelson has been at the forefront of research on such controversial issues as the biological basis of intelligence, sex differences in the brain and sexual orientation. Her research also looks at differences in language and spatial cognition found in the left and right brain hemispheres. Dr. Witelson is a Fellow of the Royal Society of Canada.

MAY COHEN LECTURE IN WOMEN'S HEALTH

WELCOME

Dr. Cathy Risdon

On behalf of the Faculty of Health Sciences and McMaster University, I would like to welcome you all here to the 7th biennial May Cohen Lecture in Women's Health.

This afternoon you have an opportunity to hear from two distinguished May Cohen Lecturers, Drs. Antoine Lagro-Janssen and Katarina Hamberg, who will speak on the impact of gender on health. For some of you, this lecture is the beginning of a 3-day institute that will explore in greater detail the complexity of some of the issues that will be raised here.

But before we get to that, I have the pleasure of introducing to you our Professor Emeritus, May Cohen, for whom this lecture has been named.

Dr. Cohen is a powerhouse of a physician. She was a family physician in Toronto for nearly 20 years before she joined McMaster University's Faculty of Health Sciences and its Department of Family Medicine in 1977.

While at McMaster, Dr. Cohen was Associate Dean, Health Services from 1991 and 1996 and the founding Chair of the Women's Health Office in 1991 until her retirement in 1998. May Cohen

has defined her career by an unfailing commitment to women's health and by the pursuit of equity in health care research, education and practice.

Her singular record in gender issues in health care stands out for the way it touches the lives and well-being of women, both as patients and caregivers.

She has also had a major interest in the career development of women physicians. May has championed change not just here at McMaster, but across Canada and around the world.

She has written on gender and practice issues as complex and diverse as breast cancer, wife assault, menopause, sexual counseling, sex after 60, gay and lesbian sex, power in the patient-physician relationship, the nature and causes of differing practice patterns between men and women physicians, and career choices among women doctors.

She has also been an advocate for clinical



Toine Lagro-Janssen

trials that give better indications of the suitability and effects of drugs for women, children and the elderly.

And it's not just us who recognize May's influence. She has been the recipient of several awards:

- The College of Family Physicians of Canada's W. Victor Johnston Orator for Outstanding Service to Family Medicine in 1993
- The Federation of Medical Women of Canada Award for the Promotion of Women's Health AND the Governor General's Award in Commemoration of the Persons Case AND the American Association of Medical Colleges Women in Medicine Program's Leadership Development Award in 1995
- The Hamilton Academy of Medicine's Distinguished Service Award in 1996.
- The Ontario Medical Association bestowed May with a life membership in 1997, and in 2000, May received the prestigious Medal of Service from the Canadian Medical Association.
- In 2001 a picture of May was hung in the Hamilton Gallery of Distinction and in 2003 she was an inaugural member of the Faculty of Health Sciences' Community of Distinction.

May's legacy at McMaster lives on. The Eli Lilly Canada – May Cohen Chair in Women's Health is held by Dr. Sonia Anand, who is also here with us, and, as today, with the biennial May Cohen Lecture in Women's Health.

PAST MAY COHEN LECTURERS IN WOMEN'S HEALTH

2007 Dr. Harriet MacMillan

McMaster University
Intimate Partner Violence and Women's Health: Problems and Prospects

2005 Dr. Frank Blye

Dalhousie University
Men Have no Gender?

2003 Dr. Nancy Kreiger

Harvard University
Gender, Sexes, and Social Inequalities in Health: An Ecosocial Perspective

2002 Dr. Sonia Anand

McMaster University
What Makes Women Sick: Does Biomedicine Have all the Answers?

1999 Dr. Patricia Ganz

University of California, Los Angeles
Quality of Life After Breast Cancer

1997 Dr. Monique Begin

University of Ottawa
Gender as a Determinant of Health

MAY COHEN LECTURE ON WOMEN'S HEALTH

PRESENTERS:

Prof. dr. Antoine Lagro-Janssen
Dr. Katarina Hamberg

RESPONDENTS:

Dr. Sandra Witelson
Dr. Sonia Anand

SESSION MODERATOR:

Dr. Anne Niéc

FROM SAME BODIES TO GENDER MATTERS

PROF. DR. ANTIONE LAGRO-JANSSEN

Dr. Lagro-Janssen opened her presentation with a historical overview of feminist waves of influence in medicine, highlighting Dr. May Cohen as a second wave feminist who advocated that more attention be directed towards women's health. At this point in time, we are moving from a consideration of women's health to a perspective that focuses on gender and its impact on health. Despite this move toward a more comprehensive understanding of gender, funding for gender and health research remains marginal. The reasons for this lack of recognition by funding agencies can be attributed to:

- Gender blindness
- Male bias
- Biomedical focus of medicine

Gender blindness arises from a principle of neutrality and leads to the neglect of gender differences. Gender blindness is embedded in medical textbooks and results in male normativity with women expressing atypical or deviant conditions. Dr. Lagro-Janssen cited the examples of intervention studies on salicylates and cholesterol-lowering drugs for men.

As well, depressive disorder presents differently in men and women which results in women's symptomology being the norm and included in the DSM. This serves as an impediment to recognizing depressive disorder in men

Male bias is a function of male dominance and results in sex stereotyping. The male body is the "norm". For example, angina, which is activated in men by exercise and reduced by rest, is expressed differently for women who experience angina at rest and find no relief in reduced activity. Women are seen to express atypical angina symptoms. This results in women underestimating their own risk as well as delaying physician diagnosis of angina.

The biomedical focus of medicine downgrades the importance of the psycho-social context which serves to downgrade the influence of gender. The primacy of biology supersedes psycho-social and gender contributions to health and disease. Focusing again on depression, Dr. Lagro-Janssen stated that much of women's depression has to do with social and domestic violence and sexual abuse. Using alcoholism as an

Gender sensitive
medicine requires
gender sensitive
education

Toine Lagro-Janssen

example, Dr. Lagro-Janssen stated that male alcoholics tend to be supported by their female spouses while female alcoholics are taken care of by their children. The challenge is to link biology to the psychosocial.

Men and women are different. They have different:

- Patterns of illness
- Responses to therapy
- Susceptibility to diseases
- Coping mechanisms
- Patterns of health care utilization.

Dr. Lagro-Janssen argued that our understanding of disease must be informed by a biopsychosocial perspective that includes an integrated concept of illness, one that recognizes the relationship between sex, gender and health. Gender sensitive medicine requires gender sensitive medical education.

GENDER IN MEDICAL EDUCATION - MORE THAN SEX DIFFERENCES

DR. KATARINA HAMBERG

In Sweden, there is no system-wide integration of gender in medical education.

Gender theory, knowing the difference between sex and gender and its influence on men and women, is an important tool for medicine for it recognizes and challenges gender stereotypes; stereotypes which typically represent women as subordinate to men and which are used to disadvantage women.

Also, intersectionality, that is, the influences of age, class, ethnicity, education

and wealth, interact with gender in complicating ways. Gender is constantly undergoing construction in interactions between people, and in interactions between doctors and patients.

A concept that has appeared on the agenda recently is heteronormativity. A heteronormative approach means that heterosexuality is seen as normal while homosexuality, bisexuality and other sexual identities are made invisible or deviant. Being invisible or defined "not normal" has negative implications for health and self-esteem.

What is sex and gender?

Sex refers to biological characteristics and is determined by reproductive organs, chromosomes and hormones.

Gender refers to the social roles and expectations ascribed to men and women by society and culture. Gender means seeing men and women in a perspective of wholeness.

It involves:

- Biological processes
- Psycho-social living conditions
- Power and control in own life
- Relationships

However, highlighting gender is not enough, it must be analyzed using a gender perspective.

In medical education, a gender perspective informs four key areas:

1) The healthy and diseased body

- Biology and living conditions

Musculoskeletal disorders are more common in women (intersection of body+living+violence) and can lead to depression which influences how gender is constructed and understood.

2) Investigations and treatments

- Differences and bias

Women are treated 25% less than men for psoriasis and are responsible for their own treatment whereas men are treated in the hospital

“... a gender perspective advises us to be aware of the risks of oversimplification”

Katerina Hamberg

3) The patient-doctor relationship

- Power, preconceptions, expectations and behaviour

Women doctors are more participatory and take more time with patients. Patients expect different responses from male and female doctors.

4) Learning/working conditions and gender equity

- Career, cooperation and harassment

Wages and working conditions vary by gender. For example, female nurses are not as helpful to female doctors who do not ask for help as often as male doctors. Harassment continues to be an issue with 33% of women and 14% of men experiencing sexual harassment in the workplace.

Researchers are uncovering evidence that men and women are more similar than different and new knowledge about women is probably new knowledge about men also. However, a gender perspective advises us to be aware of the risks of oversimplification.

RESPONDENTS

DR. SANDRA WITELSON

Sex/gender is a subset of the nature/nurture discussion. The latter should be thought of as “and” rather than “or”. The brain is a sexually differentiated organ from the beginning and this is activated throughout life. For example, the temporal lobes, important for language, differ in organization between men and women. Neuroscience and neurology are at the forefront of scientific enquiry about sex and gender.

A specific example follows... the amygdala is activated by emotional stimuli and is involved in conditions such as post-traumatic stress disorder and depression. This activation occurs in different regions in the brains of women and men. In men, the amygdala has strong connections to the motor cortex involved in action. In women the amygdala activates the hypothalamus and limbic system involved in emotions such as breathing, sweating.

The challenge is to understand the mechanisms behind sex differences in the brain and to determine whether sex differences in biology have consequences

in behaviour.

DR. SONIA ANAND

Recognizing gender difference is both necessary and problematic, as we can see with the medicalisation of menopause.

Researchers in the 1970s who looked at estrogen in men discovered that the incidence of stroke and heart disease increased and these trials were stopped.

The Nurses’ Health Study led to an

application to the National Institutes of Health for prescribing estrogen to women as a preventative for coronary artery disease. The one female member of the panel dissented, citing the lack of randomized trials on women.

Sex hormones are being recognized in all sexes and re-described as growth hormones. We need to be alert to too much emphasis on difference and open to exploring what difference means.



Sandra Witelson, Gillian Einstein

“Wonderful presentation. Very empowering and inspiring. Critical and dedicated thinking on gender and health.”

Conference participant

DISCUSSION

The floor was opened to questions and moderated by Anne Niéc.

Question: Attitudes are the primary factor influencing relationships. From animosity to partnerships, attitudes can change and are strongly influenced by the community. Role modeling from faculty is critical. How do we evaluate this?

Discussion: In different ways. K. Hamberg reported that in Sweden it is compulsory to give a report to tutors. They learn that they have to reflect on their own actions instead of simulated patients. A. Lagro-Janssen suggested that the focus is in communication skills where simulated patients are trained to give feedback. Other tactics used can include an “eavesdropping” session on patients with the students/doctors sitting silent in observation with a concluding debrief.

Dr. Lagro-Janssen offered the example of an elective course where students are asked to write an essay answering the question: How did I become a man or woman and how do I feel about it? At the end of the course they have to add in a personal interview to assess their development. For practising GPs there is a gender aspect in existing assessments. An audience member suggested that we ask the patients how to evaluate. Adopting participatory action research methods can unearth a lot of new and surprising data.

Question: There are interesting tensions in incorporating gender. Highlighting gender through competency learning is one way, another is reifying gender as a certain topic e.g.: violence, women’s health. Gender as a lens is relevant in most cases. How can we avoid focusing on gender as a special topic?

Discussion: Tension is a good word. Too many topics can lead to tokenism and we need to avoid tokenism. We must be mindful of a balance between gender being everywhere and nowhere.

Avoid covering it too thin as that will lead to invisibility and diminish its value. Avoid always comparing men and women

‘ Our students say:
Show me the evidence
Where is it?
Does gender matter?
Conference participant

as this becomes predictable and can lead to entrenched stereotypes.

Question: What about other genders, for example, transgender or other non-normative minority issues?

Discussion: The basic concepts still apply. All cases have difference re: male/female. There is an OSCE station where a long-term gay couple present in which one of the partners has Alzheimer’s. These cases become instructive to tutors as well. It was noted that in Canada students tend to do well on content; the weakness is in behaviour.

There is no brand of medicine that is subjected to the same level of scrutiny as gender. It was pointed out that the biological aspects are easy, but the attitudinal piece is too difficult and can’t be delivered in a lecture. Enculturation happens in a milieu and the hidden curriculum is a powerful force. The challenge is to influence the tutors. It was suggested that cases be written for

both male and female patients and that stereotypes can be induced to create discussion.

Question: How do you effect teacher education?

Discussion: In Sweden and the Netherlands competencies have been established.

Question: Cultural competencies can be merged with gender. Generally students want to discuss cultural differences. How do we keep the focus on gender in those discussions?

Discussion: At McMaster, we have a very diverse ethnic community; we have no problem meeting the diversity requirements. No one arrives without a background. What is needed is an openness to discuss our backgrounds. We need more uncomfortable discussions. Whenever there is conflict and confusion there is an opportunity for discussion and action, for us to raise our understanding. We need to mobilize this energy in order to effect change.

Question: Our students say: show me the evidence. Where is it? Does gender matter?

Discussion: Evidence-based medicine asks the question: will this evidence apply to my patient population? We don’t have all the evidence. Evidence is poor when it comes to gender difference, same with culture. We’re trying to change the way this happens.



Susan Phillips, May Cohen

INSTITUTE ON GENDER AND HEALTH

DAY 1: GENDER IN HEALTH RESEARCH

WHY GENDER RESEARCH IN HEALTH SCIENCE EDUCATION?

DR. SUSAN PHILLIPS

Using as examples the IQ and US SAT tests, Dr. Phillips noted that test designers altered these tests to downgrade areas where women excelled, i.e.: verbal tasks, and substituted math questions, areas in which women typically do poorly. As it is understood that science informs medicine and that research uncovers science; methodologies exist that can reduce sex/gender bias in research.

This presentation addressed three overarching questions by describing examples of relevant research addressing:

- Why do women outlive men (except where oppression of women is extreme)?
- If longevity is tied to income, how can we understand male wealth and female longevity?
- Why might equality be bad for the health of women in developed countries?

She first examined the difficulties and shortcomings of current research on gender and health. Gender bias in research arises from several factors including:

SESSION MODERATOR:

Dr. Anne Niéc

RESPONDENT:

Dr. Deborah Cook

- Excluding one sex or aggregating sex-specific data and applying this data to all;
- Assuming common meanings of words and terms in self-reported data;
- Assuming that indices are cross-culturally relevant.

Gender bias can be reduced by including a gender perspective in designing studies and surveys.

Gender is not a valid MeSH term. In researching the medical literature we find it maps onto gender identity while equity, a related concept, refers to remuneration. Authors often confuse sex with gender in reporting results. Gender goes further and considers difference in exposure, diagnosis and treatment as well as income.

The social determinants of health refer to the impacts and influences on health and are related particularly to income and measure social capital and connectedness. Gender as a social

“When applying a gender lens to research, gender becomes an independent variable

Susan Phillips

determinant of health not only addresses sex differences, but also includes a consideration of discrimination and the individual acceptance and social constraints of gender roles.

Including an analysis of sex difference is necessary but insufficient in uncovering the influence of gender on health. Caution must be taken to avoid the problem of over-interpreting small sex differences and consideration given as to whether differences are between groups or within them.

It is often in the interaction of sex with the social determinants of health where we discover gender-related outcomes e.g.: married men are in better health, married women are in poorer health.

See Appendix A for a bibliography of examples of research papers that account for gender and address the questions stated at the start of this section.

of health care found that women receive fewer hours of care, both formal and informal. Disabled women living alone receive less care.

In the ICU, sex-based differences account for the fact that 20% more men are admitted to the ICU. This same study found that women are less likely to be offered interventions, although not by much, and women are less likely to survive the ICU.

RESPONDENT

DR. DEBORAH COOK

It is impossible to pick up a biomedical journal without seeing confusion over the terms gender and sex. It's a fascinating social problem and one with implications for health research and clinical care.

Male/female are the basic descriptors for

medical research. In reviewing exclusion criteria in RCTs, Vanspall, Toren et al found that conditions relating to the female sex were grounds for exclusion in 39.2% of the trials. Overall, they found that only 47.2% of exclusion criteria were graded as strongly justified in the context of the RCT.

A 2000 JAMA study on markers for receipt

Compassionate, knowledgeable and enthusiastic presenters

AFTERNOON SESSION

The afternoon session began with a presentation from Joke Haafkens on a filter designed to locate sex-specific evidence in clinical research papers using the search engine OvidSP™.

There is quite a bit of evidence on sex differences that do not appear in clinical guidelines. Using this filter greatly increases recall and specificity in retrieving articles.

This filter was tested on clinical evidence and has not been validated with observational or qualitative studies. See: Moerman, Deurenberg and Haafkens, "Locating sex-specific evidence on clinical questions in MEDLINE: a search filter for use on OvidSP™", BMC Medical Research Methodology, 2009, 9:25.

A copy of this article was distributed at the conference. See Appendix A.

For the remainder of the afternoon, participants were split into two discussion groups that were to report back with their discussion results.

QUESTION FOR BOTH DISCUSSION GROUPS:

How do we address the dilemma of the psycho-social:

CANMEDS are becoming ingrained, but the social determinants of health are slipping out of the practice context (how do we push social determinants of health to become mainstream).

Professionalism has become mainstream.

How do the following impact gender and health?

- Public demand/sensitivity
- A priority in education in all health-related fields
- Practical implications / common sense relevance

Participants were encouraged to ask the questions that will include gender as an integral, independent variable in the research question.

GROUP 1

Questions need to be asked that can expand our understanding:

What does gender mean to the "public"?

- Does gender health matter?
- Does being a male or female affect experience of health care?

Public demand is influenced by government and policy makers and funding agencies. Is this enough support?

Financial benefit for gender "health tracks" in hospitals, money can come from pharmaceutical companies.

- Men's clinics for erectile dysfunction
- Women's breast cancer is politically mobilized

Ask the public to think about gender in a personal way to produce pressure to bring the personal into the public/political sphere.

In Japan, health care is funded by the government. There are 400 women's health clinics in Japan, many of them

focused on reproductive health, not on a holistic approach (i.e.: psychological, etc.). Increase collaboration to increase holistic approach.

Increase political support by engaging with key political figures to speak up for gender (top-down approach).

How would you want your mother or father to receive health care?

- A doctor who is sensitive to menopausal, gendered issues?

Incorporating concepts of a "sense of well-being" into traditional western medicine

- Marketing gender into "sense of well-being"
- Frame it in terms of well-being
- Marrying technically proficient medicine with a gender proficient medicine.

A "technical" doctor or one that is gender-sensitive (technical expertise or gender expertise?)

Prioritizing gender:

- Target learners by assessing them on

gender competencies

- Ask students to imagine patient as woman/man/trans person.
- Create a database of standardized patients – an international database?
- Expose students to standardized patients as a strategy to personalize gender medicine.

Can have a multidisciplinary approach

Cultural specificity of gender medicine without getting into cultural stereotyping

GROUP 2

- Do you include equal numbers of sex or as they are represented in the population?
- Do you have sex-specific groups/facilitators?
- Focus on same-sex experience of medical encounters i.e.: gender roles with same-sex couples
- Qualitative in-depth interviews with staff of public health and their understanding of gender to map their different understandings. Start

by asking what people know.

- Explore the effect of the researcher on the research
- How to capture hidden information, i.e.: illegal immigrants, domestic violence, same-sex sexual problems.
- Focus on media content, the meaning of media texts. New approach: diffusion of information through opinion leaders and decision-makers about health.
- Researching educational practice, interviews and focus groups with students, senior students and preceptors.
- Mixed method study with key stakeholders on accountability. Focus on health education research. Mixed methods can draw on the strengths of both qualitative and quantitative methods. This is a new field with a lot of terminology questions.
- With interviews/focus groups you can go to maximum variability to discover what is possible, or minimum variability because you want to drill down on a specific question.

Study both sexes even if the condition is most prevalent in one sex

- Avoid “boys versus girls” and instead describe “boys” and “girls”
- Study both sexes even if the condition is most prevalent in one sex.
- When studying children, include the parents because the impact of the surgery on the parents is substantial and they may see a lower quality of life for their kids than their kids experience. They do not return to their doctors despite having significant concerns.
- The researcher as the research instrument – reporting what you bring to the research.
- Women interviewing women.
- Bracketing out your influence
- Reflect on the impact of yourself as a

researcher on the research

- May need to bring in someone outside your research relationship who is neutral
- Examine power relationships in the research encounter
- It is possible to take notes while interviewing, digitally record for reference.
- Use same-sex focus groups and leaders, e.g.: male doctors with male facilitator blamed the women for domestic violence for refusing sex, which women did not mention. Female doctors talked about the effect on the children which men did not mention.
- Use qualitative data to find out what is going on and then establish generality through quantitative research. Alternatively, use interviews/focus groups to explore what meaning people make from quantitative findings.
- When method is challenged, respond with ‘the findings are important, could you have done better’?

DAY 2: GENDER IN HEALTH EDUCATION

COLLABORATION FOR CURRICULUM DEVELOPMENT

DR. ALAN J. NEVILLE

The **Gender and Health Collaborative Curriculum Project** was developed at the request of the Undergraduate Education subcommittee of the **Council of Ontario Faculties of Medicine (COFM)** and was awarded funding by the **Ontario Women’s Health Council** for 4 years.

See Appendix B for more information.

The **impetus for curricular change** can come from a variety of sources:

- Social accountability
- Innovations in education
- Clinical exposure
- Community-based placements
- Revised assessment practices
- Accreditation

SESSION MODERATOR:

Dr. Nahid Azad

RESPONDENTS:

Dr. Antoine Lagro-Janssen

Dr. Katarin Hamberg.

Successful change occurs through the dedicated efforts of effective change agents

Alan Neville

How to implement curricular change?

- Decide on the “over-arching” curricular goal
- Define the expected competencies
- Link objectives with competencies
- Develop measureable learning objectives
- Determine curriculum delivery format
- Assemble educational resources

What factors enable successful curricular change?

Content: characteristics of the school that can facilitate change e.g.: Mission and Goals

- The history of previous effective change increases the likelihood for further innovation
- Schools with focused goals implement change more readily
- Informal networks are often preferred methods to institute change
- Change “Champion” who exerts influence
- Student allies
- Integrated over departmental structures

Curriculum: characteristics pertinent to the curriculum itself e.g.: need for change; scope and complexity of the innovation

- Advantages to implementation outweigh costs
- Must appear relevant to users
- Innovation central to core mission of the school
- Importance of pilot projects

Process: planning, initiation, implementation, and institutionalization; key elements are collaboration, communication, evaluation and leadership.

- **Collaboration** creates a sense of creative, supportive tension and leads to a feeling of collective

- ownership
- Open, clear, and safe **communication** mechanisms in place in order to create energy and exchange ideas
- Attention to faculty needs e.g: faculty development, change management
- **Evaluation** of strategies to monitor progress, including the use of focus groups to elicit data
- **Leadership** is ALWAYS cited as a major factor.
- Visible, assertive and participative
- Qualities include – visionary, risk-taker, credible, energetic, enthusiastic, conflict manager, focused, effective communicator

New Curricula Lessons from Innovative Schools:

- Keep vision broad, use evolutionary planning
- Give faculty time to learn about the innovation
- Be inclusive, encourage group sense of ownership
- Promote open communication with both supporters and opponents
- Develop strong, visible leadership
- Develop organizational structures that support innovation
- Process is guided by evaluation
- Maintain financial support
- Expect change to take longer than expected

RESPONDENTS

DR. LAGRO-JANSSEN commented that in The Netherlands, they use CanMEDS. It was relatively easy to incorporate gender in her presentations. Access to evidence in the literature and involvement in a discussion of what constitutes a “gender curriculum” was necessary. Existing modules were screened using a gender lens and organized around themes. Gender was integrated into compulsory themes and a gender elective was developed to provide more in-depth learning opportunities.

Facilitating factors include:

- Involving module creators to discuss how gender could be included with practical and concrete examples
- Showing the evidence that demonstrates improved quality of care
- Having a prestigious and well-regarded champion who will advocate and be visible
- For physicians, the advocate must be a physician
- Identifying key political figures to be a voice
- Access to resources, funding
- Having a curriculum with bio-social structure is easier to work with
- Dedicated times for educators who are interested and willing but know little and have no time
- Establishing a knowledge centre for gender and diversity content, developed modules, trained simulated patients, trained physicians, documentation

- Reimagining traditional western medicine, which is pathology focused, and introduce the concept of wellness, which must incorporate wholeness and gender
- Continuous evaluation of implementation and ongoing assessment
- Matching competencies with curriculum
- Involving students in a study group
- Organizing symposia

DR. HAMBERG noted that the experience in Sweden has been similar. There are 6 medical schools that compete with each other for students and resources; collaboration can be difficult. Dr. Hamberg introduced gender into the teaching environment without a gender-based curriculum and with the encouragement of male leaders, despite some resistance from students. Trial and error was the most effective teacher.

Dr. Hamberg found the most important element for success is to provide instruction and support to the teachers; find who will do it and ensure they have some gender theory to support them and organize some courses for them.

The “hidden curriculum” poses a particular challenge. Faculty must be encouraged to practice what they preach. Gender education is a competence, something that can be acquired. A gender committee was provided with resources and charged with promoting gender and

health. Provide good, and not too much, literature. At Umeå a book was produced for students and teachers that includes gender history, theory and examples. The book is updated and compulsory reading for the students.

Gender theory is discussed in term 1 and is taken up in subsequent courses: gender and osteoporosis, gender and sickness, physician gender, violence and abuse toward women and children.

Gender education is about values; this provides a challenge to teachers. It is a struggle to get students engaged and difficult to get them to talk about themselves, whether in same-sex or mixed-sex groups. There is a continuous need to clarify examples which are contradicted by individual experience.

We try to engage students through student work experiences, for example, explore the curriculum material. We try to get students thinking about how gender shapes biology using osteoporosis and by finding fun ways to do that.

It’s important for us to continue to challenge other presentations for their lack of gender analysis and provide training to students in critical thinking.

In wrap-up, Dr. Azad commented that she had to be both an agent of change as well as a curriculum and content expert and noted that it is critical that advocates be someone with credibility. There is a lot to learn while doing the work.

AFTERNOON SESSION

The Gender and Health Education Initiative at McMaster holds an annual grant competition to fund projects that further the integration of gender and health education.

All Institute participants were requested prior to the meeting to submit abstracts describing projects that are piloted or in place at their home universities. The afternoon session was a “show and tell” of these projects, an opportunity for participants to share experiences and provide input on gender and health projects from other schools.

A handout containing the abstracts was distributed. Project representatives were on hand to present their projects and answer questions.

Teaching the History of Health and Medicine: Towards a More Gender-Balanced Approach

Dr. David Wright, Associate Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University

This project will revisit the curriculum of Bachelor of Health Sciences 3Y03, History of Health and Health Care in Canada, and revise it to reflect not only the innovations in gender and health history, but also reflect the changing interest of the student body.

This project will create an on-line web-based resource of secondary and primary source literature on gender and health history that can be used by undergraduates, postgraduates and other faculty members.

In addition, this project will fund a public lecture series on gender and health history. The goal is to invite a number of scholars in women’s health history to discuss selected topics in a lecture aimed at a general audience. The lecture series will be advertised to the 3Y03 students and open to faculty and the public.

One important new subject area in what is now known as the history of health and medicine has been the incorporation

of women’s history into medical history, creating vibrant new fields (such as nursing history itself) but also innovative gendered perspectives on the medical encounter in past generations.

For more information:

David Wright: dwright@mcmaster.ca

Gender and Health E-Module: Exploring Gender Narratives

Lisa Fu, Student, Undergraduate MD Program

Joshua Smalley, Student, Bachelor of Health Sciences Program, McMaster University

Our student-led working group intends to develop an e-learning module relevant to gender and health education. This module would build upon the Narrative Medicine movement through the exploration of patient stories. These stories will be explored through the close analysis of short works of literature, fine art pieces and a series of video clips using actors portraying patient narratives. Throughout the e-module, participants will be asked to reflect upon their own perspectives and the stories they encounter.

We intend to implement this module in a Gender and Health Series in the 2010-11 academic year. This series will be comprised of an interprofessional and interdisciplinary group of students that will meet regularly to work through and discuss the modules.

This module will explore patient and societal perspectives of mastectomy from differing viewpoints including those of women, men and individuals who are gay, lesbian, bisexual or transgendered.

For more information:

Lisa Fu: lisa.fu@learnlink.mcmaster.ca

Joshua Smalley:

joshuasmalley@learnlink.mcmaster.ca

Helping Health Professional Learners be Comfortable and Confident with Sexual Screening: Instructor Resource DVD

Dr. Kristina Trim, Instructor, Bachelor of Health Science Program, McMaster University

We are interested in developing a learning module that helps health

professional instructors and learners feel comfortable initiating conversations about Human Papillomavirus (HPV) sexual health screening for young adults and their parents. Current learning modules available through the Society of Obstetricians and Gynecologists of Canada focus on how HPV is transmitted and the clinical science of the HPV vaccine, but less focus is on how practitioners should approach patients about their sexual health screening (e.g.: risk factors, vaccination, pelvic examinations and PAP smears).

We will develop a DVD with print and video resources that provide practical tools instructors can use with their health professional learners. It will be designed to improve health care learners’ comfort and confidence to initiate conversations about sexual health with adolescents, their parents, and young adults.

For more information:

Dr. Kristina Trim: trimks@gmail.com

Using Qualitative Research to Develop a Program for HIV-Positive Women at an Outpatient HIV Clinic

Allyson Ion, Research Coordinator, Psychiatry and Behavioural Neurosciences

Dawn Elston, Research Coordinator, Pathology and Molecular Medicine

The goal of this project is to identify the unique challenges, barriers and needs of female patients at the SIS Clinic, 66.6% of whom are newly diagnosed (since 2001) and are of childbearing years (18-50 years of age). Enhancing our understanding is essential to improving service delivery, improving cultural competency among clinic staff, building capacity for delivering women-focused services and developing long-term strategies for translating knowledge about HIV best practices in caring for women and children.

Our objectives for this project are:

- To understand and be sensitive to the complex and diverse needs of the SIS clinic patient population;
- To develop, implement, and evaluate educational intervention aimed at:

- Reducing barriers
- Facilitating communication
- Improving service delivery; and
- To encourage long-term knowledge translation and exchange activities among SIS clinic staff related to cultural competency and sensitivity.

For more information:

Allyson Ion: iona@mcmaster.ca

Dawn Elston: elstond@mcmaster.ca

Planting Seeds: The Growth of Community-Centred Health Initiatives

International Women and Children's Health Conference Committee

The theme of the 11th annual International Women's and Children's Health Conference (IWCH) is "Planting Seeds: The Growth of Community-Centred Health Initiatives". Our overall objective is to inspire, initiate and support delegates' active engagement in community-centred projects that promote women's and children's health. We will move beyond rhetoric and emphasize active participation in improving health conditions for women and children. We will provide delegates with tools and opportunities to put their passions and skills to good use in their local as well as global communities. We want to encourage our delegates to think and act locally and globally whenever and wherever possible.

The IWCH is a collaboration of health professionals, faculty and students dedicated to improving health conditions for women and children in impoverished and low-resource areas of the world. The Network was created in 1998 through the mobilization of professionals and empowerment of dedicated students with a mandate of leadership development in education and research. IWCH holds an annual conference that brings together leaders and learners from various disciplines and fields that are committed to global women's and children's health, and facilitates the presentation and

discussion of contemporary issues in this area. Once organized by faculty, the conference is now student-led to foster leadership, interdisciplinary collaboration and scholastic achievement. With a focus on interprofessionalism, the 2009 conference is co-chaired by a medical student and a midwifery student, who are leading an executive of peers from across the Faculty of Health Sciences.

For more information:

iwchconference@gmail.com

Towards a Gender Sensitive and Sex Specific Medical Curriculum – Highway or Dead End?

Dr. Bärbel Miemietz, Equal Opportunities Officer, Hannover Medical School

Being aware of the gender bias in medical care, I was enthusiastic about the chance to support gender sensitive and sex specific medicine when I started my work as equal opportunities officer at Hannover Medical School in 2004. The first lecture, however, attracted an extremely small audience and passed without any consequence.

We therefore started a poll among all professors and scientific works with three objectives:

- To learn more about the need for gender sensitivity and sex specific aspects in each specific field of medicine;
- To identify the most relevant fields of interest for our own university, and
- To establish a network of people interested in gender / sex-specific medicine.

We used a questionnaire from our colleagues at Charité Berlin.

The poll was funded by a grant from the Ministry of Science, Lower Saxony. About ¼ of the scientists answered

the questionnaire (424/1833). Two-thirds (67%) of respondents said that there was need to cover gender / sex-specific aspects in the teachings of their respective fields and named concrete topics. Sixty-six percent wanted to take part in the network. The study was published in 2007.

In 2008 we started the next step, supported again by a grant from the Ministry. We succeeded in winning the support from the dean for students to participate in the project, which consisted of two parts: implementation of gender and sex-specific aspects in the curriculum, under the responsibility of the dean; and a series of workshops for teaching faculty and students, under the responsibility of the equal opportunities office. To some extent, areas in the curriculum to address gender and sex specific aspects have been identified.


Since April 2008, 8 workshops have been organized, each with 4 expert lectures (young investigators as well as more experienced faculty from Hannover and elsewhere). The workshops covered the fields of nephrology, forensic medicine, anesthesiology, gastroenterology, cardiology, human genetics, neurology and hematology. More workshops are in preparation. The workshops are certified for continuing medical education. The workshop regularly attracts a few people engaged in the field of science that is on the agenda. A few women attend for personal reasons and a very few students. The feedback of the audience is always positive, but there is hardly any dialogue across discipline borders or on didactics. The abstracts of the lectures exist in print and online. A publication is planned.

The aim now is to establish a virtual centre for gender and sex-specific medicine and to organize an international conference on gender sensitive and sex-specific medical education.

For more information:

Dr. Bärbel Miemietz:

Miemietz.Baerbel@mh-hannover.de

 I enjoyed learning about what others are doing at their schools through the gender education projects

A Graduate Program in Women's Health: Collaboration Across the Biological Sciences, Social Sciences and Humanities at the University of Toronto

Dr. Gillian Einstein, Director, Collaborative Graduate Program in Women's Health

At the University of Toronto, sponsored by Women's College Hospital, we have brought the biologic, social, and human sciences together in order to explore the re-unification of sex and gender in bodies of women.

The Collaborative Graduate Program in Women's Health (CGPWH; Master's and PhD) includes the graduate units of Anthropology, the Bloomberg School of Nursing, Dalla Lana School of Public Health, Dentistry, English, Exercise Studies, Faculty of Information, Health Policy, Management and Evaluation, Immunology, Ipperwash School of Social Work, Medical Sciences, Ontario Institute of Studies in Education, Pharmacology, Philosophy, Psychology, Religion, Women and Gender Studies, as well as numerous Centres and Institutes including the Centre for Girls' and Womens' Health and Physical Education, and the International Programme on Reproductive and Sexual Health Law.

The purpose of the CGPWH is to foster a generation of practitioners, policy makers, and women's health scholars with the conceptual and methodological tools necessary to treat as well as to bring perspective on sex/gender into their practice and/or work. Our goal is that graduates with our certificate will lead medicine and academia in devising health solutions that will be meaningful in the many contexts in which women's bodies and lives evolve. Students apply for graduate study to the disciplinary department of their choosing. Once accepted to that department, they then apply to the CGPWH. In order to qualify for the certificate that comes with completing the program successfully, students take the core course – Gender and Health – and present their own work for cross-disciplinary comment in the student seminar series. PhD students work with a cross-disciplinary faculty member who serves as their mentor in

multidisciplinary work. Students who have completed or are completing the CGPWH gain an appreciation for theory with practice, honing their skills of active interrogation of accepted norms and coming to appreciate the intricacies of biologies of difference.

For more information:

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gillian.einstein@utoronto.ca

Integration of Gender Medicine into Medical Education Curriculum: The First Trial in Japan

Miyuki Katai, Chief & Associate Professor,
Department of Gender Medicine, Tokyo Women's
Medical University

The evidence of sex and gender differences in common diseases is becoming fully apparent. We report that this is the first integration of gender medicine into medical education at Shinshu University School of Medicine in Japan.

The first Japanese Women's Health Care Clinic based on gender medicine was founded in 2001. Clinics based on gender medicine for women spread rapidly throughout the country with more than 400 in existence since 2005.

We have integrated gender medicine into medical education at Shinshu University School of Medicine since 2003. Because we thought that the most effective way to teach gender medicine systematically was to integrate with the medical school education curriculum. Our first trial was begun as a small-group lecture for the senior grade of medical students in 2003. Student feedback and evaluation were positive and we expanded it to the whole class lecture for middle grade medical student in 2004. Since 2006, gender medicine has become a compulsory subject with credit in middle grade at Shinshu University School of Medicine. It consists of 7 lectures: gender medicine, sex and gender difference in the brain, mental disease, cardiac disease, urology, endocrine and metabolism.

Tokyo Women's Medical University began to integrate gender medicine into medical education as an optional subject in 2009. Several other medical schools in Japan

also have classes addressing gender medicine.

There are some barriers to this. Participants agree regarding the importance, however they state that there is not enough staff who can teach Gender and Medicine; there are relatively few faculty trained in gender medicine in Japan.

The next step is to develop and share teaching material of gender medicine among medical schools. Then we should train educational staff, including those who do not specialize in gender medicine to teach with the materials at each medical school in Japan.

For more information:

Dr. Miyuki Katai:
mkataigm@dnh.twmu.ac.jp

European Module in Gender Medicine

Ineke Klinge, Associate Professor, Maastricht University, Netherlands

A consortium of 7 European Universities has joined forces and successfully applied for the development of a European Module in Gender Medicine in the Erasmus Life Long Learning Programme / Curriculum Development Projects. The project will start in the fall of 2009 and run for two years.

The universities involved are Charité Universitätsmedizin, Berlin; Università degli Studi di Sassari, Italy; Medizinische Universität Ommsbruck, Austria; Maastricht University, the Netherlands; Semmelweis University Budapest, Hungary; Radboud University Nijmegen, the Netherlands; and the Karolinska Institute, Sweden. The consortium will generate a flexible module "Gendermedicine" (GM) that teaches sex and gender differences in a range of diseases, therapy and research throughout Europe.

Starting in 2006, the partners identified in yearly conferences medical disciplines where sex and gender differences and the need for sex and gender sensitive knowledge are most prominent. We now combine the expertise of the partners in these disciplines to assemble scientific

content and learning goals for a common GM module and to build a common pool of teachers. The GM module can be flexibly integrated into bachelor or master programmes or vocational education at different universities and will lead to an internationally recognized certificate. This will promote innovation in medical education and contribute to harmonization of biomedical study

structures in Europe.

The project will generate internationally recognized experts for gender-sensitive medicine and create an expandable European network from university and non-university partners. Network members will sensitize universities, medical professional organizations, health care politics, funding organizations

and insurance companies for gender aspects. Dissemination of gender aspects will improve the practical treatment of women and men and will reduce deaths and side effects from pharmaceutical mismanagement. Lay organizations are requiring such knowledge also

DAY 3: GENDER IN HEALTH PRACTICE

ATTENTION TO SEX AND GENDER RELATED FACTORS IN CLINICAL GUIDELINE DEVELOPMENT

DR. JOKE HAAFKENS

Clinical practice guidelines translate research evidence into recommendations for clinical practice and are important tools for improving patient care. If guidelines are gender blind, then the practice will be flawed. Our study sought to answer the question: What is needed to address gender in clinical guidelines?

Many countries have guideline organizations that follow a standardized process of guideline development. In the Netherlands there are two bodies responsible for guideline development, the Dutch Institute for Healthcare Improvement (CBO) and the Dutch College of General Practitioners (NHG). Both groups use an internationally accepted, standardized methodology for developing guidelines. Guidelines are developed by committee members with no connection to industry or who derive no financial benefit from its recommendations. Patient organizations are also involved, although in a limited way.

Guideline development typically follows 5 steps:

- Formulate the key question
- Undertake systematic literature search
- Critical appraisal of evidence
- Evaluation of evidence/experience
- Phrasing recommendations for practice

SESSION MODERATOR:

Dr. Susan Phillips

RESPONDENT:

Dr. Wilfreda (Billie) Thurston

For our study, we reviewed 7 guidelines, observed committee meetings, conducted focused interviews, and did a content analysis.

When asked why no attention is given to sex and gender, those interviewed expressed a range of opinions: such differences are not relevant; guidelines should not include “special interest” groups; lack of competence in identifying and evaluating sex/gender evidence; no comprehensive instruction in guideline handbooks. And indeed, the World Health Organization, an advocate for sex/gender and health, offers no guidance for including sex/gender criteria in guideline development.

Factors that may facilitate the consideration and inclusion of sex/gender differences:

- Sex-balanced guideline committees
- Technical support in understanding sex/gender differences
- Written information, education, and personal feedback to committee members

Several tools were developed by the researchers to aid the incorporation

of sex/gender differences in guideline development:

- Chapter in handbook for guideline developers
- Training course
- Framework for consultation and feedback to committee members.

A training course was offered to staff members of CBO and NHG responsible for providing methodological support to the guideline working groups and included information on:

- Understanding the importance of sex/gender
- Developing skills for determining whether sex differences are relevant
- Recognizing sex-specific search terms
- Appraising literature
- Critical reading of subgroup analysis
- Practical examples of how to do it

Evaluation of the pilot training course suggests that the course was successful in achieving its objectives in raising awareness and stimulating the development of practical skills. There was some level of attention directed toward sex differences and more gender and sex-specific statements in evidence and recommendations.

Can this challenge bias in practice? Maybe, however, the implementation of guidelines in practice is problematic itself.

RESPONDENT

DR. WILFREDA (BILLIE) THURSTON

Feminist analysis asks us to look closely into the problem under discussion, how is it articulated and who benefits from the solution?

The problem can be identified as follows:

- Medicine does not think the lack of sex/gender analysis is a major problem
- Medicine is not designed to deliver patient-centred care, so it is not interested in patient-specific characteristics

- Medicine is slow to take up social sciences and humanities; women continue to be under-represented in science
- Some governments have responded by stating that change is required (citing the Beijing Platform) however it was noted that Canada has recently removed 'equality' as a priority
- Medicine can use the excuse "lack of training" as a mode of resistance, despite having some of the "best and brightest" personnel. Once gender

consciousness has been raised, gender is evident everywhere; it changes the comfort level in being part of the mainstream.

Possible goals:

- Change medicine to consider that a gender analysis is an important aspect of patient care that contributes to patient safety priorities.
- Open medicine to the influences of the breadth of sciences, social sciences and humanities.



Farewell Lunch

“ I was amazed that our experiences are so similar on an international scale, yet there were many new ideas and different approaches to share

Conference participant

FINAL DISCUSSION

The organizers of the First Canadian Institute on Gender and Health have the vision of moving gender from the margins of education, research and clinical practice to the integration of gender in all aspects of academic activities and health care.

STRATEGIES FOR MOVING THE DISCUSSION FORWARD INCLUDE:

Our **strategic direction** includes:

- Adopting **participatory action** in research methods;
- Highlighting gender through **competency learning**; and
- Addressing the **intersectionality of gender with other social determinants of health** in standard practice.

Achieving our goals in these areas needs a **comprehensive approach**, both at the individual and at the public levels.

The key success factors in these domains have to be measured along the way.

Our ongoing **engagement and collaboration** should be maintained with the next conference focusing on issues such as:

- How do we **measure success**, and
- What are we going to **measure to ensure progress**.

Engagement and Collaboration

Allies can be found in colleagues who are **field experts**, but not necessarily in sex/gender analysis. Invite them to conferences and symposia. We can all learn from each other.

Encourage men to get involved. Men are gendered and how it affects their health needs more attention. However, we must be mindful not to let go of women in favour of men.

Interdisciplinary research can help us shed light on how medicine thinks about sex and gender. For instance, sociology has a long tradition of thinking about sex and gender and its impact in the world. No need to reinvent the wheel where there are opportunities for interdisciplinary collaboration and learning from each other. Researchers need to be mindful that communicating across the disciplines can be difficult.

Methods and Theory

Technical knowledge is needed to understand and analyse gender competence in research. Offer courses in **gender-based analysis**.

The concept of **cultural safety** originated in Australia and has supplanted cultural sensitivity or difference. Cultural safety refers to understanding your own culture(s) and what that means in creating a safe environment in a professional encounter.

Intersectionality may be the next thing to think about, that is, the intersection with ethnicity, migration experience, socio-economics, and 'stratified analysis'. The concept originates in psychology. In epidemiology, the odds of something happening are determined and everything else which is not sufficiently predictive is removed. In other disciplines, intersectionality can be used to define and consider how gender relates to health and health care. It was noted, however, that sociologists have abandoned intersectionality as too complex.

Use evidence that science is new and exciting when it includes a gender perspective.

Advocating for Change

How is the successful integration of sex and gender into guidelines to be measured? Influence guideline organizations to include a sex/gender course for developers and make it an aspect of the standardized quality of guidelines.

Continue to push for publishing opportunities in prestigious medical journals like Archives of Internal Medicine.

“ We need to strategize ways of expanding the knowledge shared at this conference to a broader audience

Conference participant

APPENDIX A

Examples of research papers that account for gender:

GROUP LEVEL

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APPENDIX B

Gender and Health Collaborative Curriculum (www.genderandhealth.ca)

Site Coordinators at each of the 6 Ontario medical schools worked with medical students who contributed to the project through summer studentships.

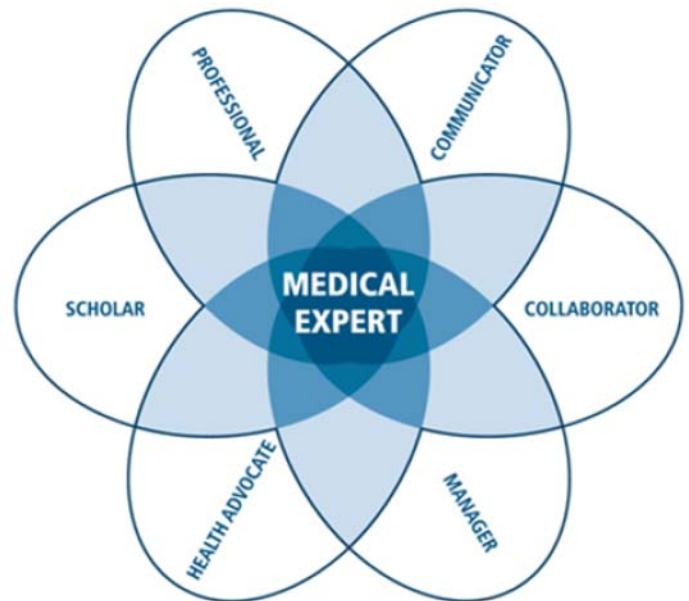
The project deliverables included:

- a web-based learning resource consisting of a number of modules, including an introduction to gender and health;
- the application of gender as it pertains to specific disease conditions (e.g.: Gender and Lung Cancer); and
- a toolkit, the Gender Lens, which provides a framework for understanding health problems from a gender perspective.

A self-authoring tool was developed as well as a manual for integrating gender into medical education and a portfolio for tracking student activity on the site. Gender competencies were mapped onto the Royal College of Physicians and Surgeons of Canada CanMEDS competencies.

The graduating student will:

- know the difference between sex and gender and be able to apply a gender lens for approaching any medical problem from a gender perspective (**Medical Expert**)
- be able to elicit and synthesize information from a patient, family or community from a gender perspective, outline sex and gender-based influences on health and describe approaches for dealing with them (**Communicator**)
- be able to consult with other physicians and other health care professionals to develop strategies for addressing gender and other social determinants of health for individuals and populations (**Collaborator**)
- be able to identify ways to make the operation of the Canadian healthcare system more responsive to gender inequity in policies and programs (**Manager**)
- be able to identify gender biases in health care delivery and propose ways to address gender in patient care (**Health Advocate**)
- be able to recognize and analyze gender bias in research design, implementation and analysis (**Scholar**)
- be able to perform clinical duties in a manner that is nonbiased and in which all patients and their families feel safe and receive good care (**Professional**)



APPENDIX C

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NOTES

