Step Up to Overcome Gender Bias in Health Care

By Mark Harris

The goal of modern medicine is to prevent, treat, and relieve suffering caused by illness and disease. As such, the health care system strives to deliver high-quality patient care, promote wellness, and improve quality of life.

Aligned with these goals, an important principle in health care is the concept of health equity. This concept means that everyone has what the Centers for Disease Control and Prevention (CDC) describes as a "fair and just opportunity to attain their highest level of health."[1]

But health systems face many hurdles and challenges on the road to achieving health equity. These include broad societal or nonmedical factors—known as social determinants of health—that can influence access to care and health outcomes. Economic stability, the accessibility of quality health care and education, neighborhood and community safety, family relationships, and one's social context can all affect health equity.[2]

Accordingly, a lack of job opportunities, exposure to domestic or community violence, limited access to nutritious foods and physical activity, racism, discrimination, and language and literacy barriers are among influences that can contribute to health care disparities.[1]

Barriers to Health Equity for Women

Gender bias is another significant barrier to health equity. This involves disparities that women, including transgender and non-binary individuals, may encounter in the course of receiving medical care and treatment. Two major facets of gender bias in health care are (1) the history of cis-male-focused research and (2) the prevalence of women's health concerns or symptoms being dismissed, underdiagnosed, or misdiagnosed by clinicians.

Exclusion from Research

In the past, women were often excluded from clinical research studies. As a result, the historical focus on male research subjects has led to gaps in understanding the full impact of some medical conditions and treatments on women.

To some degree, the earlier exclusion of women from clinical studies reflected a time when few women in science or medicine were in clinical or research leadership positions. But,

in the United States, there was another factor. In 1977, the Food and Drug Administration (FDA) recommended women of childbearing age, even those who used contraception or were single, be excluded from Phase 1 and early Phase 2 drug trials. The policy reflected concerns over potential drug harms, particularly the serious harm caused by the drug thalidomide, a sedative that had been widely prescribed for morning sickness to pregnant people in Europe and Canada in the 1950s and early 1960s. The drug was later linked to thousands of severe birth defect cases.[3]

Consequently, it was not until 1993 that the U.S. Congress passed legislation requiring the inclusion of women and minorities in clinical trials funded by the National Institutes of Health (NIH). Today, NIH-funded research must be designed to also ensure the results show whether the variables under study affect women and minorities differently than other trial participants.[4]

Unsatisfactory Interactions

An important aspect of quality care is the degree to which patients feel satisfied with their health care providers. Is the patient-provider relationship based on mutual respect, open communication, and shared decision-making? Does the patient feel the provider actively listens to their health concerns? Are they empathic? Do they respond with informed, timely, and appropriate treatment recommendations?

Unfortunately, women are more likely to report negative health care encounters than men. According to the 2024 KFF Women's Health Survey, 23% of women report being treated unfairly or with disrespect by a physician, health provider, or staff. Men also report negative experiences, but to a somewhat lesser degree (18%). Notably, more Black (26%) and Hispanic (25%) women report disrespectful or unfair treatment than White (21%) women.[4]

Of course, there can be many reasons for a dissatisfying encounter with a provider. The KFF survey cited weight as the most common reason patients felt disrespected or unfairly treated. 9% of women cited gender as the principal reason for feeling disrespected. A significantly larger share of the LGBTQ population, women with disabilities, and those in a low-income category also reported negative encounters with providers.[4]

Maternal Health

Poor communication can worsen maternal health outcomes[9]:

- Pregnant women may find it hard to ask questions or share concerns. Maternity care providers can improve communication by creating an environment of trust.
- Providers can take time to really hear women's concerns and have an open conversation to make sure any issues are adequately addressed.
- When there is good communication about health concerns between moms and providers, it is more likely there will be accurate, timely diagnoses and treatment for potentially life-threatening pregnancy complications.

A 'Man's Disease'?

The culmination of these two facets of gender bias is exemplified in cardiovascular care. The health system tends to be weighted toward the male experience of how a person experiences a heart attack, observes Ambika Eranki, MD, MPH, AAHIVS, an infectious disease specialist at the University of South Florida Health in Tampa, Florida.

"In popular culture, a heart attack is often portrayed as a very male-centered event in which the man just clutches his chest and keels over, and there you go, he's having a heart attack," she says. "But the outcomes for women who have cardiac events are actually poorer because of these underlying gender biases. Women tend to have more subtle symptoms of cardiovascular events, and they are labeled as 'atypical' because the male experience is considered the norm. Oftentimes, women delay seeking out care for cardiovascular events and end up having poorer outcomes because there's a delay in diagnosis and treatment."

These observations likely resonate with the experiences of many women with heart disease. "Generally, we do think of a heart attack as that elephant sitting on your chest," says Denise Sullivan, CMA (AAMA), ABC-AHE, an onboard instructor in human resources for Northern Light Health in the Bangor, Maine, region. "But we know with women the symptoms can be very different from men. They might involve nausea and vomiting; sudden extreme fatigue; jaw, back, or shoulder pain; and other less obvious symptoms."

As a heart disease patient, Sullivan is especially sensitive to the unique needs of female cardiology patients. As a supporter of WomenHeart, a leading peer support organization for women living with or at risk of heart disease, Sullivan regularly shares her story and advice on living with heart disease with other women and groups. A *WomenHeart Champion*, Sullivan has completed the group's patient advocate and educator training program in conjunction with the Mayo Clinic in Rochester, Minnesota.

Her medical story includes quadruple bypass surgery at the age of 47 and later a transcatheter aortic valve replacement. A passionate advocate for women's health needs, Sullivan recognizes that women's concerns about heart issues can sometimes be dismissed or overlooked. In turn, she emphasizes how important it is for women to seek out providers who will listen carefully and respectfully to their health concerns.

Similarly, Sullivan also emphasizes how vital clinic staff listening skills are to patient interactions. "For medical assistants, just really listening to the patient is so important," she says. "What you write down in the pre-examination or when checking in the patient—don't think [it's] something not important just because you've heard it before. If we've heard it before, we probably should be listening better. You can help the provider in this by bringing some concerns to their attention. These days, health care providers can move around, and patients very often don't see the same health care provider. The continuity of care is not always there. If the medical assistant knows that a patient is seeing a different provider than usual, they can make sure the provider is aware of certain issues or health complaints that may not have been resolved."

Respectful Maternity Care

While measures of health equity and quality care are universal concerns in medicine, these concerns come into particular focus in reproductive health care.

"We know there is a plethora of evidence and anecdotal reports of delays to diagnosis, misdiagnoses, and dismissal of women's health care concerns," says Lucy Bucher, DO, an ob-gyn and the vice president of clinical affairs at OhioHealth O'Bleness Hospital in Athens, Ohio. "For one particular condition, endometriosis, the average time from first voicing concerns about the symptomatology related to endometriosis to getting a diagnosis is seven years, which is just absurd."

Fortunately, a developing care model known as *respectful maternity care* (RMC) is increasingly recognized for its emphasis on a rights-based framework of maternity care. This is a patient-centered model of care built on the respect for the rights of women during pregnancy and postpartum, recognizing the harm caused by disrespect, mistreatment, and abuse during pregnancy and postpartum. The RMC model emphasizes criteria for respectful care, such as patient privacy, informed consent, dignity, safety, and equitable care. The value is on patient-provider relationships informed by good communication and a fundamental regard for the patient's well-being.[5]

The value of respectful care for all pregnant people is especially important in the context of a worsening U.S. maternal health crisis, says Amy G. Cantor, MD, MPH, FAAFP, a professor of medicine in the medicine, family medicine, and obstetrics and gynecology departments at Oregon Health & Science University (OHSU) in Portland.

"Maternal morbidity and mortality in the United States are higher than any similar country, with even higher rates among Black women," says Dr. Cantor. "Increased awareness of maternal health disparities in the United States has led to urgent calls for changes in health care delivery that improve safety, eliminate racism, and improve health outcomes for all who are pregnant and postpartum. Although many factors contribute to maternal health disparities between the United States and other high-resource

countries and within the United States, particularly between White and Black women, there is increasing attention to the role that [RMC] may play in shaping these outcomes.

"There are many factors that contribute to substantial disparities in maternal morbidity and mortality for Black women," adds Dr. Cantor. "While there is general agreement that clinicians have moral and ethical obligations to treat birthing people with dignity and respect, emerging research suggests that mistreatment during childbirth plays a prominent role in maternal health disparities. A 2023 CDC survey described that 1 in 5 women recalls experiences of mistreatment during maternity care. Lack of respectful maternity care, or disrespectful care, has been identified as part of systems' failures leading to worse outcomes among those who are the most vulnerable during childbearing. The failure to listen or failure to respond to concerns or symptoms of pregnant or birthing people is a central factor associated with an increased risk for severe maternal illness or death."

As Dr. Cantor notes, the disparities in maternal health outcomes take on even more significance as they occur in the context of an already poor comparative U.S. standing in global measures of maternity care. In turn, the RMC model represents an emerging response to an important component of health equity in women's health care.

"Respectful maternity care has been described extensively throughout the literature and has become recognized in the obstetric community as a strategy to improve patient care and reduce maternal health disparities, but a consensus around a common definition is needed," explains Dr. Cantor, principal investigator for a recent OHSU-led study on RMC in *Annals of Internal Medicine*.[5]

"Mistrust in the medical system is a huge problem," remarks Dr. Cantor. "This ranges from how patients relate to their personal clinicians to how they interpret scientific evidence and guidelines. There is so much misinformation lately that it is up to the scientific community to uphold standards that are based on strong evidence and also to call out areas where there are gaps and where we need more research."

Dr. Cantor identifies several key aspects of RMC:

- Recognizing the unique needs and preferences of women and families
- Protecting patients from harm or mistreatment
- Providing care based on dignity and respect for autonomy
- Providing information to facilitate informed choices that are respected
- Supporting individuals and their needs in the labor and delivery context
- Facilitating connectedness between these individuals and their babies and families

"None of this can occur without trusting and respectful relationships in the health care setting," she adds. "And RMC is one important strategy for moving this forward."

Funded by the Agency for Healthcare Research and Quality, the OHSU-led study provides a framework for further research and work in this area. "Clinicians who provide pregnancy care can use this report to help inform a clearer understanding of strategies to measure how health systems are doing in the context of RMC, including the impact on maternal health outcomes and patient experiences," says Dr. Cantor. "Unfortunately, unconsented procedures, poor communication, and failure to listen or failure to respond to concerns or symptoms of pregnant individuals are key factors framed within *disrespectful* care and associated with an increased risk for severe maternal illness or death. Collectively, clinicians can use strategies such as shared decision-making to engage patients and families in care decisions to improve patient autonomy and document consent to improve equity along the care continuum."

As many experts acknowledge, a patient-centered approach is a critical driver in efforts to reduce barriers to equitable maternity care.

"The patient's experience is central to how the implementation of RMC impacts care decisions and leads to clinical outcomes," emphasizes Dr. Cantor. "Results of our review signal the need for a careful consideration of respectful care for all childbearing individuals—with particular attention to racial disparities and populations at risk for experiencing discrimination—to inform culturally competent care as well as safe maternity care systems. These failures have been characterized as 'dismissal'—proposed as one of three leading racism-related drivers of U.S. maternal mortality that include 'denial, delay, and dismissal.' As a fundamental driver of disrespect, these factors should be examined both as an underlying contributor to maternal health disparities and overall rates of maternal morbidity and mortality in the United States. While mortality is the most severe outcome, the examination of RMC raises questions beyond death to include the consideration of a person's humanity across the childbearing cycle."

Addressing Implicit Bias

Another barrier to health equity involves the issue of implicit bias. This involves the more subtle or unconscious forms of bias or discrimination that people may display toward others.

"We know there's explicit bias, which is basically overt racism, sexism, homophobic attitudes, and other actions or behaviors on the part of individuals or even organizations," says Dr. Eranki. "But then there's this more insidious thing called *implicit bias*, which essentially means the subconscious attitudes that people have. Most people have at least a few intrusive biases. These are unconscious

Heart Disease

Several factors contribute to why women with heart disease are misdiagnosed[10]:

- Medical bias and outdated research
- Gender stereotypes in medicine
- Cultural norms that discourage women from speaking up

attitudes or stereotypes that can lead to unintended consequences."

Health care professionals must be aware of implicit bias and its potential to affect patient care, says Dr. Eranki, who is also an assistant professor at the University of South Florida. "There is actually a lot of research on implicit bias in health care," she notes. "What that data shows—and this has held true for many years—is that White patients get preferential treatment over patients of color. This has been proven in multiple settings. This can lead to disparities both in how or how often people seek out needed medical care, their access to medical care, how the provider communicates with the patient, and the overall quality of care."

As Dr. Eranki notes, implicit bias can influence many aspects of patient care, from decisions regarding pain management and other treatment decisions to preventive care issues such as whether a provider offers someone a colonoscopy or mammogram.

"There are interventions that have been proposed to mitigate or to at least counteract some of these implicit biases," says Dr. Eranki. "The problem is it's not easily measurable. There are scales or tools that have been developed; the most famous one comes out of Harvard [i.e., Project Implicit[6]] that has been used by researchers to try to measure implicit biases in health care provider groups. Some groups have looked into providing trainings on implicit bias, either in-person or virtual, as part of medical training. But the data is not that promising on whether this actually works. There's no easy answer to this issue."

In terms of countering gender bias, Dr. Eranki believes the availability of more female clinicians can help create more equitable care for women. "There is data in the past several years that shows women providers and clinicians tend to have better health care outcomes, both in ambulatory and in-patient settings. This is important especially in a clinic setting. It's been shown that women providers actually take more time than male providers to sit down and listen to their patients' concerns. Not to generalize, but the data has shown this objectively. Finding a woman provider would be another strategy I would recommend."

If there are no straight paths to address implicit bias in health systems, that does not mean health care professionals are powerless to effect change. "I think the onus falls on us as providers to actually be aware that implicit bias even exists, and then to try to address it," says Dr. Eranki. "Especially those of us who are teaching medical students or other students in health care, we have to make a conscious effort to actually be inclusive in how we train them so that their biases are not magnified as they're going through their training."

Indeed, the health system's response to implicit bias and other barriers to health equity is complex, intersecting as it does with often entrenched cultural and social influences. In today's challenging times, this is all the more reason perhaps why health care professionals should persevere in pursuit of their improvement goals in women's health care.

"Longstanding inequities in the way that health care is accessed, received, and experienced are the result of interactions between individuals, clinicians, health systems, and society at various levels," remarks Dr. Cantor. "All of these factors affect the quality and experience of care. Some institutions have or were previously incorporating bias training as an expectation for their health care workforces. I can't speak to how those efforts are going in our current environment. But perhaps now, more than ever, it is vitally important for the health and safety of all patients to have this as part of staff training so efforts to achieve health equity are elevated and not undermined."

Patient Voices, Patient Advocacy

Certainly, health care providers want good outcomes for their patients—and for patients to be satisfied with the care they have received. Ideally, the health system should provide equal opportunity for everyone to achieve their best health.

And yet, any and all patients can take practical steps to ensure their needs are properly addressed and to best advocate for themselves as patients.

To ensure their questions and concerns are addressed, Dr. Bucher tries to talk to her patients about the importance of preparing for appointments. "If you can take some time to prepare beforehand for your visit, that can be helpful," she suggests. "Think about the questions you may have and write them down ahead of time. Document your symptoms clearly and concisely. It can also be really beneficial to bring a second pair of ears, a trusted support person, a family member—whomever you can bring with you. Oftentimes, having two sets of ears is better than one."

As a physician, Dr. Bucher does not want any patient leaving an appointment feeling unheard. "If you feel like you're not being heard at your appointment, try to think about the language you need to address that concern. You might try to restate your question or concern in a way that highlights what's important about it to you. An evaluation or treatment plan for a particular health concern can rest on how impactful it is to the patient's day-to-day life. So, for example, 'I know my headaches are impactful because they're causing me to miss work three times

Resources

Interested to learn more?

Center for Women's Health at Oregon Health and Science University
https://www.ohsu.edu/womens-health

OhioHealth Women's Health
https://www.ohiohealth.com/services/womens-health

WomenHeart: The National Coalition for Women with Heart Disease
https://www.womenheart.org

Association for Women in Science: Fighting Gender Bias
https://awis.org/fighting-gender-bias

a month. What can we possibly do?' Couch your concerns in a way that highlights their importance and the impact on you."

In terms of follow-up, Dr. Bucher also suggests that patients review their records for their visits. "You have a right to view your medical records," she remarks. "You can review your records after the visit, and see the notes and laboratory results. Make sure you understand what's in that note. Does it confirm what you remember about the visit? Are there things that don't make sense? If so, then follow up on them. This is advice I would give to anybody to guard against that sense of not feeling heard."

"What I've learned is that you really do have to advocate for yourself," says Sullivan. "If you go to a physician or a provider, and they don't seem to listen, go to someone else. With heart health especially, if you have a symptom or you just feel something's not right, you suddenly break out in a cold sweat or have unusual back pain for example, don't dismiss it. You know when something's not right. It's your body. Nobody knows it as well as you do. Do not just say, 'Well, they said it's all in my head or it's just indigestion.' Women are so worried about going to the emergency room and being told they're fine that [*that*] can prevent them from going."

If a patient is frustrated with their care, they should know they can take steps or make other choices, says Dr. Bucher. "Trying to navigate the health care system, you always have the opportunity to try and make your voice heard. If you don't feel like your health care providers or team is advocating for you, or that you're not being heard, there are options. You can ask about patient advocate options, for example. So, there are ways to escalate these concerns. While it can feel uncomfortable in the moment, it's super important."

More generally, Dr. Eranki encourages patients to research their rights and what health services are available to them. To note, a patient advocate is someone assigned to support a patient in their health system interactions. They may accompany a patient to appointments, take notes, assist with questions, and otherwise ensure the patient's concerns are being appropriately addressed. Many hospitals and health systems have trained patient advocates available upon request.[7]

Address *All* Gender Bias

The American College of Physicians (ACP) recognizes that women's health requires proactive and empowered patient-care approaches. The 2018 ACP Position Paper, "Women's Health Policy in the United States," acknowledges that biological and social factors can lead to differences in disease expression and treatment between men and women. For this reason, the ACP encourages the medical community's ongoing consideration of the impact of sex and gender in its approach to women's health care.[8]

These considerations need to take into account every group impacted by gender bias, urges Dr. Eranki. "Gender bias in itself is already a very significant issue that affects not just cis-gendered heterosexual women but, of course, gender minorities," she notes. "I think probably some of the most disadvantaged persons among these are transgender [or] non-binary individuals. When you add racial and ethnic and socioeconomic disparities to that mix, it gets magnified significantly."

Toward a Bias-Free Future

Due to turmoil over funding of public health and research programs, uncertainty about the future of the health system is perhaps greater than ever. Yet historic efforts to advance health care equity and to improve women's health care are also ongoing and not without success.

Obviously, the medical community alone cannot solve all of these challenges. Nevertheless, health care professionals can play a valuable role in promoting greater awareness of gender bias, including the ways implicit bias and prejudicial attitudes may impair the quality of women's health care. Working together, health care teams can also do a lot to counter the negative impact of gender bias on patient care and organizational cultures.

Despite the hurdles and barriers to progress, providers must continue to work for a more equitable health care system. Women's health care advocates' expertise, dedication, and vision should be a source of hope for the eventual achievement of a health care future free of gender bias. ✦

The CE test for this article can be found on page 28.

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