CHECKLIST: A TOOLKIT FOR REFLECTION ON GENDER BIAS IN MEDICAL PRACTICE

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This checklist presents and discusses gender biases that are frequently encountered in clinical practice in primary care, across different steps of clinical reasoning (1).

Anamnesis (taking patient history)

- ☐ Are patients asked the same questions for the same complaint regardless of their gender?
- ☐ If the questions are different, is this clinically justified?

In general, equal anamnesis between women and men will be preferred, which implies **asking the same questions** for the same complaint regardless of patients' gender. A differential management (e.g., asking for menstruation in case of fatigue) must be clinically relevant.

- ☐ Did the **psychosocial anamnesis** address both the personal sphere (family relationships, living arrangements, etc...) and the professional situation?

It is important to carry out a **psychosocial anamnesis** every time an anamnesis is conducted. It provides valuable information and takes only a few minutes. We should inquire about the social context by addressing professional and personal aspects **evenly** (work, home, family relationships, leisure, etc.). A frequently encountered bias is that men are more often asked about their work situation and women about their children or domestic situation, whereas sources of stress may come from both environments regardless of patients' gender.

- ☐ Was the question of **contraception** specifically asked during the **medication history**?

Indeed, patients who take **hormonal contraception** may not consider it as a medication and may not mention it spontaneously. This is important, as hormonal contraception has side effects (e.g., headaches), it increases the risk of certain pathologies, such as thrombosis, but also because of potential drug interactions when prescribing an antibiotic for example.

- ☐ If a **sexual anamnesis** is taken, is it done in an inclusive way (are you sexually active? If yes, with women, men, or both?)
- ☐ Is the issue of contraception discussed?

When conducting a **sexual anamnesis**, to put patients at ease and minimize the risk of them experiencing certain questions as intrusive or embarrassing, it is important to explain why certain sensitive questions are being asked (clinical relevance). Furthermore, asking "do you have a partner?" or "are you in a relationship?" does not indicate if patients are sexually active (asexual persons may have affective partners). Risky sexual practices may concern anyone, regardless of sexual orientation (avoid conflation). The topic of contraception in prevention, should be discussed with all, regardless of gender.

Clinical examination

- ☐ Are men and women receiving the same clinical examination for the same complaint?
- ☐ If the clinical examination is different, is it clinically justified?
- ☐ Is there any discomfort during the clinical examination or are special precautions taken because of the patients' gender?

Performing more **intimate examinations**, such as cardiac auscultation, rectal or external genitalia examination, may cause discomfort in both patients and providers, regardless of gender. Before engaging in these procedures, providers should **explain the clinical relevance** and procedure to patients, and **oral consent** should be obtained. When providers identify that they feel discomfort in themselves, this should be an opportunity to undertake a reflection on why this particular patient-provider relationship has caused discomfort: was it due to the age, gender, religion, ethnicity, sexual orientation or another characteristic of the patient/provider? Identifying discomfort and reflecting on it may provide clues and tips for improved patient-provider relationships in the future.

Differential diagnosis

- ☐ Because of the patient's gender, has a differential diagnosis (DD) been excluded on the grounds that it is rare for that gender?
- ☐ Because of the patient's gender, should the ordering of the DD be different?

Sex/gender-specific pathologies may guide the ordering of the DDs, but one **should not exclude DDs** under the pretext that they are rare in one group.

Furthermore, the **prevalence** of some diseases **is evolving and changing.** For example, cardiovascular disease (CVD) was for a long time more prevalent in men, but for several decades the prevalence of CVD has risen sharply in women, becoming the leading cause of death. This is in part linked to changes in risk behaviours such as smoking, adopted by women as a form of emancipation.

Investigations

- ☐ In your opinion, does the patient's gender influence the choice of the additional investigations that are carried out? Are these choices clinical justified?

In the context of cardiovascular disease, studies show that women are less systematically referred for cardiovascular investigations. The reasons for this are diverse, but complaints are often overlooked due to a lack of knowledge about the prevalence of cardiovascular disease in women and sometimes atypical symptoms.

Management

- ☐ For the same pain complaint in two people of different genders, would the therapeutic response be the same?

On average, men seek consultation for complaints of **pain** less than women and have a pain threshold (i.e., triggering of a pain signal for an equivalent stimulus) that is higher than that of women. These differences have biological explanations but are also due to socially constructed aspects such as the way in which pain is expressed and tolerated differently by women and men.

The current recommendations for pain management are to administer the Visual Analogue Scale (VAS) to patients (without negotiation) and to follow the guidelines for treating them according to this assessment, with no difference across gender. The aim is to be as objective and equitable as possible and for patients to feel that their pain is taken into consideration. There is, however, a wide array of literature that shows how pain management is affected by gender bias (and other intersectional bias) (2).

Intersectionality

- ☐ Does any other characteristic of the patient such as age, origin, ethnicity, religion, socioeconomic status, sexual orientation, height or weight, ability, level of literacy, psychopathology influence how the consultation unfolds (e.g., the provider's or the patient's attitude, the patient-provider relationship) and therefore the medical care of the patient?

Gender is a social construct that must be interacted with other dimensions such as the ones outlined above. When studying gender, we have to therefore account for biological (e.g., different symptoms), as well as socioeconomic and demographic (e.g., social representations of diseases) components (3).

Glossary

"**Sex** refers to a set of biological attributes in humans and animals. It is primarily associated with physical and physiological features including chromosomes, gene expression, hormone levels and function, and reproductive/sexual anatomy. Sex is usually categorized as female or male but there is variation in the biological attributes that comprise sex and how those attributes are expressed." (4)

"**Gender** refers to the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men, and gender diverse people. It influences how people perceive themselves and each other, how they act and interact, and the distribution of power and resources in society. Gender identity is not confined to a binary (girl/woman, boy/man) nor is it static; it exists along a continuum and can change over time. There is considerable diversity in how individuals and groups understand, experience and express gender through the roles they take on, the expectations placed on them, relations with others and the complex ways that gender is institutionalized in society." (4)

Bias: Implicit associations (unconscious processes) that may influence our judgements resulting in bias. An implicit association generates a bias only when it has a negative impact on an already disadvantaged group (5).

References

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