Plain Text version of the LUNA resource on Medical Misogyny

Slide 1:

A LUNA resource on...Medical Misogyny

Exploring what it is, and how it is ingrained in all aspects of healthcare- from research, to diagnosis, and from treatment to stigma- for women's month 2020 at LUNA

Slide 2:

Medical Misogyny: Medical misogyny refers to the gender bias women face in healthcare. This can manifest in different aspects of medicine, such as research, diagnosis and treatment.

You may have head about medical misogyny in a historical context. For example, the tendency to diagnose women with "hysteria" as default.

So we DID have medical misogyny, but not anymore right? WRONG! All it takes is talking to a women or non-binary person with a chronic illness (or who is on the pill!) to know that medical misogyny is still very much part of the culture of health care.

Slide 3:

As Dr Kate Young, a public health researcher, explained the legacy of this history, in interview with Guardian Journalist Gabrielle Jackson: “For much of documented history, women have been excluded from medical and science knowledge production, so essentially we’ve ended up with a healthcare system, that has been made by men" The consequence of this is that medical misogyny is deeply embedded in every aspect of medicine and health care. In this resource we trace it through from research, to diagnosis, to treatment, and to stigma

Slide 4:

The research stage: In research examining treatments and health conditions, women are under-represented in clinical trial samples, and research projects into conditions that predominantly affect women are consistently underfunded.Less than 2.5% of publicly funded research is dedicated to reproductive health despite the fact that 1-in 3 women in the UK will suffer for a reproductive or gynaecological health problem. There is 5 times more research into erectile dysfunction, which affects 19% of men, than into premenstrual syndrome, which affects 90% of women. Endometriosis affects 1.5 million women in the UK alone yet applications for increases in funding to support research and treatment have been repeatedly ignored. Hydroxychloroquine, a rheumatology drug, was tested for effectiveness almost exclusively on men, despite rheumatic conditions being more common in women and side effects of this drug such as abnormal heart rhythms often only being present in women.

Slide 5: The Diagnosis Stage: When it comes to getting a diagnosis, medical misogyny may take the form of failing to believe/ take seriously the symptoms reported, or a diagnostic tool/test designed for men, which can lead to long waiting times to get diagnosis's, an inaccurate diagnosis. Hysteria, a Victorian era medical condition that was predominantly observed in women, was one of the most diagnosed disorders in the 18th and 19th century yet had no widely agreed upon symptoms. Hysteria narratives, albeit with slightly different terminology used, are found to still be used by doctors to fill knowledge gaps, particularly when women keep returning to the doctor because they are still experiencing pain or symptoms. Early assumptions about autism meant that research as done almost exclusively on boys, reinforcing assumptions and shaping diagnostic tools to reflect this male experience of autism. This, combined with other factors, leads to women end up being diagnosed far later in life than men. The NHS estimates that there are about 700,000 Autistic people in the UK. This is based on a 10:1 gender ratio, but research has shown it is more like 3:1, which would mean there are 200,000 undiagnosed autistic women.

Slide 6: The consequences of failing to diagnose accurately because of medical misogyny has a huge impact on mental health, and can cost women their lives. Black women are 5 times more likely to die in childbirth and 6 weeks post partum than white women (RCOG, 2020. 58% percent of women with symptoms visited their GP more than 10 times prior to getting a diagnosis of endometriosis, not to mention it takes on average 8 years to get a diagnosis! A 2000 study published in The New England Journal of Medicine found that women are seven times more likely than men to be misdiagnosed and discharged mid-heart-attack. Most often, that's because doctors fail to recognize women's symptoms, which can differ widely from men's. Women under 50 are twice as likely to die from heart attacks as men of the same age. That could be because even when women—particularly young, healthy women—experience the same symptoms as men, doctors are still more likely to dismiss them.

Slide 7: The treatment stage: Here, medical misogyny often manifests as failing to correctly recognise symptoms, or missatributing them, or dismissing them. This leads to failure to treat appropriately. Diane E. Hoffman and Anita J. Tarzian from the University of Maryland found that compared to male patients, women report more severe levels of pain, more frequent indices of pain and longer durations of pain but are treated for pain less aggressively. They also found that women are a treated more often with sedatives rather than pain relief suggesting they are perceived to be anxious rather than in pain. This failure to treat pain properly in women is not something which women experience evenly. During pregnancy Black Women are less likely to receive pain relief than white

women. They are also less likely to feel they have been understood, or spoken to with kindness. (Henderson et al, 2013)

Slide 8: When discussing medical misogyny it is important to remember that women are not a homogenous group. Someone's race, class, or sexuality has a huge impact on their experience of medical care and often result in staggering differences in the care they receive. In working to understand and put an end to medical misogyny the ways in which these factors intersect with gender must be kept central. Medical Misogyny cannot be another area where once it is at a level that works for white women, the fight stops.

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