INVITED EDITORIAL

Why should the obstetrics and gynaecology community care about sex and gender issues in health?

Over the past two decades, there has been increasing appreciation from researchers, funders, editors and healthcare professionals of the importance of understanding how sex and gender interact with health outcomes.\(^1\)\(^-\)\(^3\) In order to correctly interpret these interactions, standard terminology is necessary. The Institute of Medicine’s definition of sex and gender\(^4\) is the most widely used, where sex is ‘the classification of living things, generally as male or female according to their reproductive organs and functions assigned by chromosomal complement’ and gender is a ‘person’s self-representation as male or female, or how that person is responded to by social institutions based on the individual’s gender presentation.’

At present, there is no consensus about how to measure gender in the general population, but some existing nonbinary terms are recognised, such as ‘intersex’, where biological sex as defined by anatomic, gonadal or chromosomal characteristics is not consistent with ‘female’ or ‘male’, and ‘transgender’, where gender identity does not fit with biologic sex at birth. These terms and others are essential knowledge in obstetrics and gynaecology. A comprehensive list of such terms has recently been published in the New England Journal of Medicine,\(^5\) and a recent issue of Royal Australian and New Zealand College of Obstetricians and Gynaecologists’ O&G Magazine explores nonbinary gender issues.\(^6\)

Evidence demonstrating the importance of sex and gender in health has accumulated in recent years, particularly in the area of cardiovascular health. For example, by exploring sex and gender differences in heart disease and stroke, we now know that in acute coronary syndrome, women frequently present with symptoms such as weakness, fatigue, nausea and dyspnoea. These are different from ‘conventional’ presentations (ie the most common presenting symptoms for men), leading to delays in appropriate diagnosis and worse outcomes for women.\(^7\)

Subsequent advocacy, in large part driven by the ‘Go Red for Women’\(^8\) campaign, has aimed to dispel the myth that heart disease is an older man’s disease, raising awareness of heart disease and stroke as the number one killer of women. Greater awareness of how sex and gender impact on clinical presentation, symptoms, diagnostic and therapeutic approaches in cardiovascular disease has in turn reduced the number of early deaths from myocardial infarction in women.\(^9\) Similarly, in endocrinology, revision of the diagnostic criteria for osteoporosis to include a male-specific reference range for low bone mineral density has led to better evaluation of fracture risk in men.\(^10\)

These cases illustrate the importance of considering sex and gender differences in clinical practice.

As the ANZJOG readership is by and large mostly or entirely concerned with women’s reproductive healthcare provision, it may seem that sex and gender differences have little relevance to daily practice. In fact, sex and gender considerations are likely extremely relevant to the health of both our patients and ourselves. Below, we present key areas where considering the impact of sex and gender may have implications for training and clinical practice in obstetrics and gynaecology.

1. Education and training: the majority of obstetrics and gynaecology trainees in Australia are female (80% vs 20% male).\(^11\) The impact of this sex difference for patients and trainees is unclear. For example, might male trainees gain less experience in pelvic examination because patients prefer a female doctor?\(^12\) Male trainees in some settings report discrimination by senior clinical colleagues.\(^13\) Conversely, female trainees are much more likely than male trainees to train less than full-time and/or with interruptions for parental leave,\(^14\) and many report undermining behaviour from consultants and colleagues as a result.\(^15\) Little is known about the experiences of nonbinary trainees. Ensuring that sex and gender do not affect negatively on training male and female trainees in obstetrics and gynaecology is therefore a major, present challenge for the specialty.

2. Leadership: women are under-represented in Australia as academic leaders in obstetrics and gynaecology despite making up 80% of the training graduates each year. Only 17% of senior academics in Australia are female, and this proportion is similar in obstetrics and gynaecology.\(^16\) A systematic review of 52 studies from 13 countries on women’s choice or rejection of careers in academic medicine found that women are interested in teaching more than in research; participation in research can encourage women into academic medicine; women lack adequate mentors and role models; and women experience gender discrimination and bias.\(^17\) In physician-focused medical specialty societies, an analysis of gender equity in leadership revealed that between 2008 and 2017, presidential leadership
was held predominantly by men (82.6% of years for men vs 17.4% of years for women). In the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, there is currently only one woman on the board (2018–2021) and six men. Is this because fewer women choose academic medicine? When women do choose medicine and science, their advancement is hindered by poor access to higher education and appointments, research-funding bias, publication bias and a lack of invitation to present at top meetings. Is there a need for institutional change in order to provide solutions to these issues?

3. Research and clinical practice: obstetricians and gynaecologists care for both women and men when addressing infertility, boys and girls during delivery, and male and female fetuses during pregnancy. Additionally, whether clinical or surgical management differs by gender is currently largely unknown, and potentially has considerable patient impact. If understanding sex differences is neglected in any of these areas, we risk making the same mistakes we have seen in cardiac and other diseases, where one sex or gender is disadvantaged due to poor treatment or care.

4. Gender-diverse health: the Australian Human Rights Commission reports sexually diverse individuals may account for up to 11% of the population in Australia. Obstetricians and gynaecologists play an important role in caring for gender-diverse individuals in the following areas: (i) transgender men’s contraception and abortion; (ii) fertility preservation for young transgender adults; (iii) menopause in transgender men requesting hysterectomy and oophorectomy; (iv) reproductive endocrinology; (v) ovulation suppression; and (vi) long-term health risks from sex steroid use.

In May 2018, the authors of this editorial brought together key stakeholders to discuss how best to integrate sex and gender into health research in Australia. The outcome of this forum was a call for coordinated action (currently under review in an Australian journal) from training institutions, learned academies, governments, funders, journals and industry to address the current lack of awareness of this issue and to ensure that policy and practice within the Australian clinical and academic community is consistent with the world’s best. Integrating sex and gender into research is everyone’s business, including in obstetrics and gynaecology. To optimise health and wellbeing for our trainees, Fellows, Diplomates, and our patients, the obstetrics and gynaecology community need to know more about how these factors influence our careers and clinical practice.

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