Editor's Briefing

Nada Khan

BREAKING THE BIAS IN WOMEN'S HEALTH

In March, as I write this briefing, we mark International Women's Day. This year's theme is 'breaking the bias'; and is an opportunity to reflect on gender inequalities. Gender bias is engrained in society and indeed in health care, where a historically patriarchal infrastructure has underserved women. As the World Health Organization (WHO) notes:

'The health of women and girls is of particular concern because, in many societies, they are disadvantaged by discrimination rooted in sociocultural factors.'[1]

Disrupting our own biases is no easy task, especially if that bias is unconscious. Part of addressing knowledge-based gender bias in health care requires research, not only on female-specific issues, but also research that explicitly examines the gender differences in symptoms, diagnosis, and treatment for general health conditions.

In her editorial this month, Delanerolle writes that listening to patients is at *'the heart of change'* to develop a more equitable healthcare system. However, as noted in the recent Women's Health Strategy:

'... things are unlikely to change unless we also increase the diversity of those involved in designing research studies, and better support women in research roles.'[2]

I welcome a call to arms to our female academics and clinicians to lead the future of women's health research, but the gender disparity in top level academic jobs persists, and within our workforce the gender pay gap is surprisingly increasing.

Even after adjusting for contracted hours, female GPs earn on average 15.3% less, and female clinical academics 11.9% less than men.[3] Echoing the WHO's statement on gender discrimination, the British Medical Association highlights structural, institutional, and cultural factors at play leading to a gender pay gap. As ever, perhaps it's easier to shine a light on why these inequalities are present, but recommendations to address these factors can lack the specificity to affect real change.

In this month's Women's Health issue we are publishing editorials, research, and analysis on reproductive and general primary care health issues in women. A common thread throughout is that we don't recognise or talk enough about women's health experiences such as the Analysis article on stress urinary incontinence (Sims *et al*), the Life & Times article on menopause (Sivarajasingam), or the editorial on preconception health (Schoenaker *et al*). Understanding and increasing familiarity with our biases may be one of the best strategies to avoid them. But breaking the bias is going to need real action, and probably real reflection on our own actions, inactions, and implicit biases.

Nada Khan,
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Issue highlights

How often do we ask a woman to drop in a urine sample, but how often do we give advice about how to do this? Research in this issue looks at women's information needs around providing midstream urine samples. The inverse care law rears its head again in a study of variation in chronic care services in Danish primary care. While breast pain is a common referral symptom from primary care, in a prospective study of referrals to a diagnostic clinic, breast pain alone was not associated with breast cancer. And don't miss clinical practice for a structured approach to assessment and management of tinnitus.

REFERENCES

1. World Health Organization (WHO). Women's health. Geneva: WHO, 2022.
2. Department of Health and Social Care (DHSC). *Our vision for the Women's Health Strategy for England*. London: DHSC, 2021.
3. British Medical Association (BMA). Review of the gender pay gap in medicine. London: BMA, 2021.

Further notes from the Editor on the April 2022 issue can be found at bjgplife.com/apr22

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