Session report to Session 2: Identification of Target Audiences and Building Consensus

Chairs
Ineke Klinge (The Netherlands) and Marek Glezerman (Israel)

Active participants
Isabel De La Mata (Belgium), Astrid Golla (Germany), Ellen Kuhlmann (Germany), Radjesh Manna (The Netherlands), Virginia Miller (United States of America), Anna Szczepanska (Belgium), Anja Urbschat (Germany), Els Veenis (The Netherlands), Alan White (United Kingdom)

Rapporteur: Lucie Dalibert (The Netherlands)

Contribution of partners

Marek Glezerman opened the session by drawing attention to the centrality of day-to-day practice for the implementation of gender medicine in Europe. In fact, he invited the audience not only to think about the benefits of gender medicine for the patient-doctor relationship, but also to think about how to introduce and implement gender medicine. In this respect, he proposed a two-sided approach with a top-down dimension involving regulators, policy makers, etc. and a bottom-up – or more grass-roots-oriented – dimension involving physicians, nurses, patients, that is, everyone who enters the primary care relation. Referring to the best practice example in which German equal opportunity commissioners organise lectures, talks, discussion rounds at the local level to raise awareness about sex and gender differences in health and disease (see report session 1.2), Glezerman asserted that pressure from patients is critical for the successful implementation of gender medicine. Similarly, the press and the media in general need to be involved as they are a powerful and experienced instrument for drawing attention – and raising awareness – to the relevance and importance of gender medicine. Concerning doctors and their role for doing gender medicine, he mentioned that they are either very enthusiastic or reluctant to accept changes: there is no middle way. However, the International Society for Gender Medicine constitutes a promising platform for the implementation of sex and gender-related dimensions in European medicine. As Glezerman reinstated, many groups are dealing with sex and gender-sensitive medicine and it is important to join forces, with both a bottom-up (and grass-roots) and a top-down approach.

Ineke Klinge then asked who is our main audience? She mentioned several groups, namely NGOs (Health Centres, Health Promotion Institutes); researchers, gender and health experts, public health specialists; funding agencies; Horizon 2020 policy advisers; Patient organisations and family groups; Health education organisations; Health insurance providers; Industry and pharmacological companies; Medical societies; Ministries of Health and of Equal Opportunities in European countries; policy makers; (Scientific) Institutes for the quality of healthcare and institutes for innovation in healthcare (such as REShape innovation centre in the Netherlands); Hospital management; Alliance(s) gender and health(care); Regulatory bodies; Medical and scientific journals; the media. Els Veenis, while she was referring to the Alliance for Gender and Health in the Netherlands that aims at setting the agenda and influence the ministry of health, mentioned that everybody does not speak the same language. Therefore, how to communicate and build bridges between e.g. researchers and policy-makers? Afterwards, Ineke Klinge raised the question of whether there is or should be a hierarchy of audience(s). Are audiences different for the four working fields? She also pondered about the inclusion and exclusion dynamics of our own practices as we are setting up and developing this project: who are the included groups and are there unintentionally excluded groups? Leaving this question open, she came back to Veenis’ question concerning the different languages spoken by different fields: what kind of strategies should be developed to reach different stakeholders? How shall we ensure that all relevant stakeholders and audiences are integrated and reached? Are there appropriate tools? What
kind of strategies and tools shall we devise? As questions related to reaching effectively all stakeholders are raised, other interrogations emerge concerning the state of affairs of gender medicine and especially the need to build consensus around it. Are all the topics addressed the object of a consensus? Are there potential points of conflict and disagreement? As Ineke Klinge reasserted, although definitions and conceptualisations of sex and gender have been provided (see e.g. Gendered Innovations project: http://genderedinnovations.stanford.edu/), sex and gender are concepts that travel through different fields wherein their meaning and relevance might be different. Shall there be a consensus among all or some – and if so which – stakeholders?

Ellen Kuhlmann drew attention to the necessity of focussing on medical education to improve medicine. She also indicated that in general it is easier to change organisations and institutions than to change people: an organisational approach might therefore be more appropriate and effective. She pointed towards the ongoing changes in the organisational structure of healthcare (different levels) and healthcare systems with two examples: first of all, the management level is increasing in healthcare, and there are more doctors going into management. This clinical or medical management develops as a “gender neutral” or gender blind specialty. Yet, insofar as they are some very important decision-making bodies, it is crucial to keep an eye on these developments while implementing – and doing – gender medicine. Second of all, in terms of human resources in medical education, there is a balance between men and women. However, at the level of its organisation, the hospital remains untouched: there is a shortage of doctors, not enough flexibility of working hours, and an important drop-out of female doctors (especially when specialising). The organisation functions on a 20th-century model with 60 hours/week, masculinist values and sexism. These organisation levels also need to be looked at. We should be working towards an inclusive, participatory professionalism (e.g. hospital workforce management) and the latter as well as a gender-sensitive hospital management should be part of medical education and CDP.

Virginia Miller then offered a consensus-building tool (see section below “best practice examples”). Closing this session, while Ineke Klinge invited the participants to reflect on whether gender medicine should be a separate or mainstream(ed) discipline, Marek Glezerman drew attention to exams (sex- and gender-specific questions in students’ and residents’ exams) as powerful tools for implementing gender medicine.

Best practice examples

- Tools for building consensus

Virginia Miller invited the participants to think about whom we are talking to and discussed how, depending on our location as nurses, pharmaceutical companies, physicians, researchers from different fields, we receive messages differently. Researchers, who in general are risk takers, will receive messages differently from doctors who, generally, are not risk takers. This differential message reception is also linked to whether one is a visual or an auditory learner. In this context, to communicate new information and build consensus, Virginia Miller emphasised the necessity to make the message meaningful (from the ground up insofar as it improves outcomes with efficiency and cost savings) and proposes to adopt a tiered approach to the professional community:

- Tier 1. Scientific method providing evidence for medical practice (develop and enforce guidelines for reporting sex of research material; develop and enforce reporting of results by sex; to not do so violates a basic expectation of scientific investigation)
- Tier 2. Curriculum: embed concepts of sex and gender into all levels of professional education (graduate programs, medical programs, nursing, rehabilitation, pharmacy, Continuing Medical Education, Continuing Nursing Education, etc.)
- Tier 3. The message: make it meaningful and tailored to different learning modalities