One size fits... male?

'Man-flu' memes and the celebration of women's endurance hide the reality that the medical world routinely downplays women's pain and disease. ***Miriam Calleja*** *takes a closer look.*

We often hear that women are more tolerant to pain than men. Many are also proud of it. However, in the famous game-changing paper titled 'The Girl Who Cried Pain: A Bias Against Women In The Treatment Of Pain' the authors Diane E. Hoffman and Anita J. Tarzian found that contrary to popular belief, women report more severe levels of pain, more frequent pain, and pain that lasts longer than men's. Three Maltese women found out the hard way that confiding in medical practitioners does not always lead to help.

Culture and gender frame our behaviour around pain perception. Boys were, and some still are, told not to express pain by crying or showing emotion. Girls were told to calm down and not make a fuss. Pain meant weakness. Our language lacks the vocabulary to adequately describe pain. In 'On Being Ill', Virginia Woolf writes: 'English which can express the thoughts of Hamlet and the tragedy of Lear, has no words for the shiver and the headache... The merest schoolgirl, when she falls in love, has Shakespeare and Keats to speak for her; but let the sufferer try to describe a pain in his head to a doctor and language at once runs dry.'

GENDERING PAIN

By analysing a number of studies, Hoffman and Tarzian found that women are 'more likely to be treated less aggressively in their initial encounters with the healthcare system until they prove that they are as sick as male patients.' This is a phenomenon known as the Yentl Syndrome. In other words, doctors may brush female pain off as fabricated or exaggerated. This can impact diagnosis, disease progression, and treatment plans – delaying care and fueling mistrust.

Prescribing uterus removal when a woman was 'rebellious' may seem like ancient history, but that bias has not fully retreated. Until the early 1990s, women were mostly excluded from clinical research studies and trials in medicine. What we knew about the body, about disease, and about medicine was based on men. Drugs that didn't work on men, but might have worked on women, were discarded. With incomplete data, the medical world may have lost opportunities to improve women's health. Have today's healthcare professionals been trained to counter this gender bias?

Antonia* doubts that. As a teenager she developed digestion problems and nausea every time she ate. When she complained, her family doctor downplayed the problem and suggested that she should just stop eating for a couple weeks. After this shocking response she ignored the issue for a long time, suffering

in silence. Another doctor chalked it down to 'growing pains' and did not recommend a colonoscopy, even though Antonia asked for it.

Having received no satisfying response from her visits to medical professions, Antonia decided to do her own research, discovering that her symptoms matched the description of a condition called Crohn's. Because of her constant discomfort and pain Antonia had no choice but to persist until she was granted testing and the correct treatment after years of suffering. This means that two doctors would have left her inflamed digestive system untreated, risking further damage.

'IT IS JUST A PHASE'

Women are often told that their ailments are due to stress or other emotional factors. A little rest would solve the problem; it is just a 'phase'. Some doctors would call a woman insisting on referral for further testing a hypochondriac, even in the presence of positive clinical tests (see e.g. Samulowitz et al. 2018 study and numerous articles in the *New York Times*, *The Atlantic* and elsewhere). Thankfully, there are enough doctors who look beyond textbook-like symptoms. They make it a point to listen and investigate as much as necessary. Yet the burden of finding a practitioner ready to listen lies with the patient.

Karen visited her gynaecologist complaining of headaches and substantial weight gain. Test results revealed a high prolactin level, which is normally produced during pregnancy or right after giving birth. Yet when Karen asked to be referred for an MRI to investigate for tumours in the pituitary gland, the doctor refused, telling her that she was 'making a fuss'. Another doctor later referred Karen for an MRI, and the tumour was detected – a life or death analysis.

Gynaecologists feature often when discussing gender bias. Without systematic training to counter biases, women are left to 'shop around' for a gynae that doesn't shame them or belittle their wishes. This is surprising for a profession specialising in women's health.

Reproductive issues open another can of worms. Some women who decide not to have children are treated as though they don't know what they're doing. Their doctors imply that the patient will inevitably change their mind, or try to guilt the patient into considering the feelings of a hypothetical man they might meet.

You would think that commitment to bear biological children would be respected, but women who undergo IVF are often treated with insensitivity too. Sandra* and her husband had a harrowing story to tell me. Sandra's gynaecologist decided to immediately hurry her to IVF after the first visit about their concerns at not being able to conceive. The gynaecologist was rarely present for her many

appointments at hospital, leaving Sandra to be passed from one doctor to another, internally examined by various doctors without explanation or prior request for consent. With the exception of one doctor, none of them introduced themselves. All along she tried to ask questions, but was kept in the dark about the situation, going along with the doctors' instructions but losing trust. The outcome of the first procedure was unsuccessful, and because of how traumatising all this felt, the couple decided not to try again.

UNLEARNING THE BIAS

Pain is subjective and difficult to measure. An individual's tolerance to pain is affected by various factors, and pain perception may change with time and experience. Pain causes distress, which makes it difficult to measure objectively. So how can overworked doctors make the best possible assessment?

In her thesis titled 'The Chronic Pain Management Service: Awareness and Perceptions Among Healthcare Professionals' (University of Malta, 2008), Maria Campbell studied pain perception in other healthcare professions in Malta back in 2008, finding out that outdated attitudes have not been challenged. She writes, 'Incomplete knowledge, outdated attitudes, myths, and misconceptions about pain and its management contribute to unsafe, inadequate, and inappropriate pain management.' Medical practitioners wanted to be more up-to-date: 'The need for information in the form of leaflets, seminars, and continuing education was echoed in the overall answers (90%) of the close-ended question and in the statements declared by participants.' But before this training becomes systemic, the radical act of listening to women is a good place to start.

** Name has been changed*

Further reading:

Fassler, J. 'How Doctors Take Women's Pain Less Seriously'. The Atlantic. October 2015. Accessed at: https://www.theatlantic.com/health/archive/2015/10/emergency-room-wait-times-sexism/410515/

Hoffman D.E., Tarzian, A.J. 'The Girl Who Cried Pain: A Bias Against Women In The Treatment Of Pain'. Journal of Law, Medicine & Ethics, Vol. 29, pp. 13-27, 2001. Accessed at: https://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=1144&context=fac_pubs

Campbell, M. 'The Chronic Pain Management Service: Awareness and Perceptions Among Healthcare Professionals.' University of Malta. June 2008.