Sex and gender in family medicine in Portugal

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If you put the word sex in the title of a medical article, it has a much better chance of being downloaded and read.[1] While this may be have influenced the choice of the title of this editorial, there are other purposes here. Sex, sexuality, and gender have far-reaching implications for health and disease. It is worth reflecting on this to see how they may affect our clinical work, our teaching, and our research.

The inspiration for this article comes from recent experience with second-year medical students at the University of Minho in a medical sociology course called Family, Society and Health. While our students learn reproductive anatomy and physiology in the early years, and something about sexual dysfunction in their clinical rotations in psychiatry and gynaecology in later years, there is little attention to the meanings of sex and gender for health in other parts of their training. We need to correct this shortcoming.

To clarify our terms, sex *(sexo)* is what we do and gender *(género)* is who we are (male or female). The term sexuality refers to knowledge, attitudes, and practices that make up the sexual aspects of our nature.

Many important questions arise in relation to sex, gender and health. Why is there a higher prevalence of heart disease in men and of lupus in women? Why do Portuguese women have a longer life expectancy at birth (83 years) than men (77 years)?[2] Why do doctors show a bias in diagnosis of heart disease when men and women of the same age present with chest pain?[3] Why have we medicalized so many of the normal aspects of the human life cycle, especially for women, such as puberty, pre-conception, pregnancy, childbirth, menopause and the post menopausal period?[4] How do society's attitudes to beauty and fashion affect procedures such as cosmetic surgery and diseases such as anorexia nervosa?[5] All these questions require an examination of our knowledge, attitudes and practices related to sex and gender.

One effective way of doing this with our students is the screening of Patricia Cardoso's excellent film *Real Women Have Curves*. This is a sensitive look at issues as diverse as the effect of the fashion industry on body image, adolescent sexuality, contraception, virginity, fertility, and menopause. Issues are presented with humour and biting realism. The reader is referred to the article by Ibanez, which explores the use of this film in teaching medical students.[6] Viewing the film may provoke consideration of how doctors' attitudes to these issues affect what happens with their patients.

We are faced with issues of sexuality daily in the primary care clinic. Patients often use a ticket of admission to gain access to the doctor by presenting a symptom as a proxy for the real concern. Men and women with back pain, anxiety, or depression may really want to discuss sexual dysfunction or the breakdown of a relationship. It takes skill and sensitivity to ask the "anything else?" questions that can lead the clinical discussion to the right path. The diagnosis of sexually transmitted diseases also requires sensitive inquiry about partners and practices. Requests for lifestyle drugs (the use of sildenafil for the enhancement of performance in the absence of dysfunction, for example) also require clarification of the doctor's values regarding prescription on demand. How do we train our students to respond to these issues? Miller et al. have defined the content areas sex and gender health issues and successful strategies to teach them in medical curricula.[7]

The medicalization of everyday life has been explored in previous editorials on quaternary prevention and disease mongering. Michael Weingarten has made the deliberately provocative statement that: "By virtue of being female, the body seems to require constant (pharmacological) help even when healthy."[8] When we prescribe folic acid to all women before conception and give iron to all pregnant women, we are medicalizing healthy people. When we favour prescription-only

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contraception, we are medicalizing sex. When we push hormonal replacement therapy at the menopause, we risk medicalizing another normal life transition. Is the mass prescription of calcium, vitamin D and bisphosphonates or the ordering of densitometry testing in the post-menopausal period really of benefit to healthy women or are other interests being served? These are gender issues that require clarification.

Gender also influences the medical profession. In many societies, women are paid less than men for the same work. "Feminine" professions may be paid less than "masculine" ones. The feminization of specialties such as family medicine, paediatrics and psychiatry is viewed with alarm by some who see this as a step to further "devaluing" these professions, when compared to other medical and surgical specialities. These issues need to be addressed out loud. Our professional associations have a role to play in assuring that there is no "glass ceiling" blocking advancement and that equality of opportunity exists for all.

Sex and gender have profound influences on our health and on the ways we practice medicine. We look forward to contributions from our readers that explore this fascinating and enriching aspect of our lives.

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CONFLICT OF INTEREST

None reported

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