

Sex, Gender and Health

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Sex, Gender and Health

Developments in Research

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ABSTRACT The feminist movement was from its start in the 19th century involved in the struggle for better health care for women. The first feminists aimed at better information on birth control and sexuality. The second feminist wave focused on the unequal division of power roles between men and women. A lot of the problems women experienced could be seen as a consequence of their subordinate role in society. At the end of the 1980s and in the 1990s, the discipline women and health or women and medicine was developed. In this introduction to the theme, the developments in this discipline are described. The starting points of the new discipline followed the principles of 'women's health care'. These principles can be summarized as the emphasis on control and autonomy by the patient, demedicalization, the importance of the psychosocial context of complaints, empowerment of women and good information and communication. The central issue of the article is: what is the actual scientific state of the art and what important changes have been made on the subject gender and health? The article ends with ideas for future research.

KEY WORDS biology ♦ developments in research ♦ diversity ♦ doctor m/f ♦ gender in medicine ♦ gender mainstreaming ♦ reproduction ♦ women's health

INTRODUCTION

Right from the very start of the women's liberation movement, efforts to achieve better health for women and better access to health care have formed important goals. Justly so, because pregnancy and childbirth held a high risk of mortality, a risk that still applies in the same magnitude to women in the developing countries.

Aletta Jacobs, the first woman to become a doctor in the Netherlands in the late 19th century, emphasized the importance of effective and safe contraception for women. She subsequently introduced and distributed

the contraceptive pessary to Dutch women. Her attention focused on issues to improve health in relation to reproduction and sexuality, such as the dangers of venereal diseases, the trade in women and girls and the abysmal living and working conditions of prostitutes.

The second women's liberation movement took place at the end of the 1960s and was chiefly characterized by protests against the existing division of roles between men and women – women had the inferior role. Women's dissatisfaction and complaints should not be perceived as personal shortcomings, but as a result of the social injustice between men and women. Problems that arose from the weak position of women in society, such as the housewife syndrome, domestic violence and sexual abuse, drew increasing attention.

Another important theme in women's liberation was the right of self-determination, i.e. the right to choose to have an abortion. The perception of wrongful medical interference with the female body formed a central issue. This theme later expanded within health care into the notion of autonomy, authority over one's own life, issues that were also valid and particularly important at times when decisions had to be made about illness and health.

In the practice of health care in the same period, people felt ill informed about diseases in women and an urgent need arose for knowledge with a solid scientific foundation. Thus, at the end of the 1980s, a new scientific discipline was formed at universities under the heading of Women and Health, or Women's Health Studies.

In an earlier study, I described the development of women's health studies from this historical perspective and put forward a number of important starting points for further research (Lagro-Janssen, 1999):

- Gender blindness within medical science had resulted in a gender-specific lack of insight, because most of the existing knowledge about illness and health was based on the male figure as prototype for the human body;
- The operative concept of illness needed to be redefined as a biomedical concept that acquires meaning in the context of individual lives and social circumstances;
- Women's own perceptions and observations must receive greater incorporation into research.

These starting points largely conform with the principles of women's health care practice and can be summarized as the importance of authority and autonomy of the patient; demedicalization; incorporation of the psychosocial context into the complaint; standing up for one's own opinions and strengths; and laying emphasis on good information and patient education (Lagro-Janssen and Noordenbos, 1997).

The question arises as to whether the aforementioned starting points have indeed been put into effect in research, or whether other developments have

led to alternative paradigms. These points led to the formulation of the central question in this article: What is the present scientific status in the field of gender and health? Or more specifically, what important changes have taken place in the perception of women's health and health care?

It is my emphatic purpose not to aim for completeness in this article. I conclude with recommendations for further research.

GENDER BEYOND REPRODUCTION

That there are differences between men and women with regard to reproduction was and is clear. Divergences between the sexes were therefore easily explained by anatomical and hormonal contrasts between men and women. Even today, the specific sex-related issues in reproductive function, such as pregnancy, infertility, contraception, menstrual problems and prostate disorders, receive the most attention in social debates and within the medical profession. If people step outside this domain of differences between the sexes, then the subject mostly turns to conflicts in communication in the style of Venus and Mars, in which, astonishingly, biological evolutionary determinism (i.e. such is the female or male predisposition) is not shunned.

However, there is growing realization that the biological differences between the sexes go beyond the reproductive functions alone. A steadily increasing body of evidence has revealed disparities in incidence, complaint presentation, symptoms and prognosis in many other health problems, such as HIV/AIDS, sexually transmitted diseases, cardiovascular diseases and auto-immune disorders. Attention has been drawn to subjects such as gender and the human genome, in which the rapid progress in molecular biology has led to the discovery of a genetic and molecular basis for gender-related differences in diseases. Some are linked to the XX (female) or the XY (male) chromosome. It is not solely about the differences between the sex hormones XX and XY, but within the differences, there is also activity towards the other chromosomes and their characteristics and functions. During the course of life, the genetic information in the sex chromosome can be expressed differently between men and women, owing to a wide range of environmental factors. These genetic differences between the sexes influence other levels of human biological functioning on cell, organ and organism levels and thus also lead to differences in sensitivity and susceptibility to diseases between the sexes. Differences between the sexes can also be expressed non-uniformly in other biological phases of life, while certain factors, such as hormonal differences, can contribute to deviations in the development and course of diseases between men and women (Wizemann and Pardue, 2001). Research has revealed a number of examples: polymyalgia rheumatica (rheumatism of the muscles), chronic obstructive pulmonary disease, migraine,

fatigue, inflammatory intestinal diseases, schizophrenia, ADHD, atrial fibrillation and angina pectoris. In addition, the relationship between the hormonal cycle in women and the chance that a treatment will be successful is of importance: for example, does the timing of surgery within the menstrual cycle influence the prognosis of breast cancer? The differences in presentation form, disease course and complications between men and women mean that any preventive measures, diagnostic procedures and treatments should also be different.

In the light of the biological differences, the debate 'mind vs brain' is of importance. The debate is conducted with fervour by neuroscientists, some of whom believe that the discipline of psychology has had its day. All the emotions and behaviours of people can be demonstrated in the brain or can be expected to in the future, so little will remain for the mind, the domain of psychology. The hallmark of this debate is also that the mind and brain should not be viewed as opposites, not as dualistic, but instead presented as a monistic concept of all-explanatory unity. This unity concept arises within the notion of biopsychosocial, in which bio comes first and the psychosocial domain is incorporated into the biological domain. In this way, the psychosocial domain loses its relative independence as a scientific domain. Aspects of nature are dominant, whereas aspects of nurture become invisible. In the present treatment of disorders, the biological construction is clearly predominant – take for example the pharmacological treatment of depression and ADHD, whereas the social construction has been disposed of – take for example the disappearance of sociocultural education, district help and community work.

The debate naturally does not ignore the issue of differences between men and women. In this sense, *brain* leads to biological anchoring of differences between the sexes in the cerebrum and makes everything that has to do with gender disappear into the background.

In my opinion, however, the perception of biological irreversibility is incorrect, because a biological organism such as the human body is an open system that is influenced by environmental and evolutionary factors. Genes and sex hormones can never be the only explanations for differences between the sexes. A variety of genetic, hormonal, physiological and other factors are active at different times during the development of an organism and together they form a male or female individual. The dominant concept of evolutionary-biological cognition makes contextual factors such as individual development, social circumstances and culture subordinate to biological evolution, and considers these factors to be a function of evolution: psychology is transforming into neuroscience and sociology into bioscience.

In an earlier work, I pointed to the importance of interdisciplinarity in this context, in which neuroscientists need to be encouraged to perform research into differences between the sexes on the level of the brain and

cerebral functions, but preferably embedded in an interdisciplinary manner in other relevant social and human sciences (Lagro-Janssen, 1997).

In conclusion, the current course needs to be carefully steered towards taking research beyond the reproductive boundaries alone and focusing on women's health throughout their lives. Biological differences as possible explanations for differences in risk factors or the course of diseases between men and women that rise above the observation that the sexes are just different by nature, are gradually receiving more attention. Furthermore, it is of more importance than ever to criticize the scientifically dominant concept of the purely biological primate as an explanation for diseases within gender studies and within the daily practice of care provision.

ABOUT WOMEN, MEN, SEX AND GENDER

One of the most important differences in health between the sexes is the shorter life expectancy of men, particularly the high susceptibility of young men to cardiovascular disease and lung cancer. In addition, the high mortality rates as a result of alcohol abuse, traffic accidents, drug abuse and suicides in male adolescents and the increase in acts of violence and criminality in boys have focused the attention of society on health risks in boys and men that cannot be explained solely on the basis of higher testosterone levels. Traditional role patterns and social views about manhood lead to risk behaviour, such as postponement of consulting a doctor, or keeping silent about emotional collapse in the case of potentially catastrophic diseases, such as cancer (Courtenay, 2000; Mansfield et al., 2003). These aspects can have diverse unfavourable effects on men's health.

Now that men are focusing attention on the disadvantages of being male in terms of health, the danger arises that there will be a competition for public interest and sympathy between men and women: who is the worst off? The distinction that has been made between the notions sex and gender for the past 40–50 years therefore becomes important in the discussions. Sex refers to biological distinction between men and women, while gender refers to the social and cultural impact of being male or female and to behaviour, expectations and perceptions that are regarded as appropriate to men or women in a certain culture or society. Gender therefore implies men and women (Doyal, 2001).

Within sex-specific health care practice, awareness of differences in socialization between the sexes and genders has held a central position for some time. Masculinity as a vulnerable factor in the health of men and the consequences of masculinity and femininity, i.e. gender, also in the health of women, are considered to be important, but have seldom formed the subject of scientific research or scientific reflection (van Oosten and van der Vlugt, 2002).

This is gradually changing: research into specific problems in men and the relationship between these health problems and gender identity and the behaviour of men and women in society has started to emerge and has also claimed a distinct position in the scientific discourse (Moynihan, 1998). One of the hypotheses is, for example, that masculinity in our culture is perceived and defined in a way that is dangerous to the health of many men. By means of the same scripts of masculinity, many women will also experience simultaneous harm to their health.

Men's problems not only have firm roots in science, but also in health care. In health care practice, separate outpatient clinics for men's problems have been shooting up like mushrooms over the past few years. The spirit of the age facilitates. The present conservative-liberal government policy encourages commercialization and private initiatives and is supported by the aim to improve quality by means of competition and freedom of choice for the patient. The cry for demand-orientated care from the perspective of autonomy, consciousness and well-informed clients fits seamlessly. The pharmacological industry is playing its own role. In the past, it invested heavily in scientific research into menopausal complaints performed by gynaecologists and became involved with menopause consultants and gynaecological menopause clinics (Lagro-Janssen et al., 2003). Urological men's outpatient clinics followed. These focused chiefly on male-related micturition disorders, prostate complaints and erectile dysfunction. Potentially, there is a gigantic sales market to be won in elderly men and women. However, something that is missing from the categorical approach to everyday health problems is placing the complaints within a psychosocial context and consequently, establishing integral general practice management. Each complaint will be presented and dealt with as an isolated and independent phenomenon.

In conclusion, research has further evolved from women's health problems to gender in relation with health and now explicitly includes men and the social construction of masculinity. More attention has been drawn to men and everyday diseases. Not all this attention has led to direct improvements in the quality of care. In gender studies and adequate care provision, it is important to place these complaints into a psychosocial context as well.

THE DOCTOR M/F

The doctor of the future is a woman. More than 60 percent of first year medical students in 2006 are female and women are being recruited in all medical specialties; in some areas quite rapidly (Noordenbos, 1992). The increase in women within the medical profession has resulted in increased research into differences in communication between male and female doctors and in differences in approach and management. In

addition, differences in other professional aspects, such as teamwork/cooperation and practice organization, have started to receive attention. The differences in career prospects between men and women, the glass ceiling, are visible in the extremely low number of female medical professors in the medical specialties and general practice. The position of female doctors has also become the subject of research over the past few years.

Attention to the gender of the care provider is of great importance, because, for example, in the implementation of sex and gender in medical training or in daily health care practice, it is far more often the female doctors who recognize the relevance of considering the issue of being male or female in patients and in their own medical profession (Risberg, 2004). Male doctors, and especially those in the surgical specialties, relate professionalism to neutrality and value the notion of neutrality as being part of their competence. Professionalism therefore stands for performing the duties according to guidelines and protocols that are regarded as objective and universal. The application of these duties takes place neutrally without the issue of being male or female having anything to do with it (Beagan, 2000). Female doctors in policy-making positions are therefore indispensable, in order to carry out and give form to the importance of gender within the medical profession.

Involvement of the issue of being a man or woman as care provider in studies on the relationship between gender and health does justice to one of the basic principles of women's health care, namely that knowing one's own sex-specific socialization, course of life and context is important to the recognition and acknowledgement of sex-specific vulnerabilities in patients.

GENDER, CULTURE AND DIVERSITY

Insight into cultural differences and other perceptions of disease in immigrant patients is necessary to provide adequate care. Every doctor should take the cultural context of the patient into consideration and according to research, immigrant patients expect the doctor to consider their cultural background (Harmsen, 2003). This means extra effort on the part of the doctor. At an average general practice in a so-called multiple-deprivation neighbourhood or focus district in a large city, over half of the patients often comprise immigrants from more than 30–40 different countries. It is only fairly recently that empirical research has been conducted into the impact of cultural differences on daily medical practice. Scientific research into ethnic and cultural differences in disease and health remains scarce in relation to the size of the problem (Harmsen and Bruijnzeels, 2005). An important finding was that immigrant patients had a poorer view of care than indigenous patients; particularly the anticipatory policy did not conform with the management in their country of origin where medication is often prescribed quickly and in many different types, especially antibiotics.

In a study on the perceptions of Turkish and Moroccan women with urinary incontinence, one of the respondents spoke scornfully of her general practitioner as 'doctor normal part', which meant that in her opinion, the GP all too often explained the complaints as just being a normal part of a complaint, disorder or condition (van den Muijsenbergh and Lagro-Janssen, 2006). For reasons that include poor communication and unfamiliarity with other views about disease, these people often feel that they are not being taken seriously. Every culture has its own conceptions about sickness and health (Helman, 1994; Kleinman, 1980). More immigrant patients than indigenous patients were found to have poor mutual understanding with their GP (33 percent and 13 percent, respectively). From the perspective of the GP, immigrant patients create a high workload through frequent visits to the surgery, often outside normal hours, as well as through perceived vague and improper requests for care. Moreover, this often happens in neighbourhoods in which owing to a low socioeconomic status, the workload has always been very high. Care provision to other cultures will not follow a problem-free course and be of adequate quality of its own accord. The medical practitioner will have to develop knowledge on ethnic and cultural differences, including expertise in communication and interaction with patients from other cultures. This means that in the same way as gender, the doctor will have to reflect on his/her own cultural views and norms.

It has become increasingly clear that certain dimensions, such as gender and culture, do not operate independently. Particularly in other cultures, sex and gender can have their own specific meaning. Differences should not be considered as separate entities and moreover, there are other differences between patients, e.g. age, education level, socioeconomic status, lifestyle and sexual preferences. Thus we arrive at the notion of diversity. This transition from sex into diversity has arisen under the influence of various factors, including the target of client-orientation, market influence and care on demand. In this context, the notion of diversity is also used as a strategic argument.

In daily health care practice, the problems of immigrant patients in relation to all the aforementioned diversity aspects are the most tangible. Owing to the increase in size of this patient group, they are also visibly urgent to the care provider. Moreover, there are obvious indications that medical care for them is sometimes inadequate. Particularly in the field of reproduction (traditionally the territory of women's health care), a great deal of improvement is possible in immigrant women in view of the high numbers of teenage pregnancies, unwanted pregnancies, abortions and the high maternal and perinatal mortality rates. The danger of broadening gender into diversity is that first, gender will fade away in favour of ethnic-cultural differences. But, even more important is that the notion of diversity is separated from its original development and becomes solely a synonym for an individual-targeted approach and for the individual

differences that have always existed between men and women. A number of medical psychologists – of all people – who are occupied with doctor–patient communication are invoking the uniqueness of each individual to stigmatize knowledge on gender and cultural differences as stereotyping. The subsequent step within this notion is that an open approach is sufficient to achieve adequate care provision. Even though an open approach is a necessary condition in good health care, it is certainly not enough, because the danger arises that broadening the notion into diversity will lead contradictorily to dilution: the need for separate attention in knowledge, expertise and attitude to aspects of gender and culture on a group level will be enfeebled and disappear into the dustbin.

To summarize, over the past few years, the notion of gender has made room for diversity. This means that better shape can be given to criticism of two of the basic principles employed in medical care: neutrality (medicine is about people and not about men and women) and universality (something that applies to one also applies to all the others).

The drawback to such a high level of individuality thinking is that far-reaching knowledge and consequently scientific domains within research and education are no longer of concern.

GENDER MAINSTREAMING

The same shift occurred in government policy. Initially, the focus was to remove the discrimination against women in, for example, equal accessibility to health care as described in the UN Women's Treaty. This treaty was ratified in the Netherlands in 1991. In the 1990s, criticism arose about this strictly woman-centred orientation that also viewed women as victims. In practice, it soon became clear that very little had ensued from the recommendations. Attention therefore turned to the (im)balance between men and women in society, while the orientation veered towards gender relations. As a policy strategy, gender mainstreaming was introduced internationally and nationally (UN, 2002). People regarded the gender perspective within health care policy as a necessary step towards better care for men and women (Doyal, 2000). This notion was also supported in the Netherlands. In 1999, a report was published by a steering committee instituted by Minister Borst under the title 'Towards a Sex-Specific and Multicultural Health Care Service in the 21st Century' (Stuurgroep Vrouwenhulpverlening Ministerie van VWS, 1999). One of the goals was to create sex-specific health care in medical training, because integration of the factor of sex into the basic training is a precondition for good sex-specific health care in the future. On the one hand, sex-specific elements needed to be included in medical training curricula and would also need to be revised as necessary, while on the other hand, medical students would also need to receive education on differences in illness and

health between males and females. And so it happened. Medical curricula were revised in the Outline Plan 2001 and Women's Studies Medical Sciences in Nijmegen started an ambitious national project financed by Care Research The Netherlands to integrate sex into medical training at all medical faculties in the Netherlands (Verdonk et al., 2005). Another goal took shape in the project on gender diversity and quality policy at care centres, in which the University of Maastricht made a start with mainstreaming diversity in the quality policy by making officials aware of the importance of diversity to achieve a better policy. Furthermore, at the University of Amsterdam, standards and guidelines for physicians were analysed for gender blindness and methods were devised to incorporate the aspects of sex and gender into new guidelines right from the outset.

To sum up, over the past few years, a number of initiatives to implement sex/gender/diversity in health care practice have received attention and been backed by the government. The drawback is that a great deal of energy is being put into thematic applications of knowledge and into studying strategic implementation methods, which is having a detrimental effect on scientific innovative research.

FUTURE RESEARCH

At present, it is women who come into the most contact with the health care service, are prescribed the most medication and provide the most care for the health of their families and relations. In addition, for women, reproduction involves risks. Therefore, it continues to be important to strive for high quality reproductive health care that is easily accessible to everyone. This has been accomplished in the rich western countries for the majority of women. However, over the past few years, not only immigration and refugee problems, but also wider marginalization of people in our society, have served as reminders of the unequal risks of morbidity for example to mother and child during pregnancy and childbirth. Research should therefore focus more sharply on the conditions that threaten reproduction, preferably in the context of social reality, such as lack of knowledge, poverty, depression and violence during pregnancy and in consideration of individual life histories. The woman's voice needs to be heard in these matters.

Reproductive health will only partly dictate the research agenda. We have seen that studies on differences between the sexes revealed interesting insights into biological mechanisms. Being a man or a woman is an important basic variable that must be included in the set-up and analysis of fundamental medical scientific research and studies performed in clinical settings. For this purpose, an innovative approach to design, methods and measurement instruments, etc. may form a prerequisite. Moreover, we would recommend that when reporting the results and publishing articles, the differences between men and women should be recorded

as accurately as possible. Part of this comprises explicit attention to the hormonal status of the women, such as the phase of the menstrual cycle, premenopausal or postmenopausal, when setting up the study and analysing the results. Furthermore, it is of great importance to conduct research into differences between the sexes in the presentation of complaints, perceived meaning, course and complications and the effects of treating disorders on the daily medical care of men and women. Chronic diseases should be given priority in studies on differences in, for example, co-morbidity and preventive measures between the sexes (Pinn, 2003). Inordinate focus on implementation research will undermine the appraisal of new patient-related and disease-related knowledge; so much still remains unknown and unexplored. If all future research into illness and health were to include the factors sex and gender in a consistent, accurate and critical manner in the set-up and analysis, then a wealth of information would be acquired in the knowledge domain of medical science (and associated disciplines). These differences between men and women, in the broadest possible sense, must more strongly determine future research in the field of women's studies medical sciences.

Finally, I would once again argue strongly in favour of interdisciplinary cooperation in fundamental medical research, epidemiology, the social sciences and clinical research. Over the past few years, a little of this has indeed become visible at symposia and in public debates, but in scientific research, interdisciplinarity remains sparse.

Ultimately, men and women will experience health benefits from a sex-specific approach that is based on knowledge on the role of sex and the influence of gender in health problems.

NOTE

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