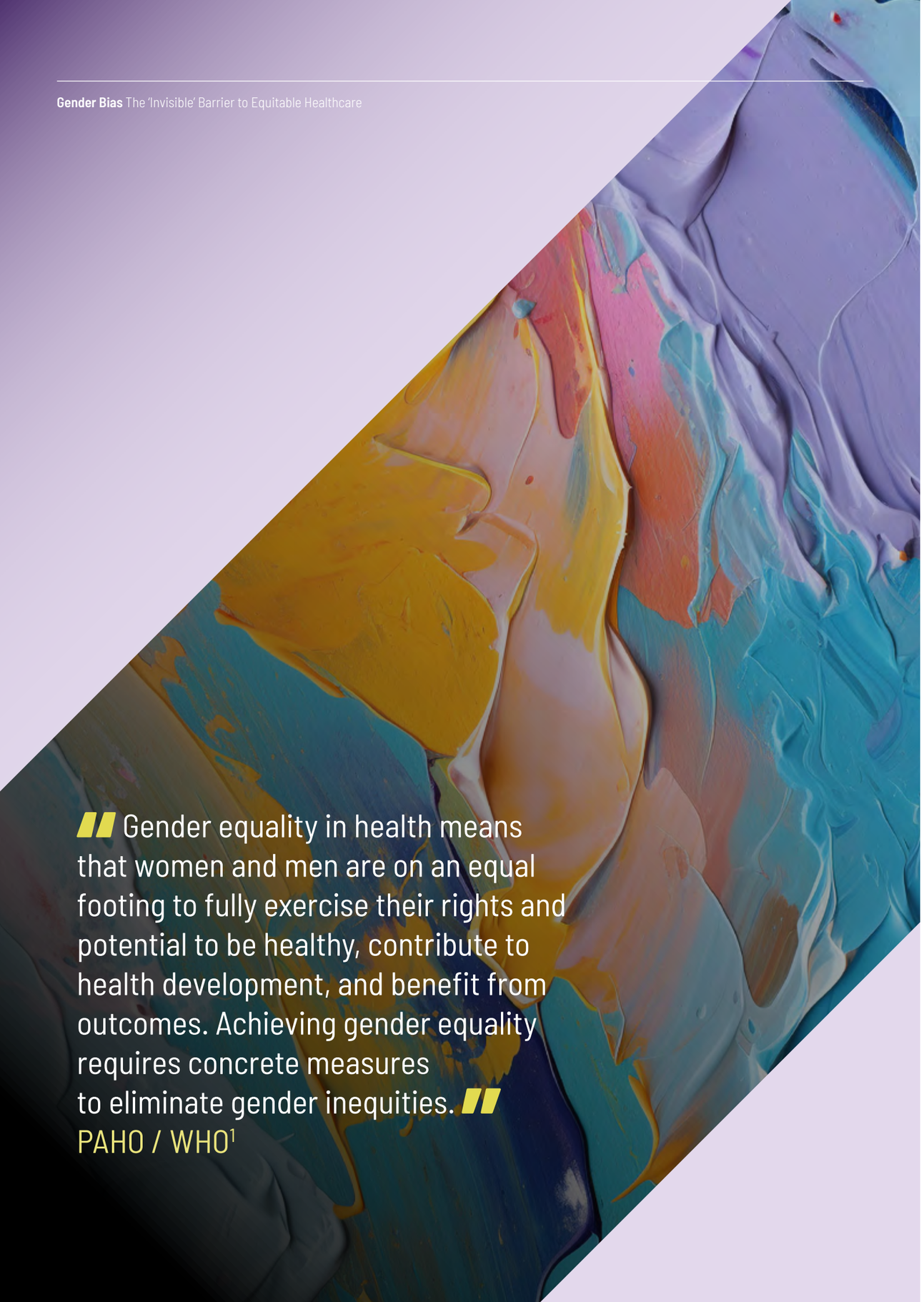
GENDER BIAS:

The 'Invisible' Barrier to Equitable Healthcare

The role of cultural and societal gender bias on the delivery, and experience, of oncology care in the UK

Ipsos



"Gender equality in health means that women and men are on an equal footing to fully exercise their rights and potential to be healthy, contribute to health development, and benefit from outcomes. Achieving gender equality requires concrete measures to eliminate gender inequities."
PAHO / WHO[1]

Gender Bias The 'Invisible' Barrier to Equitable Healthcare

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Note
For the purpose of this paper, 'gender' refers to those who identify with a gender that aligns with their sex assigned at birth. The term 'male' refers to cis-gender males and 'female' refers to cis-gender females. Whilst this paper focuses on gender, we recognise the challenges we have identified are all likely exacerbated by how far away from the 'norm' of white and male you are.

Healthcare within the UK is NOT equal across genders, nor is it equitable

The female health gap in the UK is the largest in the G20.[2] The NHS recognises these inequities and has set itself the goal to address the known inequities in care delivery for the past 10 years. However, as an institution, they are still struggling to achieve these goals.[3,4]

For care to be equitable it must be person-centred

"Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care... Often, health care does 'to' or 'for' people rather than 'with' them"
The Health Foundation.[5]

Person-centric care requires strong communication and relationship building skills, grounded in empathy.

If current care is inequitable, it follows that person-centred care is failing to be delivered. Why does this matter?

Because how care is delivered can directly impact health outcomes

A study conducted by UCLA health provides evidence for this fact.[6] They found significantly lower mortality and hospital readmissions rates amongst patients treated by female physicians compared with patients treated by male physicians. The nature of the treatment itself did not differ. Instead, they hypothesised it was the nature of how care was delivered that was likely to be the cause of the differing outcomes.

In this paper, we argue that deeply rooted cultural and social gender biases act as a barrier to the delivery of person-centric, equitable oncology care in the UK

Inspired by a number of sources (Ipsos included, Hysterical Health)[7] which have drawn attention to the cultural and social gender biases that negatively impact the health care experienced by female patients in the UK, we aimed to develop a holistic view of the healthcare system in order to understand the role of gender bias in the delivery of oncology care.

"As oncologists, we were taught to emphasise, not sympathise. The sympathy is left to the nurse."
Male Oncologist

To achieve this, we conducted a program of research* including:

- Key Opinion Leader (KOL) interviews (n=7) with influential professionals in oncology, aiming to identify current challenges in the sector
- Qualitative interviews with oncology patients (n=14) and physicians (n=17) to identify differences in the cis-gender male and female patient experience, considering both the patient and physician perspective
- An online quantitative survey with patients (n=91) and physicians (n=93) to validate findings from the qualitative phase

*For more detail on the sample, please see the technical note at the end of the document

Through this research we gained an overview of the systemic challenges of the UK healthcare system which we reference in this paper, however the focus here is the outcomes of operating within this system: the delivery of care and patient experience. Specifically, a) the provision of person-centric oncology care and b) the lived experience of this care amongst both male and female patients. Asking the question, 'Is oncology health care in the UK being delivered based on individual patient needs, or does the gender of those involved - physician and/or patient - influence how care is delivered, and therefore received?'

In our research, we observed a gendered view of 'pastoral care' responsibilities

Before we explore this topic further it's important to recognise that no matter how care is being delivered by physicians currently, it is undoubtedly done so with the best intentions. Testament to this fact is that 84% of physicians agree, 'Practicing person-centred care has the potential to have a direct positive impact on clinical outcomes' and 89% of all physicians believe that providing emotional support to patients is a key part of their role.

However, approximately half of our physicians cite lack of time in consultations as the main limitation to delivering person-centric care: 47% agree with the statement, 'I do not have time to practice person-centred care' and 46% disagree that they, 'Have time to provide patients with emotional support during consultations'. Yet, we know from reviewing current literature and conducting this research that time is not the only driver of poor delivery of person-centred care.[8]

Both male and female physicians rely on specialist cancer nurses to manage what can be perceived as the more pastoral elements of patient care. In fact, 80% of all physicians agree that the role of the cancer nurse is to provide emotional support to the patient. It is important to recognise that specialist cancer nurses in the UK are 96% female.[9,10] This reflects an enduring historic gender norm that stereotypes females as being better suited to roles which require delivering pastoral care and, therefore, vocations such as nursing.

This historical gender norm that stereotypes females as 'carers' and 'better with emotions' affects how physicians deliver care

"There's a difference in communication style between men and women. Some patients I know have definitely asked for a transfer from a male colleague to a female colleague because of communication, perhaps a feeling of less empathy from a male. One of the things I've heard a few times from male oncologists themselves is that there is quite a clear separate role between them and the nurses. That the nurse would be very much... empathetic in dealing with the emotional support, whereas they saw their role as being rational, data-driven, decision making"
Female Oncologist

"Oncology is about making treatment decisions that are data-driven and unbiased"
Male Oncologist

80%

of all physicians agree that the role of the cancer nurse is to provide emotional support to the patient

96%

of specialist cancer nurses in the UK are 96% female

During qualitative interviews we heard from female physicians that many feel a strong responsibility to deliver emotional support to their patients. This sentiment is reflected in the data we gathered on priorities of female physicians (both GPs and oncologists), compared with male physicians, in their consultations. Female physicians more highly prioritise addressing their patient's concerns than male physicians (74% vs 68%) and answering their questions (77% vs 64%) and are significantly more likely (84%) to consider patient choice as critical to delivering person-centred care (compared to 66% of males). More female physicians (63%) also state that patient communication skills training is mandatory (compared to 50% of males). In addition, 77% of female physicians state they have been offered additional professional development training about how to deal with emotional conversations compared to only 54% of males.

There is an interaction between gender of physician and gender of patient

Physicians are significantly more likely to prioritise giving disease information to male patients (62%) than to female patients (52%) in their consultations. Conversely, physicians are significantly more likely to prioritise providing emotional support in their consultations with female patients (23%) than with male patients (14%). When considering oncologists as a subset, 0% of male oncologists prioritise giving emotional support to their male patients, and only 12% of male oncologists prioritise emotional support for their female patients (compared to 50% of female oncologists prioritising emotional support for their female patients, and 33% of female oncologists prioritising this for their male patients).

What can we conclude from this data?

Female physicians appear more likely to deliver person-centric care and female patients are more likely to receive it (albeit less so when treated by male physicians). They are more likely to be offered, and place greater importance on, communication skills training (a necessary skill to deliver emotional support/ person-centred care).

Conversely male physicians are less likely to prioritise emotional support overall, but when they do, it is for their female patients. They are less likely to deliver person-centric care and male patients are less likely to be on the receiving end, especially when treated by a male physician.

In other words, care is being delivered through a gendered lens, with 'caring', 'emotional support' and 'pastoral care' shouldered by female physicians.

This hinders the delivery of equitable, person-centred care, ultimately underserving all patients, but particularly males. Yet, we know from the gender health gap data that female patient's care is most likely to be lacking.[11] So why is this?

Female patients are considered to be 'more emotional' and much more likely to come forward with 'mild' symptoms (vs males)

"Yes, I think generally speaking, women are much more emotional. They'll have a good cry. They've got female friends who they'll go out for coffee with, or they'll meet for lunch and they'll have a good cry. No, no surprise to me that these MacMillan Coffee Mornings that come out every year are attended by 99% of women"
Male GP

The biased belief that women are emotionally capable suggests that they simultaneously may be more emotionally vulnerable. In our study, 45% of the physicians state that female patients are more likely to require a lot of emotional support during a consultation (vs males). Female patients are also significantly more likely to state that they go to their physician for emotional support (74% of women vs. 54% of males), but only 42% agree that emotional support is prioritised in their consultations, suggesting that the needs of these female patients are still not being met.

76% **54%**

76% of female patients agree they need to be assertive to get the care they need compared to 54% of males

"Males present less, so when they do, we need to take their symptoms more seriously. Whereas women present more often... if someone is an infrequent attender, even if they have the same symptoms as someone else, it carries a lot of weight"
Male GP

During qualitative interviews physicians told us that infrequent attender's health concerns carry more weight than frequent attenders. The same physicians also told us that the most frequent attendees are females. Focussing specifically on GPs as a subset of our sample, 70% agree that females are more likely than males to come forward with mild symptoms they are experiencing vs 83% who agree that males are more likely than females to only visit a physician when experiencing more severe symptoms.

Considering this scenario, it indicates male patients benefit from being taken more seriously due to less frequent visits to their GP. For female patients it's the opposite. It's believed they ask for help early, when symptoms are mild. Whilst this behaviour is both proactive and preventative in its intent, it is also setting females at a disadvantage. It suggests that within the health system disease prevention remains a low priority, hence not recognising, and rewarding, patients who present early with mild symptoms. Combine this with the 49% of physicians who believe that female patients are more likely to appear anxious about their health, and it's not a great leap to see how the biased belief that women are 'emotional' leads to a distrust or minimisation of their health accounts – setting the backdrop for potential dismissal and gaslighting – which female patients are overwhelmingly more likely to experience than men.[12]

The impact of this is most evident in situations where there is no systematic diagnostic or treatment pathway (such as ovarian or colorectal cancer) and where subsequently there is reliance on physicians to judge symptoms or behaviour. These beliefs are so ingrained they can pervade even when the evidence presented is contrary, i.e. dismissal of symptoms, potentially leading to mis-diagnosis and/ or delays in diagnosis or treatment despite symptoms being clearly indicative of the disease.

Women feel they have to be assertive to get the care they need, but, when they are, they risk being seen as 'pushy' or 'annoying'

Significantly more female patients (76%) agree they need to be assertive to get the care they need compared to 54% males, suggesting that to varying degrees, minimisation or dismissal are present in most female patients' interactions with physicians. We also heard from female patients that when trying to advocate for oneself, they are told they are being 'annoying' or 'pushy',[13] which is supported by other sources.[14] A female patient presenting as assertive challenges the biased assumption that they are more likely to be emotional and/or anxious about their health (which we observed in this research). Female patients acting outside of this box are, therefore, penalised – and being 'empowered' may actually serve to exacerbate rather than reduce gaslighting / minimisation.

Males are also underserved due to the gendered belief that they should be self-reliant

"Male patients, they don't want to seek help, they don't talk about their feelings. They bury their head in the sand. The amount of men that come and see me with their wives, I always think... it's already telling me you're struggling to tell the story. You're not taking your symptoms seriously - you're just here because the wife's nagged you"
Male GP

The pervasive cultural stereotype of masculinity is one that sees males as self-reliant, not needing (or wanting) help, and, as our research shows, are assumed to be most receptive to functional or rational support to aid self-reliance (such as disease information) rather than more emotional support. This limits

"So many phone calls, me chasing, being dismissed, I called it medical gaslighting by the end... I'm not a neurotic woman who is making a fuss over nothing, which is definitely how I was made to feel ... it was from February to 30th September where the cancer was growing inside me and there was no urgency and there were red flags, and no one would speak to me... I just look back at that and think there were so many missed opportunities to get me the care I needed."
Female Sarcoma Cancer Patient, Tenovus

"I got the impression maybe they would have done more if I was a man... or maybe it was just that I wasn't shouting loud enough, maybe I wasn't as assertive as a lot of men would be."
Female CRC Patient

the degree to which person-centric care is delivered, as physicians may believe males either do not need or are not receptive to this kind of care. This creates an environment that both limits the support offered to male patients, as well as potentially reinforcing males' belief that they don't need or shouldn't ask for it. Support offerings instead tend to be designed for those believed most receptive – females - meaning that the support offerings available tend to be unfit for purpose for males.

"Women are more often offered support programmes such as acupuncture, aromatherapy and support for hair loss ... things that have proven positive affects to support life through chemo. If it is offered to men, it is likely to be packaged for women"
Patient Advocacy Founder, Strive for Five and Beyond

In summary, and to revert back to the question we posed at the start of this paper, our data suggests that both the gender of the physician and the gender of the patient influence how care is delivered and received.

Care is therefore not being delivered based on individual need, but instead through a gendered lens. Deeply ingrained societal and cultural gender bias currently hinders the delivery of equitable, person-centric oncology care in the UK.

Recognising and actively working to address these biases is crucial for closing the gender health gap and ensuring equitable outcomes for all patients.

Challenging the gendered lens of care delivery

The delivery of equitable, person-centred care will become increasingly important given that oncology treatments are becoming more advanced, and patients are living longer. These advancements require caring for the patient as a whole person – not just their disease – over the longer-term. However, these same advancements can also offer a different definition of equitable care, one where personalised and targeted therapies (particularly true of new advancement in various oncology tumours) is instead offered as person-centric care.

"You've got two trainees; one are male one are female. Where do you put extra time? Ultimately, they both get what is required. But if I have more time to give, honestly, give it to the male, they're more likely to give it back one day"
Male Oncologist

The gendered lens through which the professional role of 'physician' is perceived may have an impact as early as initial clinical training. The culturally embedded stereotyping of females as carers (and in the case of this quote, as homemakers), impacts credibility in the workplace. These same stereotypes reinforce a bias that sees physicians as either a) 'carers' – stereotypically the 'more emotional' female or b) 'scientists' – stereotypically the 'less emotional' male. The erroneous view of delivering person-centred care through personalised medicine may serve to reinforce these biased beliefs even further, with male and female physicians potentially gravitating to a definition of person-centred care that fits with the gendered expectations of their professional role.

Many have already recognised this and sought to develop strategies that challenge the traditional view of medicine as one only of science and data. Take for example, the idea of a "narrative medicine".[15] This approach trains physicians to use the power of storytelling in their work, negating the model of "detached concern" they were taught to conform to for decades, and instead replacing it with "engaged concern". This approach builds physician skills, to allow the patient to tell their own story, not only of their ailment but of their ailment in the context of their lives. The goal is to endow physicians with the ability to see an issue from multiple perspectives, and to help them understand and value every patient in their uniqueness and complexity.

Health care is an ecosystem with only one part being the physician

Unanimously, every physician we spoke with detailed the challenges of the system within which they work, be it time or resource constraints, in order to deliver the care they would like to. Our partners at Tenovus Cancer Care highlight that failures in the system begin to facilitate a sense of learned helplessness and compassion fatigue amongst physicians. And where there is helplessness and fatigue, there are errors.

Physicians are aware of this, but only 55% within our sample feel able to enact change within their role. Physicians cannot deliver true person-centric care in a vacuum.

"Person-centred care can't be achieved by any one element. Person-centred care requires empowered patients who are met by an accessible healthcare system with responsive healthcare professionals who facilitate a culture of engagement." [16]

The pharmaceutical industry is a key element of this healthcare ecosystem. So, what can industry do?

Recognise that knowledge does not equate to empowerment

There is a default belief within the healthcare industry that to empower is to inform. This is undoubtedly a critical element for both males and females, but as our research has shown, not the only factor.

Female patients advocating for themselves need to be well informed, to feel confident to ask for what they need or want. They also need to feel they have agency, control and permission not to settle for care that may be defined by negativity and disengagement as a response to their assertiveness.

It is assumed that male patients want and need information to aid their self-reliance, but undoubtedly for some males this is not the case, yet they may not have the skills, sense of permission, or agency to feel able to ask for help in whatever form that takes. And, if they do, there may not be support available to meet their needs.

Critical to meeting each of these needs is physicians' awareness of (unconscious) bias along with belief in the value of, and the ability to, listen and respond to individual patient needs. Industry can help by optimising support offerings to meet the differing needs of both males and females. As well as guide physicians through training, for example, educating physicians on communicating with patients through a shared lexicon that meets their health literacy needs – rather than compounding ingrained cultural stereotypes by using complicated medical language which closes the door to true patient empowerment.

Choose your words carefully

Language matters. Whether we are aware of it or not we internalise the words we hear, and this forms the basis of our future behaviour.

As an industry there is a need to be mindful of language or imagery that reinforces gender stereotyping and bias. Using gender-neutral language can ensure all patients feel seen and respected, regardless of their gender identity. It also reduces gender-biased assumptions which we know can often lead to misdiagnoses or the dismissal of patients based on their gender.

However, this goes beyond pronouns and gender-specific language and looks at also reducing our usage of the more nuanced language that can result in bias. We know that words such as 'pushy' are often gendered as female, whilst 'assertive' is gendered as male – and these words can impact the way physicians respond to a specific patient.

There is also an opportunity to positively affect change – to use the power of words to help facilitate a sense of agency in both males and female patients – by giving females the words to challenge dismissal, to not settle or back down if they are met with apathy or negativity and by giving males the words to ask for help and support if needed. For example, through shifting the discourse of

"There is now a built-in acceptance that people will fall through the net. This acceptability that physicians are going to get it wrong sometimes is ingrained in the system, however, this is not a rare occurrence anymore, it is happening more and more."
Director of Support, Policy & Insight at Tenovus Cancer Care

disease awareness campaigns away from passively informing patients, towards actively encouraging action – whether that is to take control or ask for help.

Influence through data and analytics

Despite observing the delivery of care through a gendered lens, we were told by physicians during interviews in this research that the gender of the patient is not actively being considered during treatment decisions. Much data[17] supports female patients experiencing more frequent / more severe side effects across tumours and treatments, yet often lack of gender representation in clinical trials and lack of sex analysis means side effects and tolerability data by gender is rarely published. Medicine will always be grounded in science and data; this is true even if the practice of delivering health care is centred on the softer skills of communication and listening.

Physicians need to have the data to hand to appropriately treat the specific needs of the patient in front of them, whether that's dictated by gender or other specific needs, which is the responsibility of pharmaceutical companies to deliver.

Systemic change is needed

This research has highlighted some of the challenges those operating within the UK healthcare system experience. There is no reason to suggest that these challenges are isolated only to oncology. Additional research is required to explore the challenges of the system further, however, what we do know is that the expected increased incidence and the associated cost to healthcare authorities means that optimising oncology outcomes is critical.

Getting patients screened and into the care pathway to access treatment early is key to optimising outcomes, as are expediated diagnostic pathways – and in fact the issues we observed were minimised in this scenario. However, screening programmes, expediated care pathways... all of this is a heavy burden for the NHS to carry alone.

By raising awareness of these issues, we hope now is the time for industry to step in and help lighten the load.

Technical note

The findings of this report are based on a multimethod research programme which explored the topic from multiple angles. The full details of the different methodologies and samples employed is included below. All methodologies and samples included were employed in the UK.

Qualitative interview with Key Opinion Leaders (KOLs)

Ipsos conducted 7 X 1-hour online interviews with key opinion leaders across the United Kingdom between the 13th November 2023 - 14th January 2024. KOLs were defined as influential professionals in oncology from within either a patient advocacy perspective or medical professional capacity. All KOLs met at least one of the following criteria:

- At least 1 paper published on the subject of inequity in oncology
- Work within a patient organisation focused in oncology
- 10+ years direct experience in oncology care in the UK

Qualitative interview with Physicians

Ipsos conducted 17 X 1-hour online interviews with healthcare professionals (physicians) across the United Kingdom between 8th January – 5th March 2024. To be eligible for interview, physicians needed to be either a surgeon, oncologist, general practitioner or oncology nurse (full breakdown see the table below). Physicians also needed to have managed (or referred for general practitioners) 2 patients in the last year with one or more of the following cancers; colo-rectal cancer, ovarian or testicular cancer.

All respondents had some experience managing (or for general practitioners referring) a patient with all 3 cancer types in the last 12 months, with the exception of 1 surgeon who only had experience in managing colo-rectal cancer patients and 1 oncologist with experience in only ovarian and colo-rectal cancer. All physicians also needed to have between 5-30 years' experience in practice and spend over 75% of their time in clinical practice.

	Gender		Total
	Male	Female	
Surgeon	2	1	3
Oncologist	3	5	8
General Practitioner	2	1	3
Oncology Nurse	2	1	3
			17

Qualitative interview with Patients

Ipsos conducted 14 X 1-hour online interviews with patients across the United Kingdom between 22nd January – 8th March 2024. To be eligible for interview, patients needed to have been diagnosed with either ovarian, testicular or colo-rectal cancer in the last 2 years (for full breakdown see the table below). A mix of female and male (sex-assigned at birth) patients were recruited, as well as patients from a mix of ethnicity groups, employment status and education.

All patients must have undergone at least one of the following types of cancer treatment; surgery, chemotherapy, radiation therapy, targeted therapy or immunotherapy and must have engaged with a healthcare professional regarding their cancer within the last 6 months.

	Gender		Total
	Male	Female	
Ovarian	-	3	3
CRC	4	5	9
Testicular	2	-	2
			14

Quantitative survey with Physicians

Ipsos conducted an online survey among 93 healthcare professionals across the UK between 28th August and the 10th September 2024. All physicians surveyed held all or part treatment decision responsibilities for their patients and spend at least 75% of their professional time in direct patient care. The sample breakdown of specialty and gender is shown in the table below. The data was not weighted during analysis.

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	Gender		Total
	Male	Female	
General Practitioner	33	37	70
Oncologist	17	6	23
			93

All healthcare professionals had between 3-30 years of experience in their field, spent a minimum of 75% of their time in clinical practice treating patients and must have spent at least some time working in public healthcare in the UK. All GPs were required to have referred at least 5 colo-rectal patients to a specialist for a suspected diagnosis in the last year, whilst all oncologists must have seen at least 2 colo-rectal patients in a typical month. All respondents were required to identify as either cis-gender female or male.

Quantitative survey with colo-rectal patients and caregivers of colo-rectal patients (18-75 years old)

Ipsos conducted an online survey among 91 people who either personally have been diagnosed with CRC cancer (n=81) or care for someone who is a CRC cancer patient (n=10) across the UK between the 12th August and the 6th September 2024. The sample was made up of 50 females and 41 male patients/ patients of caregivers.

All patients / patients of caregivers had been diagnosed with colo-rectal cancer within the last six years and must have had an appointment with a healthcare professional regarding their colo-rectal cancer within the last 6 months. All patients / patients of caregivers were 18 years of age or older and must have been cis-gender female or males.

All caregivers answered questions on behalf of the patients they care for and were only recruited if they regularly attend medical appointments with the patient they care for.

The data was not weighted during analysis.

Footnotes

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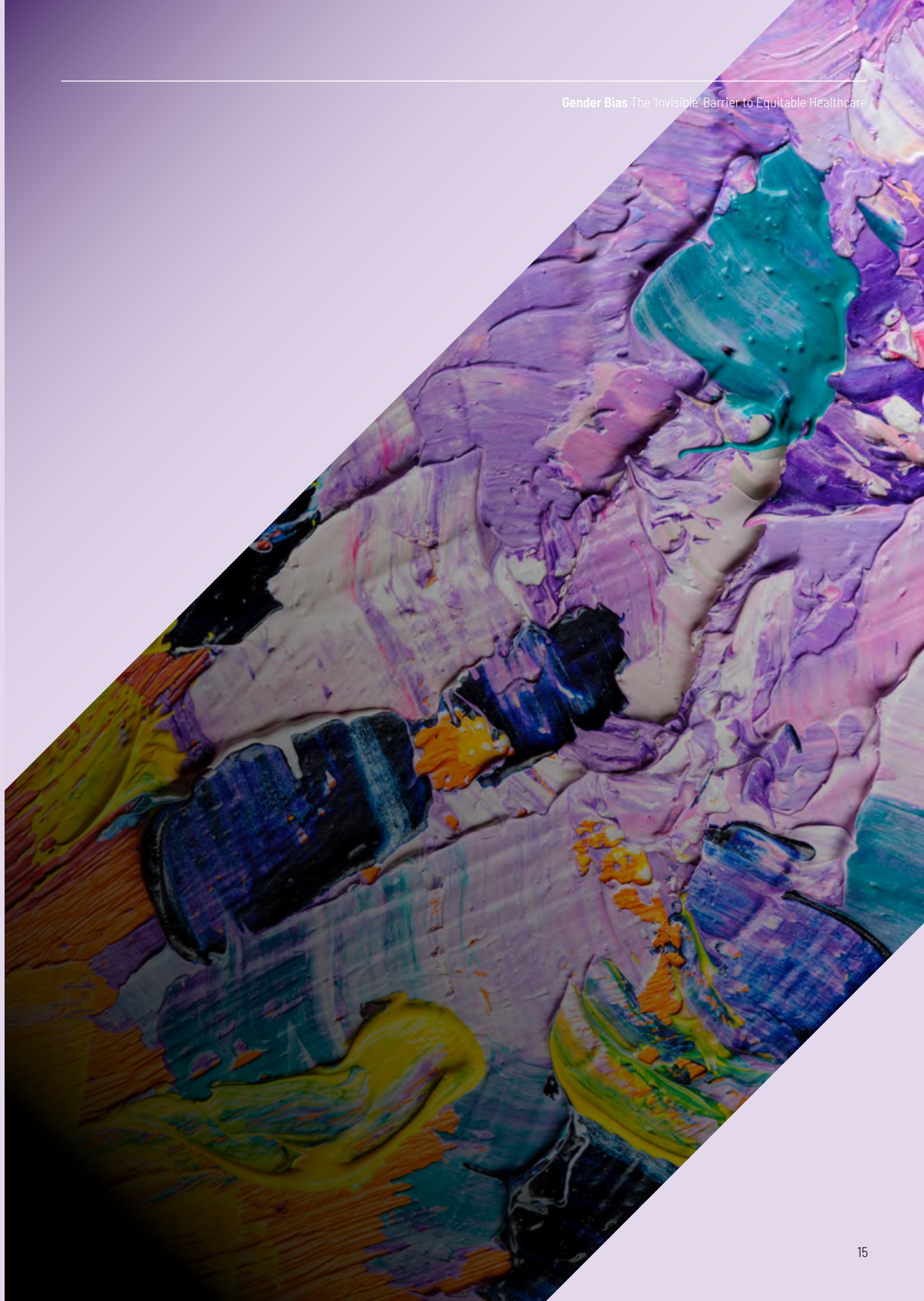
Gender Bias The 'Invisible' Barrier to Equitable Healthcare



ABOUT HEALTHCARE AT IPSOS

We are a global insight, evidence and advisory partner to the healthcare sector – and one of the world's leading healthcare primary market research businesses. We provide insights, evidence and guidance across the healthcare product lifecycle, empowering our clients to align commercial success with what matters most: Improving patients' lives.

FOR MORE INFORMATION

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