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Emergency Medicine Gender-specific Education

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Abstract

The 2014 *Academic Emergency Medicine* consensus conference has taken the first step in identifying gender-specific care as an area of importance to both emergency medicine (EM) and research. To improve patient care, we need to address educational gaps in this area concurrent with

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research gaps. In this article, the authors highlight the need for sex- and gender-specific education in EM and propose guidelines for medical student, resident, and faculty education. Specific examples of incorporating this content into grand rounds, simulation, bedside teaching, and journal club sessions are reviewed. Future challenges and strategies to fill the gaps in the current education model are also described.

Clinicians have observed sex and gender differences in patient care for decades. However, these differences have been formally recognized only in recent years. The American Medical Association style guide defines sex as the classification of living things as male or female according to their reproductive organs and functions assigned by chromosomal complement.¹ This chromosomal complement affects a patient's vulnerability to disease and his or her response to medications and treatments. Gender, however, refers to a person's self-representation as man or woman or how that person is responded to by social institutions on the basis of the person's gender presentation. Frequently confined to reproductive health, sex- and gender-specific medicine (SGM) also addresses why some diseases, such as cardiovascular diseases or strokes, are more common in men versus women and whether these differences affect treatment and prognosis. In 1994, the field of SGM gained new momentum as Congress mandated the recognition of sex- and gender-based research and education for every organ system.²

As a result of these mandates, sex and gender differences in the etiology, diagnosis, progression, outcomes, treatment, and prevention of many conditions have been described that affect care for both women and men patients in the acute care setting. Some examples of sex differences include strokes and cardiovascular conditions are more common in men and yet mortality is worse in women for the same conditions, digoxin causes more adverse events in women being treated for congestive heart failure, Brugada syndrome is 10 times more common in men due to the effect of testosterone on cardiac sodium channels, the slower metabolism of zolpidem in women puts them at increased risk for sleep-associated motor vehicle crashes, aspirin is variably effective in the treatment of myocardial infarction and stroke in men compared to women, and men have an increased susceptibility to sepsis.³⁻⁶

Despite recent advances in gender-specific medicine, this information is largely ignored in current emergency medicine (EM) research and clinical practice.⁷ The 2013 RAND Corporation report has independently documented the central role of EM in health care delivery in the United States.⁸ The report highlights how EM is uniquely positioned to influence acute care as a specialty that sees nearly 130 million patients annually, is increasingly being used by other specialties and primary care practitioners to perform complex diagnostic workups, and remains the primary access point for the majority of hospital admissions.⁹ Incorporating sex- and gender-specific EM education for emergency physicians (EPs), medical students, and residents therefore has far-reaching potential influence for acute care of our patients.

To provide optimal individualized medical care for both men and women, the concepts of sex and gender health need to be introduced early and become systematically embedded into medical school and postgraduate curricula, as well as continuing medical education (CME).

These curricula continue to primarily be taught in a unisex fashion that has the potential of introducing conscious and unconscious biases in learning and ignores the differences between men and women in response to diseases and treatments. This article provides an overview of the need for optimizing medical and postgraduate education in SGM, current challenges, and recommendations to overcome gaps in the current education model.

THE NEED TO OPTIMIZE EDUCATION IN SGM

In 1996, medical student and resident surveys demonstrated that their programs lacked education in gender-specific health, and primary care residency programs were not adequately preparing trainees to provide comprehensive health care to women.¹⁰ In late 2012, sample U.S. Medical Licensing Examination (USMLE) forms were reviewed by the Sex and Gender Women's Health Collaborative group to identify sex- and gender-based topics already covered and missed opportunities that might be addressed.¹¹ Many internal medicine programs responded by developing women's health tracks to improve competencies in areas related to women's health and gender-specific medical conditions.¹² In September 2012, the Mayo Clinic hosted a workshop in an attempt to address a need to integrate sex and gender concepts into medical education and training. Representative leaders were brought together from 13 U.S. schools of medicine and schools of public health, the National Institutes of Health, Health Resources and Services Administration Office of Women's Health, and the Canadian Institute of Health and Gender, to identify barriers to incorporating SGM in health education and to communicate and share practical strategies for addressing them. The symposium recommended the following proposals to assist implementation and sustainability using existing curricula: 1) engage educators, administrators, and professional societies early in the process; 2) collect and disseminate evidence regarding the added value of including SGM education and training; 3) foster interprofessional and interdisciplinary collaborations; and 4) develop and maintain new resources using various technologies.¹³

A follow-up 2013 survey identified nine residency programs and 23 fellowships that were designed to train future physicians in women's health issues.¹⁴ These comprehensive care programs spanned several specialties, including internal medicine, family medicine, obstetrics and gynecology, and psychiatry, but EM was notably absent. As highlighted by the RAND report, this gap represents a glaring omission, as EPs are inherently multidisciplinary and uniquely positioned to translate gender-specific research and care into lifesaving outcomes.⁸

PROPOSED GUIDELINES FOR OPTIMIZING EDUCATION IN SGM

The transfer of new evidence in sex and gender research into clinical practice requires systematic incorporation into medical education, postgraduate EM training, and CME courses for practicing physicians. Numerous educational opportunities exist, including curriculum development, grand rounds didactics, simulation, bedside and clinical teaching, and journal clubs, that allow the learner to gain a basic understanding of how sex and gender play a role in presentation and response to diseases, occurrence of injury, and acute care

management. Specific sex- and gender-specific instructional strategies can enhance this experience while tailoring them for students versus EM trainees and practitioners.

While the core concepts and venues for educational opportunities are similar between medical student and postgraduate curricula, the goals are somewhat different for each group. The main difference lies in the mode of instruction. In medical school, primary instruction is through a large amount of didactic instruction that is intended to remove conscious and unconscious biases in learning, as well as longitudinal case-based learning. Postgraduate education, on the other hand, is largely through experiential learning that emphasizes patient responsibility, professionalism, and nuances of clinical care. The following venues and strategies will need to incorporate these nuances into educational programs, student clerkships, and CME courses.

VENUES FOR EDUCATIONAL OPPORTUNITIES AND GENDER-SPECIFIC INSTRUCTIONAL STRATEGIES

Curriculum Development

A curriculum represents the expression of educational ideas in practice and should be communicated to those associated with the learning institution, be open to critique, and have the ability to be readily transformed into practice.¹⁵ Previous research has shown that curricula have four key elements: content, teaching and learning strategies, assessment processes, and evaluation tools.¹⁶

Research shows that medical school curricula have been slow in incorporating these key elements of curriculum to address sex and gender issues in medicine. Fewer than half of medical schools report having women's health curricula,¹⁷ and even fewer (7%) offer interdisciplinary courses that have structural grounding in women's health.¹⁸ Sex and gender curriculum interventions and instructional strategies are listed in Table 1, and can be used by curriculum directors and educators to better develop a curriculum for students and residents. Learners should have an appreciation for the topics in the Association of Professors of Gynecology and Obstetrics Women's Healthcare Competencies (see Table 2) and be able to describe how sex and gender play a role in the emergency care of patients.¹⁹

Examples of sex- and gender-specific instructional strategies include:

- Content delivery should be inclusive of both genders. The practice that maleness is the norm and femaleness is a deviation from the norm should be abandoned.²⁰ For instance, when the sex of a patient case is being described, the specific gender should be used, but when gender is irrelevant, the terms "person" or "human" are preferable to deemphasize the androgenic norm.²⁰
- When case studies are used for education, equal numbers of cases should be male and female.
- The gender of the case should be consistent with the epidemiology of the disease.

- Faculty should be educated to present cases with alternating gender components.²⁰
- When discussing factual information, faculty need to be cognizant of sex and gender dissimilarities and employ means to address these differences with students; for example, when discussing the difference in heart and coronary artery size by sex, implications for acute treatment should be noted.²⁰

Grand Rounds and Didactics

Emergency medicine residency didactics and curricula have historically taught gender medicine in the context of reproductive health, but not how a patient's gender affects behaviors, roles, expectations, and activities in society.²¹

Examples of sex- and gender-specific instructional strategies include:

- When discussing core content, didactics should include gender-specific examples that are routinely seen in clinical practice. For instance, when discussing cardiology, the facilitator can acknowledge that coronary heart disease is less common in younger women, but takes on a more severe form causing higher rates of myocardial infarction, congestive heart failure, and mortality, compared to male counterparts.^{22,23} Similarly, when we talk about substance abuse, the facilitator can emphasize the higher addiction risk in men, so that the EM clinician can develop sex-specific awareness and management strategies that support improved outcomes for both men and women.
- When relevant to the topic, lectures should routinely reflect on the implications of sex and gender on the disease and involve audience participation.
- Invited speakers at grand rounds offer an excellent opportunity for students, residents, and faculty to understand how crucial SGM is to patient care.

Simulation

Simulation has been shown to be an effective medium for teaching and transfer of information and resources in EM curricula.²⁴ The growing role of simulation in education may lead us to successfully address gender and cultural differences in disease.²⁵ However, the typical mannequin used for instruction is male-appearing, despite most mannequins being unisex in nature. Several steps can be taken to ensure culturally competent education through simulation.

Examples of sex- and gender-specific instructional strategies include:

- Instructors should ensure that both the simulator equipment and the cases that are developed address cultural competence while using appropriate gender representation.
- Using men and women as standardized patients, especially with newer modalities that permit the use of standardized patients with generated vital signs, can eliminate the need for mannequins.

- Case scenarios and mannequins should be modified to adequately represent those at risk. An illustrative experience might be to have one group perform a case on a man and the other group on a woman. At debriefing, the teams could discuss what differences occurred in the patients' care that were affected by their gender.

Bedside and Clinical Teaching

Classic bedside teaching and case-based patient-specific teaching in the ED clinical environment are important opportunities to enrich student and resident knowledge of gender medicine.

Examples of sex- and gender-specific instructional strategies include:

- During presentations by medical students and residents in the ED, faculty can easily include teachable gender-specific pearls of knowledge that begin to strengthen a learner's understanding of this content; for instance, discussing the diversity of complaints that might indicate acute coronary syndrome and how they vary by patient sex or the differences in reported pain and sensitivity to pain between men and women when ordering medications.

Journal Club

Evidence-based medicine is a way of combining the best available scientific evidence, the practitioner's clinical judgment, and the patient's values to make medical decisions.²⁶ Previous data have shown that journal clubs may improve knowledge of clinical epidemiology and biostatistics, reading habits, and the use of medical literature in practice.²⁷

Examples of sex- and gender-specific instructional strategies include:

- A journal club's leader has the opportunity to critically review studies for the consideration of gender as an independent variable in the analysis. The leader can seek out the importance of sex and gender in the study design (subject allocation), prognoses, outcomes, and interventions reported in each study, and attempt to make each session more patient-oriented.
- An additional resource could be the casebook, "What a Difference Sex and Gender Make: A Gender, Sex and Health Research Casebook."²⁸ This book showcases the differences that sex and gender make in health research and provides concrete examples of how gender research can be applied.
- Journal club discussions often generate meaningful scholarly projects, and trainees should be encouraged to use the opportunity to investigate and generate new knowledge in the field.
- Much of the rapid growth in gender-specific medicine is in basic science. It is important to include these translational papers in journal clubs to keep residents current with knowledge in the field.
- Use of free resources promoting advances in sex and gender medicine should be promoted. For example, the Society of Women's Health Research (SWHR) news

service is one option (http://www.womens-healthresearch.org/site/PageServer?pagename=press_newsservice).

CME

For practicing physicians and EM graduates, key clinically relevant articles should be made available for CME to facilitate dissemination and incorporation into practice. Faculty education opportunities to strengthen knowledge in this content area should be readily available.

Examples of sex- and gender-specific instructional strategies include:

- Overlap exists with the resources applicable to residents, but faculty also can select CME that focuses on sex- and gender-specific content. Faculty can propose articles that discuss sex- and gender-specific content to the American Board of Emergency Medicine for inclusion in Lifelong Learning and Self-Assessment tests.
- Opportunities exist to educate expert academicians on instructional strategies for teaching sex- and gender-specific issues by the Society for Academic Emergency Medicine (SAEM) and the Council of Emergency Medicine Residency Directors (CORD). While neither of these organizations typically teach clinical medicine, SAEM can include sex- and gender-specific research in its annual meeting, or fund this type of research. CORD also can fund this type of research, and in addition, both societies can be encouraged to include posters that discuss educational innovations to teach sex- and gender-specific knowledge to medical students and residents.
- Community physicians should be educated by providing sex- and gender-specific CME courses through key symposia such as the Scientific Assembly of the American College of Emergency Physicians.

CHALLENGES TO GUIDELINE IMPLEMENTATION

The primary challenge faced by researchers and educators is to keep up with the rapidly growing discipline of SGM and incorporate this new information into educational and training programs that will ultimately affect patient care.¹³ This is demonstrated in the various curricular models and instructional strategies that go beyond specific courses such as physiology and pharmacology. The challenges range from updating basic medical texts books with latest evidence in sex and gender research, to incorporating these findings into trainee clinical rotations. Second, a major barrier to the education of new learners is an absence of sufficient qualified educators in SGM.²⁹

Finally, new evaluation competencies are required to measure improvement in sex- and gender-specific knowledge. Previously, curricular assessment and evaluation only assessed learner knowledge as outlined in the course's objectives. However, newer models are determining if there has been a desired change in learner attitude, knowledge, and skills. This is being accomplished through portfolios, 360-degree assessments, clinical simulations,

direct observation, written examinations, and assessment by supervising clinicians.³⁰ Such models will need to incorporate sex- and gender-based competencies to measure effectiveness of the educational efforts.

PROPOSED STRATEGIES TO ADDRESS THESE CHALLENGES

Change is always difficult, and incorporating sex- and gender-specific education at a systems level requires concerted efforts at individual, institutional, regional, and national levels. We recommend the following strategies to overcome these barriers:

- To keep abreast of new knowledge and to promote a constant dialogue between faculty and trainees, we encourage the use of commonly available resources such as the SWHR e-newsletter and the development of EM-specific resources.
- To increase the number of qualified educators so they can optimally collaborate to provide access to various types of materials developed for gender-based curricula. For instance, the multidisciplinary “Sex and Gender Women’s Health Collaborative” at www.sgwhc.org has identified establishment of a digital resource for sex- and gender-specific curriculum materials as one of its project goals, and will be an important resource for educators.
- To standardize education despite lack of experience in the topic, educators can use asynchronous learning tools, easily accessible teaching materials, predefined topics for didactics, and salient discussion points to help expedite learning in this area (examples in Data Supplement S1, available as supporting information in the online version of this paper). This allows for concrete discussion points that can be widely disseminated to standardize education.
- At an institutional level, appointment of a gender medicine expert on the curriculum development and didactic committees is important. The appointee(s) should be responsible for implementing the suggestions previously outlined.
- Development of fellowship programs that focus on advancement of gender-specific emergency care is needed. The 2-year fellowship offered by Brown University’s “Women’s Health in Emergency Care” is an important step in the right direction.³¹ It was included in the 2013 Directory of Residency and Fellowship Programs in Women’s Health and offers an example for other institutions to follow.³¹
- To target competencies and evaluations, SAEM should collaborate with CORD to develop appropriate evaluation tools.
- For medical students, evaluation bodies can be targeted, such as the USMLE, and asked to include sex- and gender-specific questions on their examinations. Research has demonstrated that assessments and examinations drive teaching and learning.³² If the USMLE tests these topics, medical schools will likely teach them. There needs to be continued clinical exposure during the course of training, as standardized examinations do not assess higher levels of medical decision-making or the use of knowledge in practice.³⁰ This higher level of

medical decision-making can be better assessed during each student's medical clerkship.

CONCLUSIONS

Engagement in all aspects of medical education is essential to provide the impetus for change. Each educational component should identify opportunities for inclusion of faculty from other disciplines, as the broad scope of women's health, along with sex and gender medicine, offers significant potential for collaborative opportunities. The 2014 *Academic Emergency Medicine* consensus conference has taken the first step in identifying gender-specific care as an area of importance to emergency medicine. Continuing the momentum is critical in producing effective strategies that guide future research and educational opportunities for interdisciplinary collaboration in gender- and sex-specific knowledge and its translation to the bedside.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Sex and Gender Curricular Interventions and Instructional Strategies

Table 1

1. Degree of impact	Elective courses or seminars
Low (one to several)	Required: stand-alone didactics
Medium (one to many)	Required: core curricula with longitudinal integration or integrated themes
High	
2. Type of strategies	Didactic: organ/system/symptom-based
	Problem-based learning
	Standardized patients
	Self-directed learning and scholars tracks
	Online modalities
	Clinical education
	Interprofessional education
	Community-based education
	Continuing medical education/faculty development

Table 2

Women’s Health Care Competencies for Medical Students

I. Explain sex and gender differences in normal development and pathophysiology as they apply to prevention and management of disease.
A. Compare difference in biological functions, development, and pharmacological response in males and females.
B. Discuss the pathophysiology, etiology, differential diagnosis, and treatment options for conditions that are more common or more serious or have interventions that are different in women.
C. Discuss the pathophysiology, etiology, differential diagnosis, and treatment options for conditions and functions that are specific to women.
II. Effectively communicate with patients, demonstrating awareness of gender and cultural differences.
III. Perform a sex-, gender-, and age-appropriate physical examination.
IV. Discuss the impact of gender-based societal and cultural roles, and contexts on health care, and on women.
V. Identify and assist victims of physical, emotional, and sexual violence and abuse.
VI. Assess and counsel women for sex- and gender-appropriate reduction of risk, including lifestyle changes and genetic testing.
A. Describe current recommendations for preventive screening and routine health maintenance throughout the life cycle.
B. Assess risk and counsel for prevention of specific conditions.
VII. Access and critically evaluate new information and adopt best practices that incorporate knowledge of sex and gender differences in health and disease.
VIII. Discuss the impact of health care delivery systems on populations and individuals receiving health care.