Letters

COMMENT & RESPONSE

In Reply We thank Biskup and colleagues for their comments on and interest in our article.[1] We agree with their assessment that while a growing body of research demonstrates wide variation between men and women in the risk, presentation, and prognosis of diseases, as well as in the response to treatment, sex and gender remain inadequately considered in medical decision-making, resulting in poorer health outcomes. We enthusiastically support the development of a community standard—much like a clinical guideline, as they suggest—as a way to improve the implementation of more precise sex- and gender-informed clinical care for every patient.

Advances in the study of sex differences within research programs have been largely attributable to the development of new community standards within the research community. These standards require that sex be considered as a biologic variable and used in analyses of study data.[2] As the authors suggest, new community standards of capturing gender variables within the clinic have been shown to be feasible.[3] If implemented widely, such approaches allow more targeted care for patients, including those who are gender nonconforming and those with intersectional identities. However, the incorporation of gender variables within research remains limited,[4] resulting in inadequate attention to the effect that gender-influenced behavior and exposures have on health outcomes separate from biological sex. The authors' example of how some languages lack discrete words for the concepts of sex vs gender highlights the complexity of disentangling the roles of sex and gender, and their intersection, in relation to health outcomes.

We also agree with the authors that improvements in the training of clinicians and medical scientists in the recognition, practice, and study of sex- and gender-informed medical care should become a key component of the promulgation of best clinical practices. Some progress has been made in improving curricula of medical training programs,[5] and we welcome continued innovation and collaboration in these arenas.

In response to the letter by Peters and Woodward, we appreciate their important comment about the distinctions between relative risks and absolute risks. Their points are particularly important when evaluating sex differences because of substantial male-female differences in the absolute risks of many long-term diseases. Whenever possible, both absolute and relative risks should be provided for readers.

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