The unequal treatment and misdiagnosis of women is a prominent issue both within and beyond our community. Evident throughout our nation and deeply rooted within history, millions of women experience misdiagnosis and what is termed as “medical gaslighting” due to the downplaying of their symptoms (with many doctors accrediting many physical symptoms, which present similarly to men, and pains to “anxiety” and “depression”). It is correlated with harmful biases and stereotypes that ultimately result in little to no female representation in clinical trials, and showcases persistent misogyny prevalent in biomedical research (plus poorly noted sex/gender distinctions/limitations). In 1977, following the births of several children with deformities upon the ingestion of thalidomide, the Food and Drug Administration established a policy to exclude “women of childbearing potential from Phase I and early Phase II drug trials… including women who used contraception, who were single, or whose husbands were vasectomized” (Wood 2). As a result of this exclusion, scientists and medical professionals were faced with a shortage of data on the effects of this certain drug on women - crucial for future references and possible treatments (resulting in overall less knowledge on how certain drugs and diseases adversely affect females compared to males). This lack of data, alongside cultural tropes and gender inequality, overtime, contributed to the frequent misdiagnosis of women and the dismissal of symptoms considered to be “normal women problems,” which, in turn, led to the infamous and hysterical diagnosis of “female hysteria” that lasted until the 1980s. In fact, according to the National Library of Medicine, women typically experience longer lengths of time between symptom display and medical diagnosis as compared to men. For instance, “in CCAE, 86.3% of the symptoms for the acute phenotypes led to a later diagnosis for women, 83.2% for the mid-length chronic phenotypes, and 69.6% for the long-term chronic phenotypes” (Sun et al., 2022). Such misdiagnoses can have a severe impact on the lives of these patients, thereby rendering this issue as significant in our nation. As a matter of fact, an estimated 795,000 patients die or are permanently disabled each year as a result of misdiagnosis, as stated in a study published in the BMJ Quality and Safety Periodical. While some steps have been made to correct this issue, the problem of implicit bias towards women in healthcare has not gone away. Therefore, it is crucial to implement long-lasting solutions that will improve this current situation, especially locally in Stanislaus County, California.

To address this life-threatening problem, we can focus on the core areas of Health Education and Promotion and Health Policy and Management. A potential solution for the former core area involves the implementation of a public awareness program to inform and educate the public on the implicit gender bias in healthcare. This program can be similar to the American Heart Association’s “Go Red for Women” campaign, as this would allow us to inform a large audience and garner funds for our program. We can also implement a mandatory healthcare training program to educate students and professionals on the sex and gender differences between women and men. This can help combat the traditional assumption that the only difference between the two sexes is their reproductive organs (this was a commonly-held belief throughout history as most medical research was based on male anatomy). However, this program has major drawbacks, as it may be difficult to gain the funding or resources necessary to

implement it (unless we manage to attain government aid and funding). In addition to the aforementioned solutions, we can focus on the latter core area of Health Policy and Management by managing clinical trials and ensuring proper female inclusion and representation, whilst enforcing better policies that require proper sex/gender documentation in contemporary biomedical research. We can also establish a policy mandating check-ups for women regardless of what the physician believes to be the root of the symptoms. This would help reduce the amount of dismissed symptoms. These proposed solutions can help reduce gender inequality and misdiagnosis for women in healthcare.

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