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***CMAJ* headlines:**

- Closing the gender pay gap in medicine: an action plan
- Fertility preservation for young women with breast cancer: a discussion tool for physicians

Closing the gender pay gap in medicine: an action plan

Closing the gender pay gap in medicine in Canada requires a multipronged approach to overcome systemic bias, including payment and hiring transparency, changes to medical education, better parental leave and more, as outlined in an analysis article in *CMAJ (Canadian Medical Association Journal)*. VIEW ARTICLE

In Ontario, male family physicians earn 30% more, and male specialists earn 40% more than their female counterparts on average.

“The gender pay gap exists within every specialty and also between specialties, with physicians in male-dominated specialties receiving higher payments,” write Drs. Tara Kiran, St. Michael’s Hospital of Unity Health Toronto, Toronto, Ontario, and Michelle Cohen, Queen’s University, Kingston, Ontario. “The gap in not explained by women working less but, rather, relates more to systemic bias in medical school, hiring, promotion, clinical care arrangements, mechanisms used to pay physicians and societal structures more broadly.”

Research from the United States and the United Kingdom indicates that the pay gap persists after adjusting for physician age, specialty, number of hours worked and other factors. In Canada, the proportion of female physicians has grown from 11% in 1978 to 43% in 2018, but women make up only 8% of Ontario's highest billing physicians.

"Women in medicine face discrimination throughout their careers," the authors write. "This discrimination is rooted in the history of women's exclusion from the profession, along with the institutional legacies of sexism in medical schools, clinical care arrangements, health organizations and the fee system itself. In the early stage of their careers, the 'hidden curriculum' both subtly and overtly encourages women trainees to enter specific, often lower-paid, specialties."

Provincial and territorial governments, institutions and faculties of medicine, professional associations, clinical leaders and individual physicians all have a role to play.

Actions to close the pay gap include

- Transparent data, including reporting of physician payments by gender and other demographic characteristics
- Antioppression training for leadership
- Addressing gender bias in medical schools and medical curricula
- Standard, fair, and transparent hiring and promotion practices
- Actively seeking and encouraging women for leadership roles
- Better maternity and parental leave programs

"[W]ork to address gender pay equity in medicine cannot be done in isolation," write the article's authors. "The medical profession should remain mindful of the relative privilege of physicians in society and support advances for women struggling in precarious, lower-paid work; solutions for the medical profession should not exacerbate broader societal income inequality. Efforts to close the gender pay gap in medicine should embrace efforts to measure and reduce pay gaps related to other intersecting forms of discrimination, including race and disability."

"Closing the gender pay gap in Canadian medicine" is published August 31, 2020.

MEDIA NOTE: Please use the following public links after the embargo lift:

Analysis: *http://www.cmaj.ca/lookup/doi/10.1503/cmaj.200375*

Podcast permanent link: https://soundcloud.com/cmajpodcasts/200375-ana

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Fertility preservation for young women with breast cancer: a discussion tool for physicians

A new review provides guidance for physicians to discuss fertility preservation with young women diagnosed with breast cancer who may want to have (more) children. The review, which includes lists of resources for patients and health care professionals, is published in *CMAJ (Canadian Medical Association Journal)*. VIEW ARTICLE

“[H]aving such a discussion sends these young women the powerfully positive message that they are expected to not only have a normal lifespan but also to continue to pursue the goals and dreams they had before their illness,” writes Dr. Ellen Warner, Division of Medical Oncology, Sunnybrook Odette Cancer Centre and the University of Toronto, Toronto, Ontario, with coauthors.

About 80% of women who undergo treatment without metastatic disease at diagnosis are expected to be long-term survivors but, as treatments will affect fertility, the potential loss of fertility can affect treatment decisions. For women who undergo the recommended treatment, subsequent infertility may be extremely distressing. Fertility issues rank second after the fear of cancer recurrence.

The review provides a summary of the impact of breast cancer treatment on ovarian function, an overview of fertility preservation options, and evidence for the safety of fertility treatments and pregnancy after chemotherapy.

Most women under age 40 diagnosed with breast cancer will require chemotherapy. There is a 9%–46% risk of permanent loss of ovarian function, and these treatments can “age” ovaries by 5–10 years in terms of reproductive function.

“Routinely discussing childbearing plans with young patients with breast cancer as soon as possible after their diagnosis and offering prompt referral to a fertility clinic to those who have not yet completed their families enables these women to choose from a number of safe and increasingly successful fertility-preservation options without delaying their cancer treatment,” the authors write.

"Update on fertility preservation for young women with breast cancer" is published August 31, 2020.

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