EDI PAPERS JAN – APRIL 2025

“Closing the gender pay gap in Canadian medicine”

<https://www.cmaj.ca/content/192/35/e1011>

Jan Suggestion:

Time to send: perhaps Jan 17th, or early week of Jan 21 to line up with Jan24th event

KEY POINTS

* Women in Canadian medicine consistently earn less than men.
* The pay gap between women and men exists within every medical specialty and also between specialties, with physicians in male-dominated specialties receiving higher payments.
* The gender pay gap in medicine is not explained by women working fewer hours or less efficiently but, rather, relates to systemic bias in medical school, hiring, promotion, clinical care arrangements, the fee schedule itself and societal structures more broadly.
* Actions for closing the gap include anti-oppression training, challenging the hidden curriculum in medical education, fair and transparent hiring and referral processes, changing the relative value of fee codes and transparent reporting of physician payments stratified by gender.

February Suggestion:

“Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites”

Time to Send: Anytime, theme relating to Black History Month

<https://www.pnas.org/doi/10.1073/pnas.1516047113>

**Abstract**

Black Americans are systematically undertreated for pain relative to white Americans. We examine whether this racial bias is related to false beliefs about biological differences between blacks and whites (e.g., “black people’s skin is thicker than white people’s skin”). Study 1 documented these beliefs among white laypersons and revealed that participants who more strongly endorsed false beliefs about biological differences reported lower pain ratings for a black (vs. white) target. Study 2 extended these findings to the medical context and found that half of a sample of white medical students and residents endorsed these beliefs. Moreover, participants who endorsed these beliefs rated the black (vs. white) patient’s pain as lower and made less accurate treatment recommendations. Participants who did not endorse these beliefs rated the black (vs. white) patient’s pain as higher, but showed no bias in treatment recommendations. These findings suggest that individuals with at least some medical training hold and may use false beliefs about biological differences between blacks and whites to inform medical judgments, which may contribute to racial disparities in pain assessment and treatment.

March Suggestion:

**#MedicineToo—Gender Bias in Medical Training: A National Survey of Residents**

<https://link.springer.com/article/10.1007/s11606-021-06613-y>

When to Send Out: Any time for Women’s History Month – maybe before Canadian’s Women Physician’s Day? (March 11)

**Introduction**

Gender bias and sexual harassment are ongoing issues in the American workforce, with recent widespread public attention drawn by the “Me Too” movement. Despite this well-known problem, little is known about the current prevalence and impact of gender discrimination in healthcare. A 1995 study of US medical school faculty found that half of female faculty experienced gender discrimination or sexual harassment in the academic environment.1 Another 2005 survey demonstrated that these experiences begin early in training, with nearly 90% of fourth-year medical students having experienced, observed, or heard about at least one incident of gender discrimination or sexual harassment.2 This is the first study to characterize the prevalence, experiences, and effects of gender bias within US medical training using a national cohort of all specialties.

April Suggestion:

**Understanding and addressing Islamophobia through trauma-informed care**

* Timing: Anytime, maybe earlier in the Month as Ramadan ends on March 29th

<https://pmc.ncbi.nlm.nih.gov/articles/PMC9259421/>

Key Points:

* Islamophobia in Canada has individual, societal and structural manifestations, including extreme violence perpetrated toward Muslims.
* Physical and mental health outcomes and patient experiences of health care settings are affected by Islamophobia.
* Principles of trauma-informed care can be used to address and mitigate the consequences of Islamophobia in health care settings.
* Clinicians should reflect on biases and prejudicial views that they may hold toward Muslim people.
* Based on the clinical context, when appropriate, clinicians should consider exploring the impact of Islamophobia on their patients and supporting them as needed.

May Suggestion:

June Suggestion