This study by Lee et al surveys female (assigned female at birth and those identifying as female) oncologists about the barriers they faced in pursuing their childbearing aspirations and most notably found that 1 in 3 of those surveyed experienced infertility, and 1 in 3 experienced discrimination during pregnancy and/or maternity leave. Lee et al recommend more education in, as well as access to, assisted reproductive technologies (ART) and paid pregnancy leave policies in medical school and residency. While both of these items would certainly be steps in the right direction, challenges to childbearing constitute a national problem that transcends women in medicine or any other profession. Large cultural changes, which physicians can and should lead, are necessary to offload the unreasonable burden placed on people who are attempting to conceive, are pregnant, and/or are raising children.

There have been multiple reports of gender-based inequity in medicine with a focus on childbearing. Often cited is a delay in childbearing associated with medical training that leaves female physicians “involuntarily childless.” A study by Stack et al reported on a survey of 804 female medical residents in the US and found that 61% of those who were married or partnered were delaying childbearing, with most of their reasons including a busy work schedule, desire not to extend residency training, and fear of burdening their colleagues. Dishearteningly, only 38% of those delaying childbearing reported they were satisfied with that decision. A study by Rangel et al surveyed 850 surgeons and found that among 692 female surgeons, 42% had experienced a pregnancy loss, twice the rate of the general population. Furthermore, compared with male surgeons, female surgeons had fewer children, were more likely to delay having children due to training and were more likely to use ART. In a Society of Gynecologic Oncology (SGO) evidence-based review, Temkin et al report that parenting affects academic advancement opportunities more for women than it does for men and that perceived workplace pressures (such as those related to institutional productivity goals) as well as concern about retaliation lead to truncation of maternity leave. This segues into the study by Lee et al, in which one-third of survey respondents reported discrimination due to pregnancy or maternity leave.

Female physicians who want, will soon have, or do have children do not have it easy. Lee et al advocate for early education on ART risks, benefits, and success rates, but this is not getting at the underlying issue: pregnancy discrimination and unfair distribution of childbearing responsibilities are a reflection of a larger problematic culture rather than an issue specific to women in medicine. These cultural values are so deeply pervasive (one could also say invasive) that they affect even these most educated and wealthy professional women, such as those who participated in this survey. Increased access to ART only delays the lack of support and discrimination women will face if and when they do ultimately bear children. Medical students are already taught that as women age, their fertility decreases. Encouraging formal and directed education regarding the infertility risks specifically toward female physicians (which Lee et al recommend) could be perceived as a blanket recommendation that it is best for women in medicine to delay childbearing and pursue ART. Medical schools and residency and fellowship training programs should instead focus their energy on creating a framework and culture that normalizes conception during these points in training while also subsidizing and supporting trainees and physicians who prefer to use ART and delay fertility until after training. Women medical students become women residents and fellows who become women...
attending physicians. Whether they are becoming pregnant at the beginning or end of this spectrum or not at all, there will be a workplace that must support them.

Physicians are respected members of society, and as such, their voices may enact grassroots changes in issues affecting childbearing. Many participants in this study were recruited from their respective professional organizations. Within the cited specialties, these organizations set standards for members of their specialties. It would be well within their members’ interests for these organizations to set standards for recommended maternal and paternal leave policies. as well as lobbying for more just leave policies on a national level. There are likely male partners in these specialties and across the nation who would like to be more supportive but who are also limited in the amount of leave they are afforded by their workplace—paternity leave is still a novel and emerging concept at this time. If there are policies put in place for better maternity as well as paternity leave, supportive partners may be better able to avail themselves to participate more equally in at least early childbearing. Being a supportive professional organization includes these larger responsibilities as well as perceived smaller ones, such as prioritizing having dedicated lactation spaces at professional conferences, offering a virtual or more local option for credentialing examinations that require travel in case a participant is pregnant or recently postpartum, and facilitating formal parenthood mentorship pairings for newer and more seasoned parents. It is imperative that professional medical organizations prioritize gender equity within themselves and also lobby for these changes on a national level.

ARTICLE INFORMATION

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Conflict of Interest Disclosures: Dr Blank reported receiving grants from AstraZeneca, Aravive, Akesobio, GlaxoSmithKline, Merck, and Seattle Genetics outside the submitted work. No other disclosures were reported.

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