Letters to the Editor

Examining Gender Disparities in Medicine

To the Editor: Dr. Walter and colleagues fail to prove their startling claim with the cited sources.[1] The stated 16% difference in earnings[2] is based on an analysis of the 2019 American Board of Family Medicine National Graduate Survey Data.[3] The article by Walter assumes respondents' employment status will not change after 3 years into their career, but the publicly available survey data does not address future career choices. That data set also highlights a wide range of employment choices without gender differentiation. Only one-half of respondents reported working in a private patient care setting, and one-fourth were employed in a government-run or government-funded work setting.[3] Were adjustments made for work settings by gender in reaching their estimated 16% difference in hourly compensation? In my experience, government employment pays less but provides greater nonmonetary benefits than private sector employment, but the authors' estimates appear to be based only on total incomes, excluding benefits.

Walter and colleagues state that evidence does not support reduced work hours as a cause of lower female family physician earnings; however, the policy brief by Jabbarpour and colleagues and the study by Ganguli and colleagues document that female physicians work fewer hours than their male peers.[2,4] This disparity does not explain the entire earnings gap, but the assertion that "'...women elect to work fewer hours'...[is] not supported by evidence" is itself lacking evidence. Using Jabbarpour's method to calculate yearly hours worked, a 3.9-hour weekly difference equates to more than 202 hours over a year, or nearly 4 work weeks. Ganguli found a smaller but statistically significant 5.3-day difference per year. This study also documents an adjusted 10.9% difference in generated revenue between male and female family physicians, which contradicts the assertion that there is no evidence of a productivity difference.

I hope the authors will clarify their assumptions and provide stronger evidence for their claims. I agree that gender pay disparities are an important issue in medicine.

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In Reply: We appreciate this reader's attention to our critical evaluation of the gender wage gap in medicine. Our analysis addresses the concerns that female physicians' choices (e.g., number of hours worked, changes in employment, diversity in employment settings) may affect their earnings.

We do not track employment changes over time for males vs. females. Our analysis is based on starting salaries, which other studies have shown predict future salaries[1] and the widening of this wage gap throughout their careers.[2] Therefore, we project that a lower starting salary predicts a lower salary overall, but we do not assume that salaries never change, nor do we incorporate bonuses or significant raises across one's career into our conservative estimate.[1]

As the reader mentioned, work settings can affect pay disparities. However, more women work in these lower-paying settings, and the disparity persists even after controlling for work settings.[3]

Jabbarpour controlled for differences in hours worked by calculating the difference in hourly wage to determine wage differences,[4] finding that females earn less than their male counterparts per hour. Ganguli found that female physicians saw fewer patients but that female family physicians also spent more time with each patient than their male counterparts.[5]

As the number of female family physicians continues to increase, advocating for wage equity in family medicine becomes ever more important.

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Treatment of Allergic Rhinitis During Breastfeeding

To the Editor: I enjoyed the article by Drs. Weaver-Agostoni, Kosak, and Bartlett on treating allergic rhinitis in diverse patient populations, including during pregnancy.[1] The article would benefit from addressing treatment in the postpartum period. Family physicians should use patient-centered decision-making when discussing the risks and benefits of allergic rhinitis medications with patients who are breastfeeding.

The *American Family Physician* article "Medication Safety in Breastfeeding" provided general considerations for minimizing the potential risks of drug therapy while breastfeeding,[2] but there is limited high-quality evidence that evaluates the effect of medications for allergic rhinitis on lactation in patients who are breastfeeding (Table 1[3,4]). The greatest risk of these medications is their effect on milk supply; intranasal corticosteroids, cromolyn, and ipratropium (Atrovent), followed by second-generation antihistamines are preferred because they are less likely to affect milk supply. Use of first-generation antihistamines, oral decongestants, and montelukast should be minimized while breastfeeding.[2-4] Intranasal medications are generally safer than oral medications.[3,4] These recommendations limit the systemic absorption of medications in breast milk and conserve milk supply.

Family physicians should understand the effects of medications on lactation to provide full-spectrum care for the birthing person/newborn dyad. Allergic rhinitis is a common diagnosis and treatment can affect a person's ability to breastfeed effectively. Although more research is needed, medications for allergic rhinitis do not show a significant risk to infants who are breastfeeding and are likely safe for use.[3,4]

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Editor's Note: This letter was sent to the authors of "Allergic Rhinitis: Rapid Evidence Review," who declined to reply. ■

TABLE 1

Treatment of Allergic Rhinitis During Breastfeeding

Class	Drug	Risks to infants during breastfeeding	Effects on milk supply
Intranasal corticosteroids	Beclomethasone Budesonide Ciclesonide Flunisolide Fluticasone Mometasone Triamcinolone	Probably safe due to low bioavailability	No effect on milk supply
First-generation oral antihistamines	Chlorpheniramine Diphenhydramine	Probably safe due to low bioavailability; observe for sedation in infants	May reduce milk supply
Second-generation oral antihistamines	Cetirizine Desloratadine Fexofenadine Levocetirizine (Xyzal) Loratadine	Probably safe due to low bioavailability; no sedative effects	May reduce milk supply
Intranasal antihistamine	Azelastine	Probably safe due to low bioavailability; observe for sedation in infants at higher doses	May reduce milk supply at higher doses
Combination intranasal corticosteroid and antihistamine	Azelastine/fluticasone (Dymista) Olopatadine/mometasone (Ryaltris)	Probably safe due to low bioavailability; observe for sedation in infants at higher doses	May reduce milk supply at higher doses
Oral decongestants	Pseudoephedrine	Probably safe due to low bioavailability; observe for agitation in infants	Reduces milk supply through reduced levels of prolactin
Intranasal mast cell stabilizer	Cromolyn	Probably safe due to low bioavailability	No effect on milk supply
Intranasal anticholinergics	Ipratropium (Atrovent)	Probably safe due to low bioavailability	No effect on milk supply
Leukotriene receptor antagonists	Montelukast	Probably safe due to low bioavailability; U.S. Food and Drug Administration boxed warning for use in people younger than 18 years because of mood-related changes and suicidality	Reduces milk supply through reduced levels of prolactin

Information from references 3 and 4.