Failure to progress: structural racism in women's healthcare

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There has been tremendous progress in the field of women's health in the last 100 years. Impactful innovations include intracytoplasmic sperm injections and a wide range of complex procedures such as intrauterine fetal and robotic-assisted surgeries. Yet the juxtaposition of advances in reproductive medicine and the persistent racial gap in reproductive health outcomes highlights where there is a lack of progress: racial equity. Black, American Indian, Alaskan Native, and Latina women in the United States (U.S.) are more likely to experience preterm birth compared to White women, and Black women are significantly more likely to die in childbirth.[1,2] (We acknowledge that the term 'women' does not adequately encompass the reproductive health needs of trans-men and gender non-binary people who can become pregnant, give birth, and need abortion care. However, we use 'women' to reflect the historical context of events, and the gender-inequitable treatment of women in health care). Black and Latina women are more likely to have unintended pregnancies and experience delays in accessing abortion care.[2] Given that race is a social, not biological, factor, these examples of health inequities reflect the effect of structural racism[3] on women's health, which leads to worsening clinical outcomes, poor experiences, and mistrust. Reproductive justice begins with acknowledging the racism in our field, obstetrics and gynecology.

In the U.S., pregnancy and childbirth have been marked by inequity since the nation's beginnings. Enslaved women were forced to reproduce against their will, bearing children for the benefit of slaveholders. Forced reproduction became more pronounced after the slave trade ended in 1807; from that point, the only way to continue the institution of slavery was to force enslaved women to bear children. When physicians were called to assist with difficult births, they used the opportunity to experiment on enslaved women. A French physician, Francois Marie Prevost, came to the U.S. and performed experimental and dangerous cesarean deliveries in Louisiana on enslaved women in the 1830s.[4]

The White male physicians who experimented on the bodies of enslaved Black women were not condemned for being unethical but instead were revered for their medical contributions. A classic example is the adulation afforded J. Marion Sims. He refined surgical techniques for vesico-vaginal fistula repair in the 1840s through repeated surgery on enslaved women including three named Lucy, Anarcha, and Betsey. Sims performed more than 30 surgeries on Anarcha alone, without anesthesia.[5] Until recently,[6] the women he operated on remained unacknowledged.

Once slavery was abolished and Black children no longer had monetary value, it became common for physicians to sterilize Black women without their consent. In 1961, Fannie Lou Hamer went to a hospital in Mississippi for removal of a uterine fibroid but a total hysterectomy was performed without her consent. She later became a civil rights activist and coined the term 'Mississippi Appendectomy', meaning an unindicated or undesired sterilization without consent performed on Black women during surgery for other indications.[4] These egregious practices are not only historical events; they continue today. Between 2006 and 2010, more than 100 women incarcerated in California, primarily Black and Latina women, were sterilized without their consent.[7] The profession of medicine has continually given Black, Indigenous, and Latina women reason to mistrust their care when seeking reproductive healthcare.

Pregnant Black and Latina women continue to report that their medical concerns are not heard, validated, or addressed. Black healthcare providers and Black families express concerns that Black women receive different treatment in pregnancy leading to medical errors and even preventable deaths.[8]

Based on the history of structural racism in women's healthcare, continued increases in maternal mortality and disparities, and perceived disregard for patient concerns, mistrust of clinicians in our field is not surprising. The Supreme Court's recent decision to revoke the constitutional right to abortion, *Dobbs v Jackson*, will disproportionately harm Black and Latina women because women of color experience significantly worse maternal and reproductive health outcomes, including unintended pregnancy, due to structural racism.

Post-*Dobbs*, existing mistrust is likely to increase as clinicians become hesitant to provide evidence-based patient care for conditions such as pregnancy loss and ectopic pregnancy due to fear of legal repercussions.

Continued advancement in women's healthcare requires retooling and restructuring our systems of care to affect progress across the entire field (Fig. 1).

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For clinicians to:
- provide evidence-based reproductive health care, without inequity by race or ethnicity
- advocate to close gaps in access to the full spectrum of evidence-based reproductive health care
- effectively listen to the needs of vulnerable patients including Black, Latina, and Indigenous patients to recognize and address the impact of racism on health
- ensure that patient privacy is protected, and that private medical information is not shared inappropriately with authorities

For departments/ women's health practices to:
- create a culture of justice by educating clinicians and staff and implementing structures and processes to ensure accountability, backed by tangible metrics
- uplift and expand the work of advocates and demonstrate their intentions by committing the necessary time and financial resources to produce and sustain change
- identify and address racist behaviors in the workplace with concrete action
- employ a diverse workforce to ensure that our practices and departments are welcoming and inclusive and reflect the diversity of our communities

For professional societies and medical boards to:
- uphold the goals of reproductive justice in their vision, mission, and organizational strategies by reinforcing anti-racism position statements and activities during national meetings, and devoting attention to these issues through leadership roles and publications
- encouraging members to engage in continuing education on bias in medicine such as through maintenance of certification
- endorse using tangible metrics to measure progress towards addressing racism in our field and closing the gap in health disparities

For institutions of medical education to:
- ensure that trainees and faculty have a deep grounding in anti-racist training
- make concrete efforts to advance health equity in medical education to ensure that learners understand the effects of racism on health outcomes and that race-based biases are not perpetuated in the curriculum
- ensure that students and faculty who are under-represented in medicine are recruited and supported by role models with shared identities

For reproductive health researchers to:
- consider when and how to include race as a variable in research to ensure we understand the effects of racism on health without using non-biological determinants of reproductive health as variables
- ensure researchers from affected communities are engaged in research understanding and addressing the effects of racism on reproductive health outcomes
- validate tangible metrics to measure progress towards addressing racism in our field
- advocate for increased funding from the NIH and foundations to support measuring interventions to address racial disparities and racism in women's healthcare and to adequately fund research on the full spectrum of reproductive health care inclusive of abortion care

Fig. 1: Recommended actions to support anti-racism in Women's healthcare: A call to action to ensure progress towards undoing racism.

Dismantling the structural racism that is deeply rooted in our field goes beyond advocacy and requires recreating systems of care conducive to reproductive justice. This includes cultivating systems that offer reproductive choice, including safe and respectful birth or abortion care.

We acknowledge the growing national efforts to address reproductive equity (examples include Sister-Song and State Perinatal Quality Collaborative equity projects). However, the failure to progress is unacceptable. The U.S. has now taken a step backward, eliminating legal abortion care in many states, thus worsening reproductive injustices. The Joint Statement "Collective Action Addressing Racism"[9] released in 2020 by leading professional organizations in the field, highlights that anti-racism work in our field must have accountability structures and measurable goals. As these goals and structures are being solidified, accountability will include dedicated resources to optimize progress. Elimination of racial inequities that persist in our field requires honest reflection and effective, urgent action. Clinical outcomes must reliably reflect the best possible outcomes - without racial or ethnic injustices – then we can talk about progress in our field.

Contributors
SA conceptualized and wrote the original draft. All authors reviewed and edited the final draft.

Declaration of interests

The authors have no conflicts of interest to report.

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