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Commentary

Racial Discrimination against Minority Healthcare Workers in Women's Health

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Abstract: The women's sexual and reproductive healthcare sector, one of the largest employers delivering services globally, does not always commit to equality, diversity, and inclusion. There is objective, published evidence that not only care provision but also workforce treatment permits inequality and discrimination. The black and ethnic minority workforce in the women's health specialty, compared to their white counterparts, is often treated unfavorably in appointments, is less often afforded academic development opportunities, is, at many sites, subjected to disproportionately greater disciplinary penalties, tends not have representation in positions of authority, and undertakes training in what is often perceived as a climate of fear due to racism. This problem deserves immediate action by professional bodies. They have the responsibility to remove feelings of exclusion and lack of belonging to all staff, the negative impact on wellbeing caused by unnecessary stress, and concerns over career progression among minority ethnic healthcare workforce and other workers who report discrimination. This duty is part of the societal responsibility to ensure fairness and eradicate discrimination under the equality, diversity and inclusion agenda.

Keywords: obstetrics and gynaecology; equality; diversity and inclusion; protected characteristics; racism; discrimination; equal opportunities

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1. Introduction

It can be argued that the women's sexual and reproductive healthcare sector, one of the largest employers delivering services globally, have a larger duty than any other sector to commit to equality, diversity, and inclusion. In the early months after the start of the 2020 coronavirus pandemic, as the news of higher mortality rate among Asian healthcare workers surfaced [1,2], Dr Gloria Esegbona, a London gynaecologist and a global women's health activist [3], wrote an open letter to the UK Royal College of Obstetricians and Gynaecologists stating, 'I've experienced racism throughout my life—but what I've felt in my career has been stark and brutal. I want it to stop—no one else should suffer because of the colour of our skin'. Her opening remark was that she "can't breathe!!!", like the callously murdered George Floyd in the USA, reverberates with the academic papers about structural racism in the healthcare sector in that country [4–7].

It was exceptional to see a currently working gynaecologist of the black and ethnic minority group coming forward with demands that her professional body, the UK Royal College of Obstetricians and Gynaecologists, stop racism by looking at its diversity policies [3]. As soon as she posted her comments on the professional network LinkedIn, droves of colleagues came forward in her support with comments of their own experiences of racism and discrimination [3]. They asked the UK Royal College of Obstetricians and Gynaecologists to listen. Their stories highlighted that this College was repeatedly and continuously discriminating against doctors of color, who come largely from low- and middle-income countries as the UK is a net importer of doctors from these regions [8]. As the UK healthcare workers urged tackling of racism and inequality in the health service [9], in the USA too there were calls to rise against racism in the healthcare sector [7]. This discrimination within healthcare and demands for change are likely widespread [10].

2. Racism against Healthcare Workers

According to the law, in most upper-income countries, discrimination means practices and policies that apply to some workers and not to others. By law, protected characteristics include a diverse range of features such as age, disability, gender, pregnancy, race, religion or belief, and sexual orientation, amongst others. If the protected characteristic under perceived threat is race, the discriminatory act implies an act of racism that puts people of minority races at a disadvantage [11]. This is what Dr. Esegbona was complaining about in her LinkedIn post [3]. She was providing one clear example of the various ways in which different groups and subgroups of black and ethnic minority healthcare workers experience discrimination.

Racial and other disparities in health organizations breed a hostile environment not conducive for safe healthcare delivery. Racism, according to critical race theory, is an organizing principle for different sectors of society where, for example, features of skin color become markers of relative inferiority. It is well-established that in the health sector, compared to their white counterparts, black and ethnic minority professionals suffer from racial inequality practices. They are treated unfavorably in appointments [12,13], are less often afforded academic development opportunities [14], and are paid less [15]. While being treated as an outsider in service, they are also subjected to disproportionately greater disciplinary penalties [16,17]. A recent court judgment confirmed that the doctors' regulatory body, the UK General Medical Council, was not free of racism [18]. Disadvantaged groups tend not have representation in the high offices [19,20]. The unconscious bias of members of senior staff who do not have the lived experience of the minority ethnic communities plays a covert role in discrimination. Mischaracterization and stereotyping, even criminalizing, is a common experience of minority ethnic groups [21,22]. During training, black and ethnic minority medical students and doctors often work in a climate of fear, including the threat of assumptions about inferior clinical competency, derogatory comments, bullying and victimization [23]. There are similarities and differences in the experience of different discriminated groups, e.g., women's healthcare workers may experience multiple forms of discrimination at the same time. Many other professional groupings including, e.g., the coalition for diversity and inclusion in scholarly communications have pledged to respect diversity, promote marginalized voices and eliminate barriers [24].

3. Racism in Provision of Women's Healthcare Services

That minority populations are at risk with respect to the healthcare they receive is accepted widely [25,26]. However, the fact that inequality and bias exists not only against the patient population but also against the healthcare workers is seldom recognized [27]. When it comes to the women's health specialty, there are no good news stories [28]. Citing official published data, a recent BMJ blog makes clear that 'Women from ethnic minorities face endemic structural racism when seeking and accessing healthcare' in the UK National Health Service [29]. Another article concerning disparities in maternal care stated that 'Black and ethnic minority women are paying with their lives for the lack of action on racial bias' [30]. It is incumbent on all professional associations to examine their practices and policies. Like professional bodies in reproductive health in other upper-income countries, in the UK, the Royal College of Obstetricians and Gynaecologists has presided over the provision of women's health care since its creation. These colleges and bodies are run largely by white officers at the exclusion of non-white colleagues. UK government ethnicity facts and figures confirm that in the health service there is a higher proportion of staff from minority ethnic backgrounds in supporting and middle grades compared with senior and very senior manager grades [20]. One must wonder how officers of the Royal College of Obstetricians and Gynaecologists are selected for honors and why they accept them, knowing their college is perceived as discriminatory both towards patients and workers [27–30]. There is a need for greater insight into this issue by professional leaders across upper-income countries where there are migrant patients and workforce from low- and middle-income countries who are directly affected by discriminatory practices.

4. The Way Forward

Marginalization and social exclusion of specific groups exists in the general population but also in professional institutions. The evidence of racism in women's health has been shown in peer-reviewed papers [27–30]. I recommend, as a first step, to set an example that professional bodies, while denouncing institutional racism, could return the honors awarded to them as a gesture of their commitment to go forward with structural reform. They need to take note of the history lesson from the debacle of their own "father of modern gynaecology", a known racist in the profession who used female slaves as experimental guinea pigs [31].

An article in the *Journal of Medical Ethics* concluded the following about J. Marion Sims: "his fame and fortune were a result of unethical experimentation with powerless Black women . . . in his quest for fame and recognition, he manipulated the social institution of slavery to perform human experimentations, which by any standard is unacceptable" [31]. His statues in South Carolina and New York have now been removed [32]. The Medical University of South Carolina renamed an endowed chairmanship previously named for Sims who was known as the medical giant of Alabama [33]. In Montgomery, Alabama, there now stands the "Mothers of gynaecology" statue to recognize and honour the three enslaved women, Anarcha, Betsey and Lucy, on whom Sims ruthlessly experimented in the 1840s [34]. One could also look at the example from the recent history of Nobel laureate, James Watson, who jointly discovered DNA's structure. Watson's repeated statements about the inferior intelligence of the black population have been documented [35,36]. Cold Spring Harbor Laboratory, his alma mater, stated that Watson's statements were "reprehensible, unsupported by science" [37]. Thus far, only limited reaction has been had from research institutions, and none from the award-giving organisation or women's health professional bodies, despite demands for a break in the silence [38,39].

5. Conclusions

Upper-income countries need to engage in soul-searching and take corrective and concrete meaningful action to eliminate all forms of discrimination, racism being the most prominent, and to prevent its emergence. The professional bodies have a responsibility to remove feelings of exclusion and lack of belonging caused by lack of inclusion and negative impact on wellbeing caused by unnecessary stress due to workplace inequality, and concerns over career progression among the minority ethnic healthcare workforce [40]. This duty is part of the societal responsibility to ensure fairness and eradicate discrimination under the equality, diversity and inclusion agenda.

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