Medical Discrimination Series #2:

The Discriminatory Roots of Women's Health

Welcome!

What is Medical Discrimination?

Prejudice and discrimination in medicine and within the medical and healthcare systems based upon perceived race, gender, religion, ethnicity, sexuality, or more.

Manifest itself in four different ways:

- Conceptual ideas of identity
- Discrimination result in differential medical treatment
- The experience of identity negatively impacting one's health
- Institutional discrimination

Gynecology

Partus Sequitur Ventrem

Partus Sequitur Ventrem (1662 VA) was the legal doctrine that mandated children of enslaved women inherit an enslaved status.

"That which is brought forth follows the belly (the womb)."

Slave masters would frequently rape Black women, producing biracial children. This doctrine was implemented to legitimize the enslaved status of biracial children and increase the enslaved population.

The Start of Gynecology, NOT Women's Health

During slavery, an enslaved Black woman's worth was measured by how many children she bore. **Slave masters sought doctors to fix "broken" or infertile Black women** and restore their perceived function.

Gynecology was not borne out of concern for women's health. It was born out of the need for Black women to **increase the slave population** after slave importation into the US was banned in 1807.

1800s James Marion Sims

James Marion Sims, credited as "The Father of Modern Gynecology," was a 19th century gynecologist, a slaveholder, and conducted numerous research studies performed on enslaved Black women without consent (the only consent needed was from the slave owners) and anesthesia.

One young woman, **Anarcha, was operated on by Sims 30 times without anesthesia.** His reasoning for not using medical anesthesia was that "Black people do not feel pain." Only after four years of experimenting on Black women and perfecting his process, and with the use of anesthetics did Sims begin operating on white women.

1800s James Marion Sims

Sims later founded the first women's hospital in 1856. There, **Sims accepted only white women as patients**. They were afforded privacy during their operations, as well as sterile instruments and anesthesia. He believe that white women were too delicate to withstand the agony of an operation and **maintained the idea that it was the wealthiest white women who were the most susceptible to pain**.

1916 Margaret Sanger

Margaret Sanger opened the first birth control clinic in the United States in 1916. The clinic was opened on the premise that women should have the right to decide when to bear children and that increasing access to birth control would prevent back-alley abortions (a procedure Sanger was opposed to).

Sanger was a supporter of eugenics to "assist the race towards the elimination of the unfit." Sanger advocated for exclusionary immigration policy, supported Klansman Lothrop Stoddard, and spoke to a woman's auxiliary group of the Ku Klux Klan. **Sanger is one of many examples of women who disregard women of color in gynecological or obstetric advances.**

1950 Contraceptive Trials in Puerto Rico

The first large scale human trial of a birth control pill took place in Puerto Rico in the 1950s. Prior to these human trials, the pill had been tested on rabbits, rats, and a few women. A few known side effects ranged from depression to death.

In this trial, **over 1,500 Puerto Rican women were enrolled**, many who lived in poverty and who had multiple children. These **women were not informed that the drug was in clinical trial** and that the pill they were taking was simply experimental with unknown side effects.
Over the course of the trial, **26 women developed blood clots and 6 women died as a result. There were no investigations into their deaths.**

1951 Henrietta Lacks

Henrietta Lacks was a Black woman and mother of four, living in Baltimore in 1951 when she went to Johns Hopkins Hospital to be treated for cervical cancer. At one of her biopsies, **her cells were unknowingly taken from the tumor and cultured until they became the HeLa cell line, one of the most important cell lines in history.** Ms. Lacks died shortly after the biopsy and her cell line was the first immortalized cell line in history which went on to be used for medical research and commercial purposes.

Her family did not find out about the cell line until 1975 and to this day, they have **received none of the profits** from their mother's cells. (point to drive across: the disregard and the profiting of Black lives). **Her cells have uncovered treatments for polio, cancer, and HPV.**

1970 Forced Sterilization of Indigenous Women

With the passage of **Family Planning Services and Population Research Act of 1970, sterilizations were subsidized for those who received their healthcare from the Indian Health Service and for Medicaid patients**. Even before the passage of this act though, Indigenous Women living on reservations were forcibly sterilized. **An estimate 70,000 (40%) Indigenous women were sterilized without their consent in the 1960s to 1970s**. At the time, the sterilization rate for white women was only 15%.

The forced sterilization continued on until the late 1970s. **These procedures only stopped after pressure from Indigenous activists forced the adoption of federal regulations, which required different protections for Indigenous women who were victims of these procedures**.

1981 Forced Sterilization Laws

It was **legal in the United States to practice "forced sterilization" on women until 1981**. Most commonly, this practice was used on minority and disadvantaged women with Black and Indigenous women disproportionately affected.

While technically illegal now, between 2006 to 2010, more than **148 female inmates in Chowchilla, CA were given tubal ligation without record of proper consent** at the California Institute for Women in Corona and Valley State Prison. Knowing the overrepresentation of BIPOC in the prison system, minority women were most affected.

2020 Forced Sterilization ICE Detainees

Immigrants in a US ICE detention center in Georgia are being subjected to horrific conditions and treatment, including **"jarring medical neglect" and a high rate of hysterectomies among women**, according to a whistleblower complaint filed by several legal advocacy groups on behalf of a nurse, Dawn Wooten, who works there.

An alarmingly high rate of hysterectomies have been reported– a surgery in which part or all of the uterus is removed – being performed on Spanish-speaking immigrants, **many of whom did not appear to understand why they had undergone the procedure**.

Medical Discrimination in Gynecology Today

- After an abnormal finding on a screening mammogram, Black, Latina and Asian women all had less timely follow-up than whites, and Black women were much less likely than white women to undergo biopsy.
- Black females are less likely to have breast cancer than white females, but 40% more likely to die from the disease.
- A black female is 71% more likely to die from cervical cancer than a white counterpart.

Today, gynecology (and obstetrics) still favors wealthy, white, cisgender women over BIWOC, low-income women, and non female-identifying folx.

The Period Tax

The average cost of a box of tampons in the US is $5.99 and the average cost of a pack of pads/panty liners is $4.49.

Currently, 30 states view pads and tampons as luxury goods and impose a sales tax which is often known as the “Tampon Tax.” To give contrast, groceries and medication are considered non negotiable necessities are are tax-exempt in most states.

Secondly, men’s exclusively used items such as viagra, roganine, and condoms are exempt from the sale tax deeming them medical necessities.

Period Poverty

Period poverty is an umbrella term for inequalities related to menstruation. Students, low-income, and homeless female-bodied people struggle with period poverty.

Each day, there are 800 billion people in the world who are menstruating and 500 billion lack adequate resources such as basic supplies, facilities, information, and support for managing their periods.

One in four students have missed school or class due to lack of access of menstrual products.

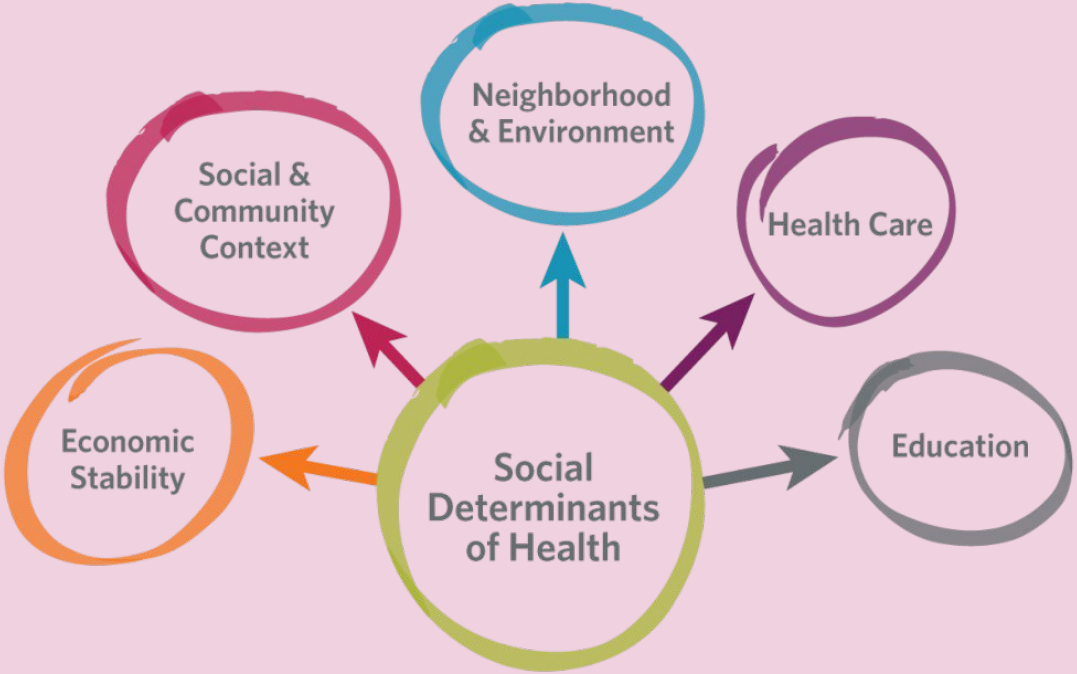
Period Poverty during COVID-19

The COVID-19 pandemic has only exacerbated period poverty worldwide.

One in three menstruating people are struggling to buy period products. Those experiencing homelessness report infection caused by tampons and pads for longer than recommended or improve with items such as paper towels or newspapers. Incarcerated individuals often beg or bargain with staff for basic hygiene needs.

Obstetrics

The Social Determinants of Health



What is Weathering?

The concept of weathering was hypothesized and coined in 1992 by Princeton University scholar, Arline Geronimus, during her time working at a program for pregnant teenagers in Trenton, NJ.

> *"Black women's health deteriorates in early childhood as a result of their cumulative exposure to socioeconomic disadvantages and racism."*

Weathering is similar to BIPOC stress and minority stress, but weathering often centers Black women.

Effects of Weathering

Chronic stress due to socioeconomic disadvantages starts to wear down on our body from a physiological level.

In a CARDIA (Coronary Artery Risk in Young Adults) study conducted from 1985-2016, researchers looked at the biological age of 2,700 middle-aged Black and white participants. They found that:

- Black participants aged 6.1 years faster than white participants
- Confirmed that difference in psychosocial and socioeconomic experiences take a larger toll in the physiological health in Black individuals than white individuals.

Weathering & BIPOC Women

For BIPOC pregnant people, weathering dangerously affects "maternal"-fetal health. Chronic stress from weathering leads to chronic illnesses such as:

- Diabetes
- Heart disease (esp. hypertension)
- Mental health disorders
- Higher risk for cancer & stroke
- Obesity

Weathering solidified the idea that it is the embodied effects of living as a BIPOC in a racist society that produces health inequalities. Weathering and its proceeding health inequalities make many BIPOC pregnancies high-risk.

BIPOC & High-risk Pregnancy

High-risk pregnancies requires special monitoring and care throughout pregnancy often due to a health problem before, during, or after delivery. Some factors of high-risk pregnancy include:

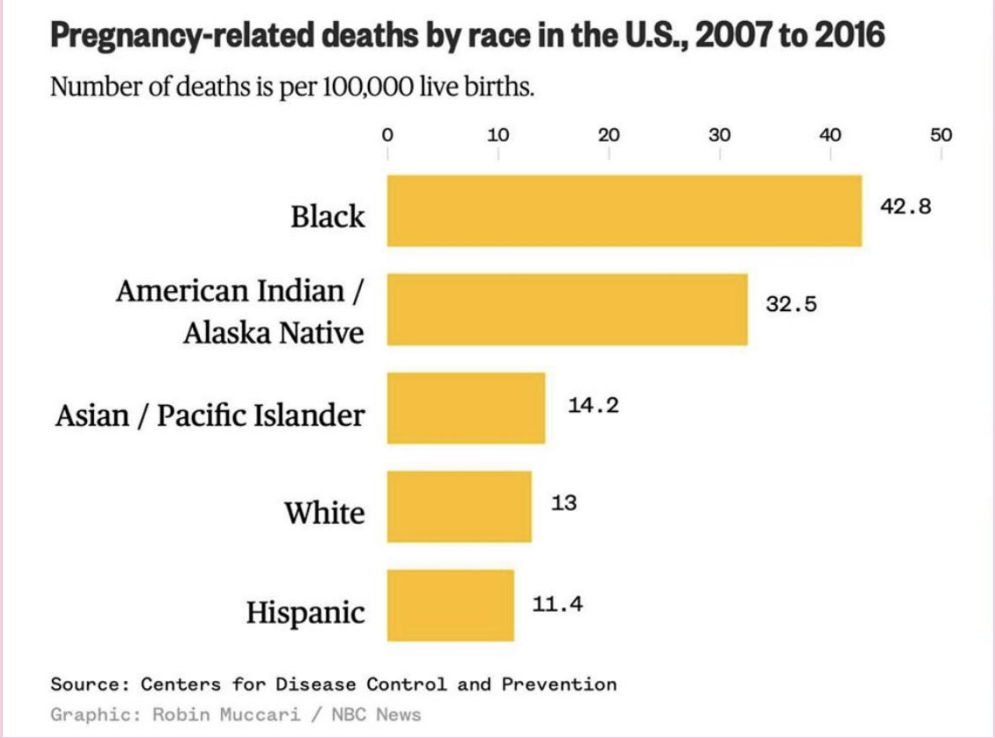
- High blood pressure or preeclampsia
- Diabetes or gestational diabetes
- HIV-positive
- Obesity
- Cesarean delivery
- Twins and higher-order multiples

Today's Black Maternal Mortality Pandemic

America has the highest maternal mortality rate in the industrialized world. These deaths are largely led by a single demographic: Black women.

- Black women in the US are 243% more likely to die from pregnancy or childbirth related causes.
- Black mothers die at: 5x the rate of white mothers, one of the widest of all racial disparities in women's health. 12x the rate of white mothers in the state of New York during pregnancy or childbirth due to racism in the healthcare system.
- The risk of death for black babies is double that of white, Asian, and Hispanic babies.

Today's Black Maternal Mortality Pandemic



Example: Serena Williams

One day after delivering her baby via emergency C-section, tennis player **Serena Williams lost her breath and recognized the warning signs of a serious condition**. Serena walked out of her hospital room and approached a nurse. Gasping out her words, she shared that she feared she had a blood clot (something that she had survived in the past) and needed a CT scan and an IV of heparin, a blood thinner.

The nurse suggested that Serena's pain meds were making her confused. Serena insisted that something was wrong, so they conducted an ultrasound on her legs to address swelling. When that turned up nothing, she was **finally sent for a lung CT which found several blood clots. And just as Serena had suggested, heparin fixed the issue.**

Postpartum Care

Maternity Leave in the US

Overall, maternity leave in the US is greatly stigmatized and looked down upon in a patriarchal society (ex. predominantly male-run institution not giving paid maternity leave).
Lack of a maternity leave disproportionately influences low-paid and part-time workers simply because they cannot afford to take time off. There is an increased likelihood of pregnant BIPOC women with working jobs that do not offer flexible maternity leaves. There are also limited options for both prenatal and postpartum care for BIPOC people, largely due to the inability to afford taking time off.

The Racist History of Breast-feeding

In the 18th century, breast-feeding was perceived as demeaning and uncultured, so white mothers would refrain from breastfeeding to maintain stature. However, children of enslaved people grew healthy from breastfeeding while white babies were dying. The solution? **Enslavers extracted the breast milk from enslaved women's bodies.**

This forced enslaved Black women to dedicate the majority of their milk to white children. To substitute breast-milk, they would feed Black children substitutes such as cow milk which caused **the death of enslaved babies to rise.**

The Racist History of Breast-feeding

Today, the racist legacy of breast-feeding resulted in a lack of Black representation in lactation and motherhood spaces (as well as academic cultural barriers).

Additionally, the CDC reports that **Black women have some of the lowest breastfeeding initiation rates (64%) and the shortest breastfeeding durations (~6.5 weeks) across all race groups**.

Stigma in Postpartum Depression Care

Among all female-bodied people, postpartum depression care is significantly stigmatized and diminished in a patriarchal society.
However, this **stigma is most prevalent in minorities communities where mental health care is not accepted**. Additionally, **among the lower-income population, sustainable mental health care is not an option**.

Provider implicit bias also infiltrates mental health care. A 2011 study revealed:

- Lower initiation rates by physicians for Black women (4%) & Latina women (5%)
- Only 23% of low-income women (especially those from a racial-ethnic minority group) were actually diagnosed with postpartum depression by their healthcare provider
- Black and Latina women were less likely that white women to accept and sustain mental health care after delivery (white women were 2x more likely).

BIWOC & Postpartum Depression Care

The differences in initiation and continuation of care imply that **a disproportionate number of Black women and Latina women suffer from postpartum depression do not receive needed services** which represents racial-ehtnic disparities related to outreach, detection, service provision, quality, and processes of postpartum mental health care.

*The study only examined Black, Latina, and white women; however, it should be noted that most minority groups experience lower rates of mental health care, especially among Indigenous and AAPI people who are categorized as the least likely of every racial/ethnic group to accept mental health services.

Non-female Identifying People & Pregnancy

Many non-female identifying people, such as transgender men and non-bindary folx with functioning natal reproductive organs, are left out of this conversation.

In 2015, a study revealed that **pregnant transgender men often experience gender dysphoria, discrimination, assault, and insufficient health provider training/awareness, and individual loneliness during pregnancy**.

This gender dysphoria can be exacerbated during pregnancy, but especially during delivery and breastfeeding (sometimes called chestfeeding). The same study indicated that **33-36% of pregnant transgender men requested cesarean delivery due to patient concerns with or disassociation from natal female genitalia**.

Non-female Identifying People & Pregnancy

The study also showed that **breastfeeding/chestfeeding potentially increased possibility for gender dysphoria and the choice to breast/chest feed varied among how the man chose to feel their infant**. Testosterone hormone therapy also played a significant role in transgender men and their pregnancies.

For mental healthcare, as baseline depression and suicide rates among transgender individuals is alarmingly high, both **depression during pregnancy and postpartum depression among transgender men and noncisgender female-bodied folx merit special attention and support**. More research needs to be done on this topic.

So what do we do now?

1. Identify, understand, and combat our implicit biases.
2. Keep educating yourself on medical discrimination.
3. Be involved in anti-racist patient advocacy programs.
4. Promote increased cultural competency and diversity training programs for medical professionals.
5. Make active allyship a lifestyle and not just a reactive mindset.
6. Understand that medical practice and science has never been "neutral." Science is an institution that has carried and normalized biases and discrimination from its founding.

Specific Action Items for OB/GYN

1. **Support black-owned birth centers and doula practices.**
    a. National Birth Equity Collaborative, Sista Midwife Productions/Directory, Black Mamas Matter Alliance, MomsRising, The Shades of Blue Project, The Black Maternal Health Caucus, Mama Glow, Sésé Doula Services, Growing and Glowing
2. **Make legislative efforts**: Black Maternal Health Momnibus Act of 2020, Repeal the Tampon Tax
3. **Demand comprehensive INCLUSIVE gynecological health education** surrounding gender fluidity in OB/GYN, menstruation, and access to period products in schools, shelters, and prisons.
4. **Donate period products** to local shelters and food pantries.

Specific Resources for Minorities

1. **Keep educating yourself** on medical discrimination.
2. Engage in **BIPOC-owned programs** that specialize in minority patient care.
3. Engage in programs that specialize in **minority patient advocacy**.
4. If you request testing or medication and a doctor says no, **ask them to document refusal in the chart**.
5. **Ask your healthcare provider if they are aware of the discrimination in medicine**, if they are actively anti-racist (or other) in their patient care and beyond. If there is any hesitation, find a new provider.
6. If you feel that one of your healthcare providers is racist, **file a formal complaint**. Most healthcare organizations have patient relations departments that are equipped to address these types of concerns.

Specific Resources for Minorities

7. **Write down questions ahead of time**. It can be easy to forget what you want to ask.
8. **Ask friends who they recommend**. Go to a physician who has made your friend or family member feel heard.
9. **Bring a support person**. Bring someone you trust to be your notetaker and to help you speak up when asking questions.
10. **Always get a second or third opinion** when available and timely.

Next in the MD Series?

Classism in Medicine

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Questions?