The pervasive issue of racism and its impact on infertility patients: what can we do as reproductive endocrinologists?

Yetunde Ibrahim¹ • Temeka Zore²

Received: 9 June 2020 / Accepted: 16 June 2020 / Published online: 21 June 2020
© Springer Science+Business Media, LLC, part of Springer Nature 2020

Abstract

Following the horrific events surrounding the death of George Floyd, we aim to shed some light on our perceptions of the pervasive issue of racism in America and how it impacts the work we do as reproductive endocrinologists. This issue is deeply rooted, and tackling it will involve a multifaceted approach. Ultimately, we are interested in starting this conversation and hope that our colleagues will not only acknowledge that there is a problem that requires immediate attention but will join us in providing sustainable solutions to it.

Keywords Racism · Healthcare disparity · Inequality · Access to care · Infertility

Like so many of you, we were horrified at the events that unfolded over the past few weeks in this country. The hurt, anger, and frustration have never been more apparent for this current generation. These events, unfortunately, underscore a larger issue, the systemic injustice and racism that exist in our country towards the black community in politics, in policing, and in healthcare. When we delve further into the healthcare aspect, including our field in particular, there are profound differences in access to care, patient outcomes, and representation that underscore how one's healthcare may be impacted by their race.

The profound and unjust inequalities of care, with regard to race, have now become a public health emergency for the black community and other disadvantaged minorities. The black community has higher rates of hypertension, obesity, and diabetes, amongst other diseases, compared with whites [1]. In fact, preliminary data from New York City suggests that amongst COVID-19 deaths, where race and ethnicity data were available, death rates amongst black persons were 92.3 deaths per 100,000 population compared with 45.2 deaths per 100,000 population in the white population (Centers for Disease Control and Prevention; COVID-19 in Racial and

Ethnic Minority Groups). Multiple studies have suggested that these poorer outcomes may be related to access to care, insurance coverage, and possibly even long-term physiologic programming (2018 National Healthcare Quality and Disparities Report).

Wilshire and colleagues in their cross-sectional study assessing the causes of infertility and reproductive outcomes of Afro-Caribbean women living in the Caribbean and Bermuda (this issue DOI: <https://doi.org/10.1007/s10815-020-01826-2>) shed some light on this concept called the “weathering” theory, a phenomenon that was first described by Arline Geronimus in a 1992 review article titled “The weathering hypothesis and the health of African-American women and infants: evidence and speculations” [2]. The impact of stress on the hypothalamic-pituitary-adrenal (HPA) axis and the effects of high cortisol on the sensitivity of the hypothalamic-pituitary-ovarian (HPO) axis have been well described and thought to occur via varying mechanisms [3]. Therefore, the idea that chronic exposure to systemic racism and socioeconomic disadvantage can cause a resultant stress milieu of inflammatory markers, which may contribute to poorer health outcomes, warrants further investigation.

While the weathering theory may be one component to explain the poorer health outcomes black women have, it is important to also note a sense of distrust the black community, as a whole, has towards the medical community which may also impact willingness to access care. This distrust goes back decades from the sheer disregard to the welfare of black men in the Tuskegee Airmen Study to the creation of HeLa cells

✉ Yetunde Ibrahim

¹ Plano, TX, USA

² Spring Fertility, San Francisco, CA, USA

from a black woman, Henrietta Lacks, without the consent of her family. Additionally, the absence of medical diversity has plagued our profession and may also contribute to the poorer outcomes of the black community. One study with 1300 black male participants reported that patients were more likely to complete recommended preventative care services when assigned to a black male physician as compared with a non-black male physician. Researchers suggested that an increase in trust and communication with having a black physician may have contributed to the differences noted in the study (Alsan et al., Does diversity matter for health? Experimental evidence from Oakland; September 2018). It should be stated that, according to 2018 data from the Association of American Medical Colleges, black physicians make up approximately 5% of all physicians in the USA (AAMC) highlighting a significant lack of representation within the medical community.

There is well documented poorer access to obstetric care and poorer obstetric outcomes in black women compared with their white counterparts; this issue is likely multifactorial, but we cannot ignore that blacks are more likely to be socially disadvantaged. Increased prevalence of preterm birth, maternal mortality, fetal growth restriction, and fetal demise, just to name a few, have contributed to the overall burden of disease disproportionately affecting black women [4]. We are uncertain whether the answers to fixing this problem are easily obtained, but an acknowledgment of the presence of this problem is certainly the right first step. Only then, can we delve into a multifaceted approach to dealing with the intricacies of this problem.

Moving towards our own field of infertility care, there have been several studies over the past two decades that have documented the African American plight in regard to fertility treatment. We know infertility impacts around 12% of women, but black women may be twice as likely to experience infertility compared with white women; however, they are 50% less likely to seek out care (NHSR). While it is difficult to pinpoint the exact causes of this, one study demonstrated that black women experienced more discomfort talking about infertility with their doctor (Ceballo et al. Silent and infertile: an intersectional analysis of the experiences of socioeconomically diverse African American women with infertility; April 2015). In the words of Reverend Stacey Edwards-Dunn who created Fertility for Colored Girls, a national organization for African American women going through infertility after her own experience with infertility, “Infertility is a taboo topic of discussion in our community...I was living in shame... It’s expected that we are hyperfertile, that we’re baby-making machines...so we live in shame.”

As reproductive endocrinologists, we have a duty to improve access to care for all women who are socially disadvantaged and experience poorer outcomes from the care that we provide. Some of our proposed approaches include:

- i) More diversity in leadership within our societies (SART, ASRM, and ACOG)
- ii) The need for coverage of fertility treatment by insurance companies, an ongoing issue that can only be solved by continued advocacy and lobbying our state legislature
- iii) Collaborations with pharmaceutical companies to dispense medications to fund treatment for socially disadvantaged couples. This would help to narrow the gap in access to fertility care.
- iv) Increased access to loan programs and funding for minority groups, who would otherwise be unable to afford services; a paper published by Feinberg et al. demonstrated increased utilization of ART services among black women when access to care was improved [5].
- v) Increased diversity among practicing reproductive endocrinologists and increased diversity training may increase access to care by black patients; as alluded above, trust is missing and as reproductive endocrinologists, we need to seek ways to rebuild that trust.
- vi) Improved SART reporting to enhance improved research across minority groups
- vii) Increased representation of minorities on clinic websites, in photos and on pamphlets

In conclusion, this is intended to be a start to this ongoing conversation. Blakemore and colleagues in their impressive descriptive study of how their academic center cares for patients with limited access to reproductive endocrinologists (this issue DOI: <https://doi.org/10.1007/s10815-020-01781-y>) alluded to this conundrum on the delicate balance of the ethical principles of justice. They stated “Offering limited or modified healthcare in places with nothing can be considered both just (something > nothing) and unjust (everything > something = nothing), leading to the concept of two standards of care” [6]. Perhaps, some agree that something is always better than nothing or some agree that something is not necessarily better than nothing if that something is significantly subpar. Ultimately, we will need to balance the ethical principles of justice in dealing with this difficult pervasive problem. We hope that our musings over this issue have not offended but enlightened our colleagues about how we perceive this problem and we in no uncertain terms, claim to know how to fix this problem in its entirety. We are simply wanting to continue this conversation.

References

1. American Heart Association. High blood pressure and African Americans. 2017. Last reviewed October 31st, 2016.
2. Geronimus AT. The weathering hypothesis and the health of African-American women and infants: evidence and speculations. *Ethn Dis.* 1992;2(3):207–21.

3. Valsamakis G, Chrousos G, Mastorakos G. Stress, female reproduction and pregnancy. *Psychoneuroendocrinology*. 2019;100:48–57.
4. Bryant AS, Worjloh A, Caughey AB, Washington AE. Racial/ethnic disparities in obstetric outcomes and care: prevalence and determinants. *Am J Obstet Gynecol*. 2010;202(4):335–43.
5. Feinberg EC, Larsen FW, Catherino WH, Zhang J, Armstrong AY. Comparison of assisted reproductive technology utilization and outcomes between Caucasian and African American patients in an equal-access-to-care setting. *Fertil Steril*. 2006;85(4):888–94.
6. Inhorn MC, Patrizio P. Is lower quality clinical care ethically justifiable for patients residing in areas with infrastructure deficits? *AMA J Ethics*. 2018;20(1):228–37.

Publisher's note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.