



RCOG Position Statement: Racial disparities in women's healthcare

6 March 2020

The Royal College of Obstetricians & Gynaecologists (RCOG) has released this policy position statement to mark International Woman's Day 2020.

Key points:

1. **Health disparities:** Black, Asian, and minority ethnic women can receive a lower quality of care and experience poorer health outcomes, including higher rates of morbidity and mortality, than other women. Disparities between ethnicities are evident in all areas of healthcare. In recognising this inequality, the RCOG is committed to working with UK governments and other stakeholders to eradicate health disparities in the UK.
2. **Racial bias:** Racial bias leads to poorer health outcomes and experiences for Black, Asian, and minority ethnic women. Implicit racial bias from medical staff can hinder consultations, negatively influence treatment options and can ultimately result in Black, Asian and minority ethnic women avoiding interactions with health services. More research is needed to better understand the impact of racial bias in women's healthcare and how it can be eradicated.
3. **Medical research:** Medical research must become more inclusive to ensure that all girls and women get the advice and treatment that is right for them. This will improve diagnostic rates, patient experience and improve morbidity and mortality rates for women, resulting in long-term cost-saving for the NHS.

Health disparities in context

Black, Asian, and minority ethnic women are more likely to experience a lower quality of healthcare compared to white women. This often results in poorer health outcomes and reports of worse experiences with NHS services.

This is well evidenced by maternal mortality data. The MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK) 2015-17 report (published in 2019) found that black women have more than five times the risk of dying in pregnancy or up to six weeks postpartum compared with white women. Women of mixed ethnicity have three times the mortality risk and Asian women have almost twice the risk.¹

Similar concerning trends are evident in infant birth outcomes. Black, Asian, and minority ethnic women are at an increased risk of having a pre-term birth, stillbirth, neonatal death or a baby born with low birth weight.² Black women, for instance, are up to twice as likely to suffer a stillbirth at all gestational ages than white women.³

¹ MBRRACE-UK, [Saving Lives, Improving Mothers' Care, Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17](#) (2019)

² R, Garcia et al., [Specific antenatal interventions for BAME pregnant women at high risk of poor birth outcomes](#) (2015)

³ J. Muglu et al., [Risks of stillbirth and neonatal death with advancing gestation at term: A systematic review and meta-analysis of cohort studies of 15 million pregnancies](#) (2019)

Poorer health outcomes and experiences are not only seen within maternity but are apparent across the whole healthcare system. Black women with breast cancer, for example, have a higher mortality rate than white women for several reasons, including stage distribution and tumour biology.⁴ Ethnic disparities in incidence and mortality are seen with cervical cancer⁵ and research has also found disparity in endometriosis diagnoses.⁶ Striking evidence of lack of parity for health outcomes between ethnic groups is also demonstrated in the area of mental health. Black, Asian, and minority ethnic men and women are more likely to come into contact with mental health services, be diagnosed with a mental health illness and be detained under the Mental Health Act. In addition to a greater diagnostic prevalence, additional negative effects include the further deterioration in their mental health due to discrimination and stigma.⁷

Historically, the reasons for these health disparities have been thought to be due to socioeconomic factors. Black, Asian, and minority ethnic women are more likely to live in areas of high deprivation, have lower incomes, experience language barriers and have poorer access to women's healthcare services.⁸

However, a growing body of research in America has shown that the reasons for health disparities among this group are more complex and multi-dimensional than previously recognised. Ethnic disparities in health outcomes have been shown to clearly exist despite socioeconomic factors and other demographic variables⁹ thus negatively impacting Black, Asian, and minority ethnic women from the lowest as well as the highest socioeconomic groups.

Reasons for persisting health inequalities include implicit racial bias, which affects the quality of care that Black, Asian, and minority ethnic women receive and can subsequently influence how women interact with health services. A lack of high quality research into ethnic disparities in healthcare means that solutions to tackle this issue are often lacking. Furthermore, the wider gender data gap significantly contributes to health inequalities.

Racial bias

Research in America shows that implicit racial bias and discrimination is evident in the US health system and remains a persistent problem that permeates every aspect of healthcare. Despite the lack of British research in this area, it is likely that this issue also affects the UK health system.

Racial bias plays a part in the poorer health outcomes experienced by people of Black, Asian, and other minority ethnic origin. It can, for instance, negatively influence diagnosis and treatment options made by clinicians, including pain management,¹⁰ and indirectly affects medical interactions through loss of patient-centeredness in treatment plans and removal of patient autonomy. Racial bias has been found to additionally

⁴ H. Møller et al., [Short-term breast cancer survival in relation to ethnicity, stage, grade and receptor status: national cohort study in England](#) (2016)

⁵ L. Marlow., [Barriers to cervical screening among older women from hard-to-reach groups](#) (2019) and The Lancet, [Ethnic and racial disparities in cervical cancer: lessons from a modelling study of cervical cancer prevention](#) (2018)

⁶ L. Farland et al., [Disparity in endometriosis diagnoses between racial/ethnic groups](#) (2019)

⁷ K. Halvorsrud et al., [Ethnic inequalities in the incidence of diagnosis of severe mental illness in England](#) (2019)

⁸ R. Garcia et al., [Specific antenatal interventions for Black, Asian and Minority Ethnic \(BAME\) pregnant women at high risk of poor birth outcomes in the United Kingdom](#) (2015), K Newbigging et al., [The role of advocacy and interpretation services in the delivery of quality healthcare to diverse minority communities in London](#) (2009), A. Tucker et al., [The unbooked mother: a cohort study of maternal and foetal outcomes in a London Hospital](#) (2010), and A. Boerleider et al., [Factors affecting the use of prenatal care by non-western women in industrialized western countries](#) (2013)

⁹ J. Dovidio et al., [Racial biases in medicine and healthcare disparities](#) (2016)

¹⁰ K Hoffman et al., [Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites](#) (2016)

feed into a negative feedback cycle where Black, Asian, and minority ethnic women and men avoid interactions with healthcare professionals through fear of potential prejudice and discrimination following perceived poor experience and care.¹¹

This negative feedback cycle has been described as ‘stereotype threat’, a factor recognised to compromise the health of stigmatised groups. Stereotypes can hinder interactions between the patient and clinician, influence how much information the patient is willing to share at a medical consultation and lead to distrust of healthcare services. As a result, Black, Asian, and minority ethnic patients are less likely to adhere to treatment advice from medical professionals perceived to hold stereotypical beliefs, further contributing to poorer health outcomes.¹²

It is extremely important to note that implicit racial bias is unconscious and often unintentional. Nor do the majority of healthcare professionals hold or endorse explicit stereotype judgements. However, it is important for clinicians to be aware that implicitly held negative stereotypes and beliefs about race, ethnicity and gender influence interactions with patients and the care that they receive.¹³ It is therefore vital that UK governments, the NHS, clinicians and the public better understand and recognise the presence and impact of implicit biases in order to eliminate health disparities in the UK.¹⁴

Existing initiatives

The RCOG supports efforts across the UK to tackle health inequalities. This includes, but is not limited to, the Welsh Government’s ‘Healthier Wales’ action plan, the Scottish Government’s health improvement initiatives, and commitments in the Long Term Plan to tackle maternal mortality and other health inequalities in England.¹⁵

Furthermore, following a recommendation in the 2018 MBRRACE-UK report¹⁶ that ‘Action is needed to address disparities’, a number of research projects are in progress to explore in depth the underlying reasons for inequality in maternal mortality, and to identify specific actions to reduce such incidents.

However, it is vital that research looks at disparities for Black, Asian, and minority ethnic women across the health system to better understand existing inequalities, symptoms and causes in the UK. Ultimately, a better understanding of this complex and multi-dimensional issue will help determine robust solutions to combat persisting health disparities in the NHS.

Medical research

There is a significant data gap in medical research contributing to health disparity outcomes in the UK. Women of all ethnicities are less likely to be invited to, or participate in, medical trials and research¹⁷ - despite women comprising 51% of the population. The treatment of cardiovascular disease in women demonstrates the

¹¹ J. Dovidio et al., [Racial biases in medicine and healthcare disparities](#) (2016)

¹² J. Aronson et al., [Unhealthy Interactions: The Role of Stereotype Threat in Health Disparities](#) (2013)

¹³ Ibid.

¹⁴ J. Dovidio et al., [Racial biases in medicine and healthcare disparities](#) (2016)

¹⁵ Welsh Government, [A Healthier Wales: our Plan for Health and Social Care](#) (2018), Scottish Government, [Health improvement](#), PHE, [Local action on health inequalities amongst ethnic minorities](#) (2018), and NHS, [Long Term Plan](#) (2019)

¹⁶ MBRRACE-UK, [Saving Lives, Improving Mothers’ Care, Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16](#) (2018)

¹⁷ A. Mastroianni et al., [Women’s Participation in Clinical Studies](#) (1994), P. Scott., [Participation of Women in Clinical Trials Supporting FDA Approval of Cardiovascular Drugs](#) (2018) and C. Perez, *Invisible Women: Exposing Data Bias in a World Designed for Men* (2019)

negative outcomes following research and data modelled primarily around men. Research shows women are 34% less likely than men to receive standard treatments including bypass surgery and stents when experiencing a heart attack, and women are twice as likely to be misdiagnosed on initial presentation.¹⁸ This has contributed to a 'heart attack gender gap' that has cost women their lives.¹⁹

Amplifying the gender disparity further for Black, Asian, and minority ethnic women is the fact that they are less likely to have participated or be included in medical research compared to white people.²⁰ Lack of understanding and preconceptions about the incidence, prevalence and presentation of common conditions within certain ethnic groups amongst healthcare professionals leads to delays in diagnosis, resulting in a higher risk of morbidity and mortality.

Endometriosis, for example, is traditionally thought to affect more white women than black. However, it remains unclear if there is a biological basis for this difference, or whether it can be explained by social bias and the continued focus in medical research on the prevalence of the disease and not on the variation of presentations. This has resulted in delayed and missed diagnosis for women of other ethnic groups presenting with the disease.²¹ Similarly, there have been calls for Black, Asian, and minority ethnic women to be better included in gynaecological cancer research, recognising the scarcity of data regarding diagnosis and outcomes in this group.²²

It is therefore vital that medical research is inclusive of all women. Understanding how women and marginalised individuals present and respond to different medical conditions and treatments will help to diminish disparities in healthcare outcomes and improve diagnostic rates. Since misdiagnosis – including failed, late or incorrect diagnoses – cost NHS hospitals in England £197.2 million in 2014/15,²³ improving diagnostic accuracy and reducing time between presentation and diagnosis for all women, and particularly for Black, Asian, and minority ethnic women, could be substantially cost-saving for the NHS.

RCOG recommendations

1. Government action to examine and report on racial inequality in maternity care and provide recommendations to be taken forward without delay.

The Government must act decisively to tackle health inequalities in maternity care amongst Black, Asian, and minority ethnic women in the UK. The Government should make a series of key, achievable recommendations to improve outcomes. This should be done in partnership with a wide range of individuals with expertise in this area, including BAME women and their families.

2. End the gender and ethnicity data gaps in medical research.

It is important that clinical research properly reflects society, and that we begin to reverse the gender and ethnicity gap that currently persists. As called for in the RCOG's report *Better for women*, there

¹⁸ BHF, [Bias and Biology](#) (2019) and BHF, [Fewer women would die from heart attacks if given same treatments as men](#) (2018)

¹⁹ BHF, [Bias and Biology](#) (2019)

²⁰ A. Smart et al., [The under-representation of minority ethnic groups in UK medical research](#) (2016)

²¹ O. Bougie, [Behind the times: revisiting endometriosis and race](#) (2019)

²² L. Pinder et al., [A Public Health Priority: Disparities in Gynecologic Cancer Research for African-Born Women in the United States](#) (2016)

²³ Data taken from Graysons Solicitors (Sheffield) FOI request submitted to NHS Litigation Authority (renamed NHS Resolution), [What Are Really The Top Misdiagnosed Conditions In NHS Hospitals In 2014/15?](#)

must be renewed effort to tackle the ethnicity and gender data gap by funding more studies which focus on women's health and responses to treatment. Black, Asian, and minority ethnic women must be properly represented in these studies. This will help to eliminate the bias sometimes evident in diagnosis, treatment and medical research.

3. Establish a robust training programme in medical schools to eradicate implicit racial bias and stereotypes.

Bias and stereotypes are ingrained in the psyche from a young age. To combat this, a robust training programme should be included in medical school curricula, to recognise the presence and impact of implicitly held biases on patient outcomes and embed positive behaviours.

Training should include making medical students aware of explicit and implicit racial bias, how to facilitate and stimulate greater information and improved social exchange by, for example, creating a question prompt list for both clinical use and patient use.²⁴

The General Medical Council (GMC) and Medical Schools Council (MSC) must investigate if medical schools have such training and improve it where necessary. Where training does not already exist, the MSC and GMC must work with medical schools to develop an appropriate programme without delay.

The RCOG will consider the role it can play in tackling racism and unconscious bias through its own training and education.

Additional resources

[MBRRACE-UK](#): MBRRACE-UK conducts surveillance of births across the UK. It produces an annual report that identifies risk factors, causes and trends and makes recommendations to reduce poor maternal outcomes for mothers and babies.

RCOG, [Better for women report](#) (2019)

About the RCOG

The Royal College of Obstetricians and Gynaecologists (RCOG) is a medical charity that champions the provision of high-quality women's healthcare in the UK and beyond. It is dedicated to encouraging the study and advancing the science and practice of obstetrics and gynaecology. It does this through postgraduate medical education and training and the publication of clinical guidelines and reports on aspects of the specialty and service provision.

The RCOG is committed to ensuring that all women receive an equally high standard of care through our work to educate, train and examine doctors, develop clinical guidance, review services, deliver audit and Quality Improvement projects and inform and influence policy.

²⁴ J. Dovidio et al., [Racial biases in medicine and healthcare disparities](#) (2016)