

Black women's health matters

We don't know much about Black women's health in Canada, largely because we don't collect statistics by race. The data, scant as they are, indicate that addressing systemic racism will lead to better health outcomes for Black women in Canada.

Caitlin Dunne, MD, FRCSC

As I write this, we are more than 3 weeks into worldwide protests following the killing of Mr George Floyd by a police officer in Minnesota on 25 May 2020. Demonstrators and activists have made it clear that they expect people (particularly White people) in positions of leadership and of privilege, who have a voice to use it. As physicians and community leaders, it is incumbent on us to listen, learn, reflect, and act. It is within our collective and individual powers to improve the health care inequity that our Black patients face. The phrase "silence is compliance" has been emblazoned on signs across the globe at #BlackLivesMatter demonstrations. It is no longer satisfactory to be "not racist"—we must be actively "antiracist." Actually, being "not racist" is a misnomer because, as Ibram X. Kendi has pointed out, inaction on racist policies has been a form of racism all along.¹

Women have historically been vastly underrepresented in clinical trials.² Black women even more so. In 2019, Nnorom and colleagues published a scoping review on breast and cervical cancer in Black Canadians (people of African/Caribbean/Black ancestry living in Canada).³ The study found that only 23 out of a possible 1921 papers they examined included health data specific to Black women. The authors wrote that Black women in Canada faced barriers to health care predominantly related to lower screening

rates rather than access to treatment.³ This is concerning because data from the United States and the United Kingdom indicate that Black women are more likely to die of cancer than their White counterparts.^{3,4} For example, the American Cancer Society's 2019 Surveillance Report cited a lower prevalence of breast cancer in non-Hispanic Black women at 126.5 (per 100 000) versus 130 (rate ratio 0.97). Despite this, the mortality rate was markedly higher in Black women at 28.9 (per 100 000) versus 20.6 in White women (rate ratio 1.41).⁵ One thing we can derive from these statistics is that Black women might have inadequate access to screening, which results in missed opportunities to detect and treat aggressive cancers at an earlier stage.

The Canadian Cancer Society does not report its annual statistics by race.⁶ So, if we don't collect data to understand the scope of the problem, how can we expect to solve it? It appears that people have been asking this question for years. A Black Experiences in Health Care Symposium held in Toronto in 2017 suggested that to make the system more equitable, "data quality challenges" should be addressed. For example, they identified an urgent need for data sets that include race and ethnicity.⁷ During the second Black Experiences in Health Care Symposium, held in January 2020, race-based data collection remained a key theme. The planning committee's number-one recommendation was for mandated data collection in partnership with Black communities, and including Black

leadership, to measure, improve, and publicly report on care and outcomes.⁸

An investigation by the *Globe & Mail* published last year exposed how far Canada lags behind other nations in collecting racial data.⁹ In the article, it was postulated that our "Canadian way" of avoiding the unease of difficult subjects (like race) is part of the reason we are less likely to collect racial data than other countries. In pretending we are "color blind," we have actually harmed Black Canadians by failing to study and address our health care disparities.

There are Canadian articles that address racism in medicine and how it affects Black women. A complete literature review is beyond the scope of this essay, but a few titles are included here for inspiration. Researchers from Queen's University and the University of Ottawa recently published a report in the *American Journal of Obstetrics and Gynecology* called "Behind the times: revisiting endometriosis and race." In it, they describe the historical bias of treating endometriosis as a "disease of white women in higher income brackets." This led to years of misdiagnosis for Black women with pelvic pain as pelvic inflammatory disease rather than the complex, chronic disease of endometriosis.¹⁰ The authors explain that these "misdiagnoses stemmed from the still pervasive myth that women of color were somehow immune to endometriosis and the stereotype that African American women were more promiscuous than their white peers."^{10,11}

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PREMISE

In *Black-White Health Inequalities in Canada*, the researchers analyzed multiple health outcomes such as diabetes, hypertension, heart disease, and mental health.¹² One of their conclusions was that “race-based discrimination, a lifelong stressor, contributes to the development of hypertension . . . and to insulin resistance.” The On the Margins project undertaken in rural Nova Scotia concluded that, “any future research [on Canadian Black women] be undertaken with the recognition that race interacts with numerous other variables and experiences [that] determine health.”¹³ This concept was echoed in a December 2019 publication by Chief Public Health Officer of Canada Dr Theresa Tam, in a report titled, “Addressing stigma: Towards a more inclusive health system.”¹⁴ A highlighted excerpt from the report calls on us all to stop the “slow and insidious practice of dehumanizing others.”

Systemic racism relates to systems, which we can control and change. This can be differentiated from individual racism, which refers to “assumptions, beliefs, and behaviours,” conscious or unconscious that are, arguably, more difficult to change.¹⁵ Recognizing the way our health systems discriminate, and actively working to fix them, will promote change and fairness. The data, scant as they are, indicate that addressing systemic racism will lead to better health outcomes for Black women in Canada.

We all have a role to play in this problem and in its solution.

I am pleased to “turn the pages over” to an invited contribution by Dr Marjorie Dixon.

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Anti-Black racism in medicine and in our glorious and free nation

Dr Dixon details some of the racism she has experienced as a Black physician in Canada.

Marjorie Dixon, MD, FRCSC, FACOG, REI

“Why did you go into medicine?” I find it curious that I still get asked this question, 15 years into practice. “Were your parents doctors?” Or “Was your father a businessman?” It’s as if being a young, Black, female doctor and entrepreneur simply doesn’t compute in the minds of the average non-Black individual. I went into medicine as a Black woman of Jamaican Canadian heritage, embracing the ideals of non-maleficence and filled with the requisite zeal and optimism expected of a future medical professional.

And let’s be honest: I knew about the disparities that existed with access to care and in particular for women who looked like me. It was (and remains) a well-known fact in our community that Black women routinely encounter barriers to care. We have learned that in order to receive equal health care opportunities, we must advocate loudly for ourselves. The system simply doesn’t work well for us. I had personally witnessed colleagues dismissing, not validating, minimizing, and exhibiting bias where Black women were concerned as they presented with a host of women’s health and fertility issues. I did my best to “be the voice” and speak up, encouraging my compatriots to not be ignored, that their race-specific health issues mattered.

But when it came to me—looking like me and in my role as physician/practice owner—I learned to be quiet about the discrimination that I experienced throughout my training

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and career. I didn’t want to make anyone feel uncomfortable. After all, what purpose would this serve? I didn’t quip back when a colleague mused that I likely got into medical school “because I filled a minority quota.” I guess it had nothing to do with my 4.0 GPA. Another colleague in recent years was chatting casually with me between surgical cases. She felt at ease with me and thus a bold statement ensued: “The only reason that you are in the position that you are right now is because you are Black, pretty,

and well spoken”. I had *no words*. And yes folks, this was right here in Canada.

So now that we have identified anti-Black racism in medicine and our glorious and free nation, we must continue to name it, speak out about it, and begin to do the hard work involved in changing the systems that have enabled it. And these must be *big* changes. I recently read that there was only one Black medical graduate from the University of Toronto’s medical faculty, class of 2020. We can, and must, change the system so that the people treating patients are actually representative of the very population whose lives depend on them. And thus, the specific health issues of our community will be addressed—finally and at long last. May this Black Lives Matter movement be the impetus to that very change. ■

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