One small step for Harry and Meghan, one giant leap backward for women

I am neither "Team Kate and William" nor "Team Meghan and Harry." I used to be ambivalent about the media narrative surrounding Britain's royal family. However, when I watched *Harry and Meghan* on Netflix, my fertility doctor brain could not help but revolt at the sixth episode. And when I learned that 28 million households had already viewed it (Netflix's highest-viewed documentary ever), I was deeply saddened that the miscarriage-without-stigma movement had taken a huge step backward.[1,2]

Rewind to 2020, before the Netflix series, when Meghan wrote an opinion piece in the *New York Times* titled "The losses we share."[3] She wrote about having a miscarriage after the first night in their new California home: "I felt a sharp cramp. . . . I knew, as I clutched my firstborn child, that I was losing my second." The essay was widely praised as a brave and raw description of the pain and loneliness that women suffer when miscarriage occurs.[4] In the piece, she also wrote about the collective grief of a nation mourning the losses of George Floyd and Breonna Taylor. I loved her essay and shared it widely, grateful that someone of her public status was talking openly about loss and calling for unity and support.

In their recollection of that same miscarriage for the Netflix series, however, the narrative changed. Meghan and Harry's description was that the pregnancy loss occurred after Meghan "wasn't really sleeping," having just moved into a new house and enduring stress caused by tabloid papers.[5,6] "I believe my wife suffered a miscarriage because of what the *Mail* did," Harry said. "Now, do we absolutely know that the miscarriage was caused by that—'course we don't. . . . But bearing in mind the stress that caused, the lack of sleep, and the timing of the pregnancy—how many weeks in she was—I can say from what I saw, that miscarriage was created by what they were trying to do to her."

Attributing her miscarriage to the media troubles me. It implies that miscarriages can be avoided, and worse, that someone is to blame. In most cases, this could not be further from the truth. I am obviously not Meghan's doctor, nor do I have any details about her medical history, but as a fertility specialist I can say that, statistically, her chances of a clinical miscarriage around age 39 would have been 30% to 40%, purely based on age.[7,8] The odds of any conception being chromosomally abnormal (aneuploid) at age 39 is even higher, at 50% to 60%, which is why many early miscarriages go unrecognized.[9]

I spend my days counseling patients, in the most compassionate way that I know how, about the negative effects of age on eggs. I am continually trying to comfort and reassure my patients that miscarriage is not their fault. People cannot be blamed for a pregnancy loss because they went to work, took a walk, ate spicy food, had intercourse, missed a prenatal vitamin, swam in a pool, or lifted their toddler. In most cases, miscarriage is not pathological. To be clear, just because miscarriage is common does not mean it's not heartbreaking, devastating, painful, and traumatic. Miscarriage can be all those things and still be a normal part of reproduction. I think that miscarriage, like any loss, can affect people differently. I encourage my patients who have endured a pregnancy loss to take time to process and to grieve. I encourage self-care, not self-doubt.

The sooner we accept that miscarriage can be normal, the faster we will reduce the shame and stigma that people face when Mother Nature errs. My heart goes out to Meghan and Harry for their loss, and I hope they have since sought the healing and care that prospective parents deserve when faced with such a difficult part of life. ■

—Caitlin Dunne, MD, FRCSC

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Providing culturally competent care to Asian Canadians

May is Asian Heritage Month in Canada. Adopted in 2002, it is a way to recognize the contributions of Asian Canadians to our society. The diversity of our population is what makes Canada such a remarkable place and provides strength to the backbone of our country.

As an Asian Canadian physician, I view this as a time to reflect on the contributions Asian Canadians have made to the field of medicine and the steps we can take in the future. It is estimated that 20% of current medical students in Canada identify as being from Chinese or South Asian heritage.[1] We have come a long way since 1922, when Dr Victoria Chung became the first person of Asian heritage to graduate from the University of Toronto's Faculty of Medicine.[2] This was only 1 year before the Chinese Immigration Act in 1923, which barred Chinese people from entering Canada and essentially halted all immigration from China for 24 years. The huge strides that have been made should be celebrated by all Canadians, but at the same time, more work can be done to promote health equity among people from all racial and ethnic backgrounds.

As physicians, we have the important role of recognizing the unique health needs and concerns of Asian Canadians, one of the most significant health issues being the high prevalence of chronic diseases such as diabetes and cardiovascular disease. More than 60% of the world's diabetic population comes from Asian countries.[3] Asians may develop diabetes at a younger age because of their genetic predisposition; therefore, complications from diabetes may also develop earlier and are more common. There is also a high prevalence of hepatitis B among Asian populations, exposing them to higher risk of cirrhosis and liver cancer. These disparities can be due to genetic and environmental factors but can also be complicated by cultural and language barriers that can make it difficult to access care.

We have the important role of recognizing the unique health needs and concerns of Asian Canadians, one of the most significant health issues being the high prevalence of chronic diseases such as diabetes and cardiovascular disease.

To address these disparities, it is imperative for us to provide culturally competent care to Asian Canadian patients. This means understanding and respecting our patients' cultural beliefs, values, and practices, and working in a collaborative manner to provide effective treatment and care. In addition to addressing the health needs of Asian Canadians, it is important for us to be aware of the diversity and richness of Asian heritage. Asian Heritage Month provides a unique opportunity for us to learn about the history and contributions of Asian Canadians. We have the responsibility to advocate for the health and well-being of all Canadians, including Asian Canadians. By working collaboratively in a culturally competent way, we can help address health disparities and promote health equity for all. I invite you to take part in the various Asian Heritage Month activities taking place in your community. ■

—Yvonne Sin, MD

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Correction:

The Premise "Gender-affirming care for youth—separating evidence from controversy" [*BCMJ* 2022;64:314-316] has been revised online. The author provided a new citation from Turban[22] postpublication, which provides a chronological summary of the research on gender-affirming medical care and mental health outcomes. The author apologizes for the oversight; this article was used as part of the search to identify relevant primary literature.