Clinical Practice: Current Commentary

Bias in Obstetrician–Gynecologists’ Workplaces

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Obstetrician–gynecologists (ob-gyns) face similar types of biases in the workplace as any people in society. In this first of three articles exploring this issue, we present the stories from ob-gyns who describe their experiences dealing with these biases. These stories serve to personalize the issue and to encourage us to personally face bias in the workplace to build our own resilience and strength, to support those who are personally attacked or diminished, and to develop workplace cultures that are inclusive, diverse, and strong.

"Whether this was race, age, gender discrimination, it's not right."1

Who can argue with such a statement offered by Dr. Tamika Cross in a Facebook post after a midair incident where a flight attendant dismissed her offer to help a passenger in need of medical attention? Dr. Cross is African American, young, a woman—and an obstetrician–gynecologist (ob-gyn).

Although Dr. Cross’ experience gained national attention, many ob-gyns have experienced day-to-day discrimination based on some personal attribute over which they have no or little control. Our work as ob-gyns requires that we build a trusting relationship with our patients, but if some characteristic we have prevents a patient from accepting us as a health care provider, the delivery of health care breaks down. Our work is hard enough without feeling dismissed and disrespected by patients, coworkers, and peers.

A 2017 survey conducted by WebMD–Medscape and STAT2,3 of almost 1,200 health care professionals (including approximately 800 doctors) suggests that almost 60% of doctors experience bias from their patients (Figs. 1–3). Although it is not possible to determine from the data provided whether there are statistical differences between reports from different groups, 41% of women physicians, compared with only 6% of men, had heard an offensive comment about their sex. Over 20% of responding physicians had offensive comments made in their presence about their age, gender, and ethnicity or national origin. Other targets included race, weight, political views, religion, accent, foreign medical education, and perceived sexual orientation.

It is one thing to read about prejudice and bias directed at others—physicians in general, for instance—but what about ob-gyns? What is our lived experience? In an effort to illustrate the breadth of bias from patients and peers in the workplace that specialists in our field experience, Obstetrics & Gynecology put out a call for personal stories in the fall of 2017 through

See related editorial on page 811.

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social media, email blasts, and on the journal’s website. Not surprisingly, the personal stories that were submitted reflect the range of potential targets for bias present in the larger community. The following are excerpts from personal stories that we received.

PERSONAL STORY 1
Medical students can be targets of prejudice from teachers and patients.

I graduated from medical school in 1997 and from residency in 2001 from a program in the South. I was raised in the South and consider myself a Southerner. I am also an Asian woman. My parents always told me that I would have to prove myself because I was not Caucasian, and I worked very hard to do that.

I attended a small, all-female grade school. I attended Harvard for undergrad, and I am grateful to my parents for those opportunities. My experiences there helped build my confidence. My parents also always messaged to me their belief in me and supported my academic endeavors.

When I was in medical school, I rotated in a rural town for 4 weeks doing part of my family medicine rotation. My preceptor, a Caucasian man, to whom I answered every day of this rotation, said to me on day 1 that I was taking up a spot that a Caucasian man deserved. I asked him how he figured that, and he responded that I would end up leaving medicine to make babies. Although I will never forget his words, I pretty much chalked it up to his being a jerk. He did not make me doubt my standing. He did not make me feel like I did not deserve my spot in the medical school class.

During my psychiatry rotation, I was at a Veterans Affairs medical facility. I had several negative experiences with those who served in the Korean and Vietnam wars. One patient stated that I reminded him of a prostitute that he used to frequent. One patient requested I bring him a Coca-Cola from the vending machine; I refused to do this for him. First, I was uncertain whether he was allowed to have one, and, second, I was late for rounds. I told him I would get back with him. At this point he became very irate and yelled, “I fought a war so you could come to this country and have freedom! Now give me my damn...”
I was born with several congenital anomalies that require me to wear leg braces and use crutches to walk. I was raised to believe I am capable of anything and that is how I have approached life since childhood. My ultimate career goal has always been to become a physician. I always thought I would end up in a subspecialty within pediatrics. When clinical rotations began in my third year of medical school, my world was turned upside down when I fell in love with obstetrics and gynecology and maternal–fetal medicine. Very early on, I became completely enthralled with pregnancy and the complications that come with it, both maternal and fetal. I was inspired and motivated by my patients every single day, and the patients were equally inspired by an expected physician with a congenital physical disability. I vividly remember crying with joy and surprise as I opened my envelope on Match Day and saw that I matched at an obstetric–gynecologic program.

Quickly on beginning residency, I noticed the biases displayed by my attending physicians. They were enthusiastic to teach me out of the operating room, but inside was another story entirely. Their minds seemed to be made up about me from day 1. In the operating room I felt like my teachers were impatient and unwilling to help me problem-solve to come up with alternate ways of doing things to account for some of my intrinsic hand weakness. When I inquired about doing things in a slightly different way, I was dismissed and told to “keep working on it.” After several months of struggling, I began to reach out to scrub technicians, surgical first assists, and private practice physicians to help me identify ways to improve. I began using different instruments, selection guided by surgical technicians who watch lots of surgeons do the same thing in many different ways. I began putting in time outside of work practicing suturing and other surgical skills with the guidance of a private practice physician.

Despite these efforts, at the end of my intern year, it was determined that, despite some improvement, they did not think I would be able to perform all of the gynecologic surgery required of an upper-level obstetric–gynecologic resident.

After my initial anger and sadness, I am now focused on how to achieve my ultimate dream of maternal–fetal medicine. Although many maternal–fetal medicine fellowship-trained physicians no longer operate, the only current path to maternal–fetal medicine is through an obstetric–gynecologic residency program. There is no formal pathway for nonsurgical obstetrics and gynecology. If I had become a nurse, I could pursue midwifery or become a nurse practitioner and coke.” (I am neither Korean nor Vietnamese.) I chalked this up to mental illness.

PERSONAL STORY 2
Biases in the workplace can interfere with patient care and alienate relationships between clinicians and other members of the health care team.

As a resident who is gay, male, and Jewish, I fit into several “boxes” of categories that make me a little different in the obstetric–gynecologic workplace. I was working a shift on labor and delivery in my intern year with a female upper-level resident and a female attending. Citing religious reasons, a patient in labor had specifically requested that only women provide her care during her labor and delivery. Aware of this special request, my attending and upper level discussed with the patient and her husband that they would do their best to honor her wishes, but that the unpredictable workflow of the hospital may make it impossible for them to attend her delivery. The only remaining physician to care for her on our team was me, and they explained that a male physician may end up attending her delivery. The patient and her husband were in agreement with this plan, and it was discussed in the presence of her nurse. I was made aware of this well after her delivery.

By the time she was about to deliver, my upper level and attending were in the operating room with a case, and I was the only physician on her care team available for delivery. The patient had a protracted second stage of labor and there was a small concern for the possibility of a shoulder dystocia, so when she was close to delivery, I wished to be at the bedside. When I came to her door, I asked her nurse if the patient was made aware that the only physician available for delivery at this time was male. The nurse prevented me from coming in, stating that all along it had been planned that a private female physician from another practice would come in for delivery to respect the patient's preferences. I was unaware of the previous conversation among my female attending, female upper level, and the patient. In response to my quizzical look that another practice altogether would assume care of the patient, the charge nurse told me that “this was the plan that your attending made” and the nurse for the patient told me, “you know this patient is Palestinian and Muslim. Do you think she would want a gay male Jewish doctor to deliver her?” When I saw the other physician enter the room, I left the area.

PERSONAL STORY 3
Medicine and disability is an ironic dichotomy.
provide prenatal care in an outpatient maternal–fetal medicine office. Should I not be granted every opportunity to succeed before being told that I have failed? There is no other area of medicine that I feel as passionate about as obstetrics and gynecology and, specifically, maternal–fetal medicine.

PERSONAL STORY 4
We had a race problem in my residency program.

A few months into my role as administrative chief resident, I realized we had a race problem in my residency program. After fielding numerous complaints regarding resident behavior and clinical judgment from nursing staff and faculty, I began to notice a pattern. The majority of these residents were underrepresented in medicine, and more over, these complaints were not being made about their Caucasian counterparts, despite similar behavior.

In an effort to gather more information, we organized focus groups for the underrepresented in medicine residents to share their experiences. One resident recounted a time when a nurse called her “colored.” Another remembered a Caucasian labor and delivery nurse telling a patient, “Put a hat on your baby’s head so her hair does not get nappy.” There were several other accounts like this, almost always with an accompanying uneasy feeling of having to choose between keeping the peace and confronting this discrimination.

Based on the many themes elicited during this qualitative exploration into the underrepresented in medicine resident experience—including perceived harsher feedback as compared with nonunderrepresen ted in medicine residents, unequal standards of care for indigent and minority populations, lack of diversity within the faculty, and discomfort discussing race and ethnicity in the workplace—we undertook a quantitative analysis of resident evaluations from faculty. This analysis of data from 6 consecutive academic years revealed that overall, underrepresented in medicine residents received lower objective evaluation scores and that faculty characterized the performance of nearly half of the underrepresented in medicine residents as “concerning” as compared with just 10% of nonunderrepresented in medicine residents.

We presented the findings of this mixed-methods study to the department during Resident Research Day and sparked a movement. Faculty, not previously overtly privy to the findings, were stunned. As a program, we acknowledged that, although we were overachieving from a diversity recruitment standpoint, there was a lack of formal support for the underrepresented in medicine resident once part of the community. We undertook several interventions to better support underrepresented in medicine and LGBTQ residents under the umbrella of the newly formed Diversity-Inclusion Committee.

In addition to an already established research-focused mentoring program, underrepresented in medicine residents expressed a desire for another avenue for formal underrepresented in medicine mentorship. Faculty recruitment for this program has already begun. To strengthen these mentorship relationships, the social wing of the Diversity-Inclusion Committee is committed to building camaraderie between faculty and residents, currently manifested as quarterly social events at the homes of faculty. Finally, dinner clubs where underrepresented in medicine, LGBTQ, and immigrant faculty and fellows have the opportunity to speak about their career and life paths are currently in the planning phase.

Importantly, we did concede that much of the workplace environment is shaped by employees outside of the residency and faculty, including nursing and other support staff as well as patients. As such, we have specifically included nursing staff in formal unconscious bias workshops, in many cases incentivized monetarily or with continuing nursing education credits.

Underrepresented in medicine residents face unique challenges. Although increasing diversity in the workplace is an excellent and compulsory first step, raising the level of discourse regarding the frequent discrimination faced by these residents must follow. The Diversity-Inclusion Committee, and other commitments like it, are vital in acknowledging, confronting, and mitigating prejudice at a time in history where they are becomingly increasingly relevant.

PERSONAL STORY 5
Respect me for my professional identity.

I lived the poor immigrant cliché. I came to accept that being ridiculed for my cheap clothes, bushy black hair, and unfamiliarity with expected social norms was just part of the experience. However, my parents told me that if I worked hard, one day, people would look beyond those things and respect me for my professional identity. So, I set out on my path: Bachelor’s in Engineering and MD from a top 10 medical school, obstetric–gynecologic residency, fellowship, recognized for excellence in teaching, full professor in 10 years.
So why is that I still face ridicule and microaggressions from my Caucasian peers? “Hey, what is up with your hair? What kind of junk do you put in it?” “Talked to ___ today, he told me you went off the reservation again.” “Look at you, sitting on your butt. I guess you are not planning on working much today.” “Let me get this straight...so you do not drink, you do not smoke, you do not gamble, you do not swear. Do you even know how to have any fun?”

Does my experience represent racism? Actually, I do not think it does. I know many academic physicians of Asian descent who do not face the type of bullying I face. No, what I face is cultural bias. I face this bias because I cling to my cultural and religious upbringing rather than adopt the cultural norms of my Caucasian peers. I do not value the things they do, I do not talk the way they do, and I do not require my friends to conform to my world view, as they do.

I have realized that it is because of my lack of conformity that people find it easy to pick on me. If I had a few drinks with them and dropped in a few curse words to tell them to leave me alone, it would probably earn me some “respect.” However, then I would stop being who I am and become just like them. No thanks.

PERSONAL STORY 6

I had to work 100 times harder than my peer who was trained in the same or other U.S. institution to be even considered a “good enough doctor.”

“She is not that smart... You know she graduated from one of those non-American medical schools!” said one of my colleagues during a conversation of who to refer this patient to. I looked at her puzzled. She very well knew I was an international graduate and my medical school in India. This was not the first time I experienced bias. I am currently an academic women’s health specialist at one of the best university hospitals on the west coast. To get to this point, the academic struggle I had to go through is a separate story, but the biases I faced and still face are a part of my everyday story.

I think the system in the United States has been great in terms of putting us (immigrants) through the same rigorous U.S. Medical Licensing Examinations and interview process. Same examination, same fee structure, and same process for applying to residencies. However, the bias started the time I aspired to interview. Although my scores were really competitive and excellent, some obstetrics and gynecology residency programs did not even consider international graduates worthy of application. Most programs who take international graduates do it because they would rather match an international graduate than be unmatched. While I was interviewing, I found almost zero cultural sensitivity among most of those who interviewed me. Some interviewers would make faces as to how “all stories are so similar” among international graduates when asked “So what makes you interview in this country?”

The bias continued in residency. Although science is the same, the delivery of care is very different in different parts of the world. First of all, there is a bias about you being a young female physician, but being foreign-born adds a cherry on top. Nurses, fellow physicians, and patients looked at me with utmost distrust in the beginning. I had to work 100 times harder than my peer who was trained in the same or other U.S. institution to be even considered a “good enough doctor.” As immigrants, struggle becomes a part of your day-to-day life and you continue with it. I must thank some of my faculty and friends who were so kind to let go of the bias and help us grow in the program. If not for a handful of those, the burnout and frustration would have been much higher. The fellowship application process thankfully was easier because I was now trained in a U.S. residency program. Thanks to all my hard work and mentorship from some wonderful faculty, I got into a great fellowship program and also started pursuing my Master’s in Public Health.

Once I started practicing full-time, I often felt bias from some patients. I hear from my schedulers how patients call and they do not want to see a health care provider who was trained in another country for medical school (although all other parts of my training have been in the United States). One of my patients who seemed upset about not diagnosing a condition that she clearly did not have writes in a Yelp review about me: “She apparently attended a 25th tier medical school [61.45/100 in student quality] in her home country, which leads me to believe that she is just not of the caliber of doctors I expect to see…”

It breaks my heart at times, but most other times, these biases have made me stronger than ever before. I have struggled to be where I am and I will keep striving for excellence. Whenever I feel low, I always remember one thing...no matter what gender, race, color, nationality, or social status you belong to—when you have a cut, your blood is red!

PERSONAL STORIES 7 AND 8

There were some submitted stories that focused less on the clinical domains of our work and more and the
business of medicine. Although these stories reflect the individuals’ lived experiences, the biases they have dealt with relate to decisions around departmental membership rather than clinical settings. Their stories are summarized here to raise awareness of the way biases can be present in that domain.

In a multispecialty private group practice with approximately an even number of men and women obstetrician–gynecologists, the women’s schedules were overbooked as a result of patients’ preference for seeing women physicians while the men’s schedules had same-day availability. In response to the announcement of plans to hire a new physician, the writer developed a presentation to the practice leadership to argue against a new hire in favor of greater distribution of patients to the men’s schedules. Nonetheless, the chief executive of the company made the pronouncement that “The company will never hire another male obstetrician–gynecologist again.” The writer is concerned that the lack of gender diversity in obstetrics and gynecology may be a detriment and that as a specialty we should not be excluding an entire sex from our ranks. We should be encouraging people—all qualified people—to consider our specialty and echoes a medical school advisor: “In medicine, you always need to follow your passion.”

Another obstetrician–gynecologist chose to take time off after several years as an academic generalist to spend time with her young child. She returned as a part-time academician, free of the demands of research and committees, but was excluded from faculty discussions about residency education, practice issues, and the like. When she was ready to return to full-time academic practice, she was told by the obstetric–gynecologic supervisor that there was no interest in hiring a faculty member full-time who essentially needed to be retrained. The author argues that doctors who take time away from practice or who choose to practice part-time for a while should not be punished and that we as a specialty should be promoting work–life integration.

DISCUSSION

The contributors of these personal stories are courageous in sharing their vulnerabilities, anger, frustration, and strength in the face of ongoing workplace discrimination. We thank them for doing so. These stories of our colleagues’ lived experiences as a student, a resident, and as practicing obstetricians and gynecologists show us that the workplace can be cruel. We have a duty to care for our patients and to commit to learning to practice our profession. Physicians are often called on to be the authority figures in the room and to put aside the feeling of “death by a thousand paper cuts” that come from encountering both subtle and overt bias in the workplace. However, the emotional toll is real.

Each of you who have read these stories most likely recognize yourselves, partners, classmates, or colleagues in at least one of them. By illuminating what is happening daily at the hospital, clinic, office, or classroom, perhaps these stories will inspire you to be part of the solutions.

The two articles that follow (see pages 820 and 828) are suggestions for how individuals and institutions may begin to address the biases that continue to permeate all facets of society, including our workplaces.4,5 In the first article, the authors will describe what you as an individual victim or observer of workplace discrimination can do in the moment or afterward to diffuse a situation, support a colleague, develop tenacity, and to contribute to a culture that values and embraces diversity.4 It focuses on racism, because the literature is more robust for this form of bias than for others. Although unproven, it seems probable that the approach to other sorts of bias could be based on approaches to racism. The framework for how racism is present in our cultures and in our workplace is explored and the authors suggest individual response patterns that should empower you as an individual. The second article provides ideas for how institutions or health care businesses can develop and sustain a diverse and just culture and support all of its members.5

We hope these stories will inspire you to want to improve the workplace for everyone, to identify and reflect on your own inherent biases and how they might affect others, and to work with others to build a workplace culture that does not allow for unchallenged bias and discrimination. We owe such efforts to our patients who deserve to have physicians who are not burned out and depersonalized, to our partners in the care of patients so that they feel supported and included, and to ourselves.

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