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Addressing racial disparities: Time for action

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Events over the last two years, including the Black Lives Matter movement and the COVID-19 pandemic, have brought racial disparities to the forefront and placed a spotlight on the link between systemic racism and health. These pivotal events have culminated in renewed focus and sincere efforts to address racial disparities across health disciplines including maternal health. In response, the American College of Obstetricians and Gynecologists (ACOG), Royal College of Obstetricians and Gynaecologists, UK (RCOG), and the Society of Obstetricians and Gynecologists of Canada (SOGC) have committed to eliminating racial disparities in women's healthcare. We in the Obstetric Medicine care-provider and research community must join these efforts. In this editorial, we outline an agenda for our community, for real-world action to address racial disparities.

Defining the problem: racial disparities and maternal health outcomes

Health and health care disparities are differences in health, quality of health care and access to health care between groups that stem from broader inequities such as social, economic, and/or environmental disadvantage. Globally, racial disparities in maternal health outcomes are pervasive and have been widening in countries like the United Kingdom (UK) and United States (US). The most recent Confidential Enquiry into maternal deaths in the UK MBRRACE (Mothers and Babies Reducing Risk Through Audits and Confidential Enquiries) 2021 report on maternal mortality, found that compared with White women, maternal mortality was four times higher among Black women, and twice as high among each of Asian and mixed-ethnicity women.[1] In the US, Black women have the highest pregnancy-related mortality rates, followed by Indigenous women and Hispanic women.[2] A 2016 study of 10 populations carried out by the Lancet-Lowitja Institute Global Collaboration found that globally, Indigenous women consistently had higher maternal mortality rates.[3] In addition, rates of severe maternal morbidity and other pregnancy complications, such as preterm birth and hospital re-admission, are also higher in racial and ethnic minority pregnant and postpartum women.[4–6]

Understanding the contributors of racial disparities

Disparities are a complex and multi-dimensional phenomenon with multiple pathways contributing to their occurrence. There is mounting evidence that race is not a reliable proxy for genetic difference. Simplifying disparities in outcomes to genetics only without deeper examination ignores the fact that relationships between race and health reflect enmeshed social and biologic pathways. Systemic racism, structuring opportunity and assigning value based on race that unfairly disadvantages some individuals and communities and advantages others, has entrenched racial and ethnic minority women in cycles of marginalization and inequality. Racial and ethnic minority women disproportionately experience social, structural and environmental stressors that are frequently rooted in historic and present-day racism.

Physiologically, as a consequence of the cumulative effects of racism and its associated stress, racial and ethnic minority women experience "weathering" or early health deterioration putting them at higher risk for poor obstetric outcomes.[7]

Racism has emerged as a social determinant of health that may explain unmeasured factors that mediate the relationship between ethnicity and outcome that persists after adjustment for traditional confounders. For example, in New York City, a Black woman with a college degree is nearly three times more likely than a White woman with a high school degree to develop a severe maternal morbidity during her delivery hospitalization, demonstrating that some social determinants of health like education do not fully explain the difference in outcomes.[8] A growing body of research is now focusing on racism, discrimination and bias in maternal health care and their association with lower quality of care delivered. A recent national cohort study and confidential enquiry from the UK compared the quality of care received by women from different racial and ethnic groups and found multiple areas of bias including microaggressions affecting their care.[9] Recently, there have also been reports of Indigenous pregnant women in Canada experiencing mistreatment and racism and not receiving adequate and timely care resulting in maternal and infant deaths.[10,11]

Actionable steps

Below we present six areas for action. While these can apply across disciplines of medicine, we highlight strategies specific to Obstetric Medicine.

Implicit bias education and training

Developing awareness of inequalities within our own services and questioning whether the way we deliver care unconsciously disadvantages different groups of women is an important and immediate action that we can take. It is critical for each of us to have formal unconscious bias training, now readily available online through different organizations if not already part of one's mandatory annual training. At a minimum, Obstetric Medicine fellowship programs should reinforce this training as part of their curricula and strive towards making it a professional competency. Recently, states like California and Michigan have introduced legislation to make implicit bias training mandatory for healthcare professionals such as nurses.

It has been recognized that racism is embedded in medical education, and therefore, we should all take steps to examine our curricula, to ensure that they do not perpetuate racialized stereotypes and to be more inclusive, such as by using examples and photographs of racial and ethnic minority? women. We need diverse contributors to develop and review medical education curricula. Alongside, it is

important for us to understand the prevalence of issues of racism in our learning environment and work towards building a work culture of equity.

Diversity and inclusion

It is essential that Obstetric Medicine faculty and trainees represent a range of perspectives, backgrounds, and life experiences, and reflect the diversity of the women we serve. Lack of racial concordance between physicians and women has been linked to health disparities and inequities.[12] Encouraging and supporting a collective of Obstetric Medicine providers from racial and ethnic minorities can be an important step towards building collaboration and a means for advocacy for the communities they serve. The Association of Black Cardiologists in the United States is an example of a successful collective.

To develop diverse Obstetric Medicine divisions, it will be critical to mentor medical students as well as senior trainees from racial and ethnic minorities to pursue Obstetric Medicine. Similarly, ensuring equitable representation of racial and ethnic minority trainees and faculty in hospital committees, professional societies and clinical initiatives will be an important step in building diverse and inclusive divisions. Finally, we have to support racial and ethnic minority scientists and researchers to collaborate with and lead Obstetric Medicine research.

Studying disparities

In our research and quality improvement efforts, we need to accurately capture race and ethnicity data and report outcomes and quality metrics for different racial and ethnic groups. Specific to Obstetric Medicine, research is needed to examine the intersection between Obstetric Medicine and racial and ethnic disparities. To best serve our global obstetric medicine community, research focused on comparisons between countries will be useful.

Many of us participate in local, regional and national mortality and morbidity review committees and we should insist that contribution of racial discrimination is included in the review process. In the US, structural racism, interpersonal racism, and discrimination have all been added to the Maternal Mortality Review Information Application (MMRIA) to allow the systematic tracking of the contribution of racism to maternal mortality and allow a greater standardization of its identification.[13]

Throughout, it is critical that we directly engage racial and ethnic groups and communities in addressing their key health concerns and in interpreting our findings, at minimum through public and patient involvement and engagement, as well as through formal qualitative methodologies.

Delivering contextually tailored care

The core of addressing, reducing and eliminating racial disparities is to recognize that care should be tailored to the specific needs of the woman. The recent national cohort study and confidential enquiry from the UK identified lack of individualized care as a contributor to maternal mortality and found that racial and ethnic minority women were treated inappropriately due to deliberate and/or unintentional lack of recognition of their cultural needs.[9] When delivering care to racial and ethnic minority women, we need to consider the broader sociopolitical environment within which they live, and the role of their families and community networks in optimizing their health and wellbeing. For example, birthing on or near traditional territories in the presence of family and community is of foundational cultural and social importance for Indigenous Peoples in Canada yet long-distance travel for birth is a reality for many because of closures of obstetrical services in rural areas.[14]

While in the short term, we can work on delivering contextualized and tailored clinical care, our long-term goal should be to ensure that our organizational policies and clinical guidelines reflect the needs of different racial and ethnic minority women.

Strengthening postpartum care

We, in Obstetric Medicine, are in the unique position to care for women through the continuum from pre-conception to the postpartum period. After women have completed their six-week postpartum care with their maternity providers, we continue to follow them for their medical needs for weeks to months and it is in the time that we can make a significant difference in addressing racial disparities and improving health outcomes in the long term.

Data from the US shows that attendance of postpartum visits by racial and ethnic minority women is low.[15] A large proportion of racial and ethnic minority postpartum women, especially low-income women, face barriers such as housing insecurity, lack of transportation, and child-care concerns to name a few.[16,17] A first step in addressing this would be to implement routine screening for these barriers during our clinical visits so that we can identify women who need support. Broadening our collaboration with patient care navigators, community health workers, and social workers will be integral to addressing these barriers and coordinating comprehensive postpartum care. Literature from other areas of medicine such as cardiology and pediatrics has demonstrated that non-English speaking patients have worse outcomes. Therefore, it is important to ensure appropriate translator services during postpartum visits.

Culturally responsive and community-driven home visiting programs and mobile van programs can allow us to "meet women where they are". We can harness the experience from the COVID-19 pandemic and offer the option of virtual visits, remote self-monitoring, and other innovative routes of communication. This is of particular importance postpartum, to facilitate the transition to primary care given that racial and ethnic minority women are disproportionately affected by long-term medical problems, including obesity, hypertension and diabetes mellitus.

Advocacy

There are many ways for us to be involved in advocacy beyond our individual patient care, teaching, and research. These may include contributing our expertise on relevant committees, writing Op-Ed/opinion pieces in our local media, or getting involved on social media platforms our patients use. Stories are powerful tools to raise awareness and mobilize for change. We can engage with policy makers by providing subject matter expertise that can help create just legislation and the development of women centered policies especially around affordable and accessible postpartum care. Vaccine hesitancy among marginalized groups is another obvious area of need as racial and ethnic minority groups may have a deep-rooted mistrust of the medical establishment which stems from historical trauma, oppression, and mistreatment in the research and medical realm.

Conclusion

In this editorial, we have offered several actionable steps to address racial disparities. These strategies can also be used to address maternal health disparities in other marginalized groups such as the LGBTQIA + community, refugees, women with disabilities and those with lower socio-economic status. However, the data is clear that racial disparities are widening and worsening. Many women of color live at the intersection of other marginalized identities. Thus, in our efforts to address diversity and inclusion, we must make sure that we give adequate time and attention to these persistent racial disparities.

While this agenda may seem aspirational, we encourage our colleagues to reflect on these ideas and continue the conversation at upcoming meetings. We can start by implementing one or two steps either individually or

within our institutions. We can also learn from the successes of other professional organizations as they carry forward their agendas to address racial disparities . While the pandemic has shone a light on racial and ethnic disparities, we can use this window of opportunity now to effect change.

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References

1. Knight M, Bunch K, Tuffnell D, Patel R, Shakespeare J, Kotnis R, Kenyon S and Kurinczuk JJ, eds. Saving lives, improving mothers' care lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2017–19. November 2021. https://www.npeu.ox.ac.uk/mbrrace-uk/reports.
2. Petersen EE, Davis NL, Goodman D, et al. Racial/ethnic disparities in pregnancy-related deaths- United States, 2007–2016. *MMWR Morb Mortal Wkly Rep* 2019; 68: 762–765.
3. Anderson I, Robson B, Connolly M, et al. Indigenous and tribal peoples' health (The lancet-lowitja institute global collaboration): a population study. *Lancet* 2016 Jul; 388: 131–157.
4. Wagner JL, White RS, Tangel V, et al. Socioeconomic, racial, and ethnic disparities in postpartum readmissions in patients with preeclampsia: a multi-state analysis, 2007–2014. *J Racial Ethn Health Disparities* 2019 Aug; 6: 806–820.
5. Liese KL, Mogos M, Abboud S, et al. Racial and ethnic disparities in severe maternal morbidity in the United States. *J Racial Ethn Health Disparities* 2019 Aug; 6: 790–798.
6. McKinnon B, Yang S, Kramer MS, et al. Comparison of black-white disparities in preterm birth between Canada and the United States. *CMAJ* 2016; 188: E19–E26.
7. Geronimus AT. The weathering hypothesis and the health of African-American women and infants: evidence and speculations. *Ethn Dis* 1992 Summer; 2: 207–221.
8. New York City Department of Health and Mental Hygiene. *Severe maternal morbidity in New York city, 2008–2012*. New York, NY; 2016.
9. Knight M, Bunch K, Vousden N, et al. MBRRACE-UK. A national cohort study and confidential enquiry to investigate ethnic disparities in maternal mortality. *EClinicalMedicine* 2021 Dec 13; 43: 101237.
10. CTV News. They wouldn't do anything: Indigenous woman who lost baby alleges negligence, racism in BC hospitals. Available at: https://www.ctvnews.ca/health/they-wouldn-t-do-anything-indigenous-woman-who-lost-baby-alleges-negligence-racism-in-b-c-hospitals-1.5321713.
11. New York Times. After video of abusive nurse, Canada's Indigenous seek health overhaul. Available at: https://www.nytimes.com/2021/08/28/world/canada/canada-indigenous-health-care.html.
12. Saha S, Komaromy M, Koepsell TD, et al. Patient-physician racial concordance and the perceived quality and use of health care. *Arch Intern Med* 1999 May; 159: 997–1004.
13. Hardeman RR, Kheyfets A, Mantha AB, et al. Developing tools to report racism in maternal health for the CDC maternal mortality review information application (MMRIA): findings from the MMRIA racism & discrimination working group. *Matern Child Health J*. 2022 Jan. doi:10.1007/s10995-021-03284-3. Online ahead of print.
14. Smylie J, O'Brien K, Beaudoin E, et al. Long-distance travel for birthing among indigenous and non-indigenous pregnant people in Canada. *CMAJ* 2021 June; 193: E948–E955.
15. Howell EA, Balbierz A, Beane S, et al. Timely postpartum visits for low income women: a health system and medicaid payer partnership. *Am J Public Health* 2020 Jul; 110: S215–S218.
16. Ruderman RS, Dahl EC, Williams BR, et al. Provider perspectives on barriers and facilitators to postpartum care for low-income individuals. *Women's Health Reports* 2021 Dec: 254–262.
17. Taylor K, Compton S, Kolenic GE, et al. Financial hardship Among pregnant and postpartum women in the United States, 2013 to 2018. *JAMA Netw Open* 2021; 4: e2132103.

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