

# Ethical Perspectives on Racial and Ethnic Disparities in Perinatal Health

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# Where to begin?

- Wealth of recent media coverage
  - 2017 ProPublica / NPR “Lost Mothers Series,” investigating the reasons behind the US having the highest rate of mothers dying during pregnancy, childbirth and postpartum of any affluent country. Focus on racial disparities as well. Stories of mother’s dying during or after childbirth.
  - NPR show 1A, series “Beyond Mother’s Day,” program on rising maternal mortality rates, May 2018.



# Medical literature: Useful Bookends

- IOM 2003 report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.”
  - Minority patients are less likely than whites to receive the same quality of health care, even when they have similar insurance or the ability to pay for care. To make matters worse, this healthcare gap is linked with higher death rates among minorities.



# Consensus Statement May 2018

- May 2018 Workgroup Consensus Statement, National Partnership for Maternal Safety, “Reduction of Peripartum Racial and Ethnic Disparities: A Conceptual Framework and Maternal Safety Consensus Bundle,” Howell, et al, Ob. & Gyn. Vol. 131, no. 5, May 2018.
  - (Concept article as background to Council on Patient Safety In Women’s Health Care, 2016 bundle on “Reduction of Peripartum Racial/Ethnic Disparities.”)

# Overview: Disparities in Perinatal Care

- From Consensus Statement:

- “Racial and ethnic minority women experience more maternal deaths, comorbid illnesses, and adverse perinatal outcomes than white women.”
- “Black women have 3 to 4X more likely to die from pregnancy related causes, and have more than a risk of maternal morbidity than are white women.”
  - Elevated risk of postpartum hemorrhage, puerperal infection, venous thromboembolism
  - Native American and Hispanic populations also at greater risk.
- Study of 100,000 women, there were racial and ethnic disparities in frequency of inductions, episiotomy, and C-sections.

# Important IOM and “Consensus Statement” Finding

- Differences in maternal outcomes exist even when one accounts for educational and income differences.
  - 2016 analysis of five years of data in New York City: black college-educated mothers who gave birth in local hospitals were more likely to suffer severe complications of pregnancy or childbirth than white women who never graduated from high school.
- These women are receiving a lower quality of care-- Need to address factors that disadvantage women precisely because they are black or another ethnic minority.

# Challenge: to determine what those factors are?

- Institutional, system-wide level : Do our health care institutions treat minority women differently? Do our institutions fail to address specific needs of more vulnerable populations?
- Individual provider level: Do health care providers treat black women differently? If so, how?

# Institutional Level

- Language barriers (inadequate interpretation services)
- Fragmentation of health care in prenatal and perinatal experience/  
poor quality of care
  - Intersection of race and socioeconomic status
- Racial differences between staff and patients
- Inadequate education of staff about cultural differences and implicit bias
- Lack of access to care: no “right” to care, and poor are disproportionately affected – intersection with race.
  - Source: “Consensus Statement,” IOM, ;



# Important Finding: Institutional Differences

- “Interfacility” differences: women who deliver at “black-serving” hospitals (disproportionately black patient population, usually in poorer neighborhoods) are more likely to have serious complications than mothers who deliver at institutions with fewer black women. This applies not only to their black patients, but to their white patients, and healthiest patients.
  - E.g., “Performance of racial and ethnic minority-serving hospitals on delivery-related indicators.” Creanga, Bateman, et al, [Am J Obstet Gynecol](#). 2014 Dec;211(6):647

# Institutional Differences

- ProPublica recently undertook a similar study using 2 years of hospital inpatient discharge data from ‘black-serving’ hospitals in NY, IL and FL, focusing on hemorrhage cases. Their findings were similar:
- E.g., in Central Brooklyn: “At three medical centers in this area.... — Brookdale University Hospital Medical Center, Kings County Hospital and SUNY Downstate — more than half of mothers who hemorrhaged during delivery experienced complications... More than three quarters of the women who give birth at Brookdale are black, as are nearly 90 percent of the women who deliver at Kings County Hospital.”
  - “Lost Mothers: How Hospitals are Failing Black Mothers,” ProPublica, Dec. 27, 2017.
- Similar findings by Elizabeth Howell, Mt. Sinai
  - Black-white differences in severe maternal morbidity and site of care. Howell, Egorova, et al, Am. J. Obstet. Gynec. 2016 Jan;214(1):122.

# Poorer quality of care

- Hypothesis: Institutions serving predominantly black women are providing poorer care. Cannot account for differences based only on patient history and SES.
- Funding can partly explain: but why underfunded in first place?
  - Societal bias against funding programs for blacks and other minorities?
- “Hospitals have to own the conditions that women walk in with .... You have to give patients what they need to get a quality level of care. We are doing a good job of equal care, but not adjusting for needs.”
  - Mass. General Ob., How Hospitals are Failing Black Mothers.”

# Justice: Distributive / Social

- On societal and institutional level: Disparities are UNJUST.
- Distributive Justice: Not equal access to good care, for black/other ethnic minority women. (Usual sense of justice in bioethics).
- But also: disparities contributes to the social injustice of oppression of blacks and other minority groups in our country.
- Social justice in health care pays attention to how systems contribute to social hierarchies and group oppression.

# Query: Is there an Ethical Responsibility to participate in QI programs?

- Do hospitals with worse maternal outcomes for blacks and other ethnic minorities have a greater moral responsibility to improve them through Quality Improvement measures?
- Again: can argue that these disparities are UNJUST
  - Quality of care is obviously already required by the principles of beneficence/non-maleficence, but these disparities based on race and ethnic identity are also an issue of justice.

# Providers

- “How could well-meaning people (health care providers) provide inequitable care to minority and non-minority population?”
  - IOM report
- Intentional discrimination?
- Implicit biases?

# Implicit Bias

- Other contexts: “driving while black,” “BBQing while black”, “sitting at Starbucks while black”: heightened suspicion of African Americans based solely on their race
- What is “Implicit Bias”? “The attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner and cause us to have attitudes about other people based on personal characteristics” including age, race, ethnicity, gender. Consensus statement at 774.
- “Pervasive, subconscious, and activated involuntarily.”
- Explains how good people can treat black patients differently

# Biases and Vulnerability

- Stereotypes/negative attitudes about a group tend to impact groups that are already vulnerable: “corrosive disadvantage”
  - E.g., immigrants, minority groups, women, LGBTQ
- Biases entrench vulnerability because acting on them perpetuates social hierarchy



# How do implicit biases affect behavior of providers?

- Poorer communication: Provider interactions involving people of color were characterized by “dominant communication styles, fewer demonstrated positive emotions, infrequent requests for input about treatment decisions, and less patient-centered care...”
- Spend more time with white patients, and more time deliberating about treatment decisions.
- Use of dominant, condescending tones that discourages patient input, which is critical to good care.
- Making different treatment recommendations based on assumptions about treatment adherence

- Source: Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. Hall et al, [Am J Public Health](#). 2015 December; 105(12): e60–e76.
- Labor and delivery and ER departments more vulnerable to affects of implicit bias, because high stress and fast–moving, more snap decision. (Consensus Statement)

# Questions for health care providers to ponder:

- Biases, stereotypes, attitudes are usually subconscious. Need to question one's own attitudes and assumptions.
- How easy or difficult is it for you to talk about race or to interact with people from other races and cultural backgrounds?
- Do you sometimes feel incompetent or nervous about clinical encounters with persons of a different race, ethnicity, or cultural background?
- How might historical factors, racial mistrust, previous negative experiences, and your own biases influence your patient's reaction to you or trust in you?
- How often does the health care system treat people unfairly due to their race or ethnicity?
  - Recommendations for Teaching about Racial and Ethnic Disparities in Health and Health Care, Wally R. Smith et al, *Ann Intern Med.* 2007;147:654-665.

# Respect patients as persons

- One corrective to bias and stereotypes: consciously treat patients with respect
- Stereotypes/attitudes interfere with seeing patient as an individual
- SOCIAL HIERARCHY means some groups get more respect than others.

# Where is the moral obligation to “Respect Patients as Persons”?

- Health care providers are told to “respect the autonomy” of their patients to make their own decisions.
- Respect the privacy and confidentiality of patient information
- Respect cultural differences
  
- What about “respect patients as persons”?
  - Belmont report: have lost that language in medical ethics

# What does it mean to truly “respect patients as persons”?

- Study of what respect means to patients - some components:
- Attend to their needs rather than ignoring them
  - “I’m in a conference with three or four doctors and they’re talking among themselves, it’s like I’m right here, you can ask me a question. You can talk to me. I believe I am the person you’re discussing the problem about and things like that.”
- Being empathetic
  - “You’re sick and you don’t feel good and if a pain or something occurs to you in the middle of the night and you holler, you don’t want to be hollered at and told that it’s three o’clock in the morning.”

# 2

- Care

- “I think definitely the way they speak to a patient is very important. I’ve had some doctors who just kinda make you feel like they don’t really care. They’re cold, bedside manner is disrespectful.”

- Respect for autonomy

- “You tell the patient the risks that are involved so that they can make the decision and not the doctors make the decision for the patient.”

- Knowledge of Individuality

- “To me respectful conduct is that you’re not a number and a case. You’re a person, and there’s a difference between a case and a person ... So respectful means some knowledge of the background, the living background of the patient.”

# 3

- Honesty and truthfulness

- “To me respectful conduct is that you’re not a number and a case. You’re a person, and there’s a difference between a case and a person ... So respectful means some knowledge of the background, the living background of the patient.”

- Treating patients with dignity

- “Well, I certainly wouldn’t want them having a yuk over me (while unconscious) whether it’s the way or how I’m dressed or whether it’s one of my physical attributes or lack thereof. I would like, I guess, [for them to] treat me the same as if I were conscious.”

- Source: Understanding respect: learning from patients. Kass et al, [J Med Ethics. 2009 Jul; 35\(7\): 419–423.](#)



# Are black /ethnic minority women not given enough respect as patients?

- Women: data that women's pain not attended to as quickly as men's.
- Black women: Intersectionality
  - At intersection of two less powerful social groups (women and minority), so one could hypothesize that they are given even less respect and credibility, based on biases/assumptions about their gender AND their race.

# Respect means listening to patients

- “Believability”: do you find your patients’ reports of pain, other symptoms credible? Do we find black women’s reports of symptoms less credible?
- Language of medicine assumes patients are NOT telling the truth: e.g., patient “denies” such as such behavior, patient “reports” that so and so.
- Need mutual respect and trust: if we want them to trust us, we also need to trust them. Want our patients to self-report, but then don’t listen.
  
- 2 recent stories in the news

# Serena Williams

- After delivering daughter via ER C-section, Williams felt short of breath.
- She had a history of blood clots, so she told the nearest nurse that she needed a “CT scan with contrast and IV heparin right away.”
- She was told by her nurse that her pain meds were probably making her confused, but she remained adamant that something was wrong.
- A doctor then performed an ultrasound on her legs, which was negative for blood clots. Williams still insisted that she needed a CT scan and a heparin drip.
- The doctor then allowed a CT scan to be performed, which revealed several blood clots in her lung and she was put on a heparin drip
- Williams recounted “I was like, listen to Dr. Williams!”

# Shalon Irving

- Source, “Nothing Protects Black Women From Dying in Pregnancy and Childbirth”, ProPublica/NPR, Dec. 7, 2017
- CDC health officer, PhD
- After giving birth at age 34, had repeated follow-up visits for high blood pressure.
- Visited nurse with swollen legs. U/S for blood clots was negative.
- Shalon was insistent: “There *is* something wrong, I know my body. I don’t feel well, my legs are swollen, I’m gaining weight. I’m not voiding. I’m drinking a lot of water, but I’m retaining the water.”
- Before sending Shalon home, the nurse gave her a prescription for the blood pressure medication nifedipine, which is often used to treat pregnancy-related hypertension.
- Shalon died at home that night.

# Once again: Respecting patients as persons

- Trusting what they tell us: respect means deeming them credible.
- Paying attention to their unique needs. Don't assume "equal" care means equitable care.
  - Medical vulnerabilities need to be met. Think "zebra" when hear hoofbeats??
- Pay attention to how own biases can affect communication/treatment decisions.

# Closing

- Shalon's friend Raegan McDonald-Mosley, the chief medical officer for Planned Parenthood Federation of America, said
  - Her death “tells you that you can't educate your way out of this problem. You can't health-care-access your way out of this problem. There's something inherently wrong with the system that's not valuing the lives of black women equally to white women.”