Reducing Severe Maternal Complications Identified During Hospitalizations of Black Women

INTRODUCTION

Healthy People 2030 is an objectives-based initiative by the Office of Disease Prevention and Public Health Promotion. One of these said initiatives includes reducing the severe maternal complications—as identified by the Centers for Disease Control and Prevention (CDC)—during delivery hospitalizations; those complications include, but are not limited to: embolism, thrombosis, respiratory distress, cerebrovascular accident, acute kidney injury, disseminated intravascular coagulation, sepsis, shock, and cardiac arrest.[1] In 2017, it was estimated that 68.7 out of every 10,000 hospital deliveries resulted in one or more of these severe complications. This trend has been worsening, especially for racial and ethnic minorities. Healthy People 2030 aims to reduce this figure to 61.8 out of every 10,000 in-hospital births, but here we will narrow this discussion to focus on black women (and all black birthing people) whose risk is significantly higher.[2] We will discuss the actors in our system, namely nurses and physicians, and how they can actively participate in ameliorating this disturbing trend. Further, we shall address *why* it is that we owe black women our unwavering commitment to improving their pregnancy and health outcomes. And although this issue is multifactorial and systemic, there are interventions we can hold ourselves accountable to individually, whilst also using our voices to encourage change on the national stage.

THE CONTEXT

The historical context in which this issue exists is important to grasp before one can even begin to address solutions and interventions. It is no secret that the United States of America has a

shameful history of chattel slavery. It is also no secret that the downstream effects of that history play a massive role in the disparities we see for Black people across all facets of daily life. In particular, the history of obstetrics and gynecology in the United States is rife with examples of the abuse and exploitation of Black bodies. Dr. James Marion Sims, colloquially known as the "Father of Gynecology" is one such figure who epitomizes said mistreatment; Sims is lauded for inventing gynecological instruments and pioneering surgical procedures still utilized to this day. However, such achievements were attained by further robbing enslaved women of what little autonomy they had over their bodies; they were used for his experimentations—without anesthesia, without pain control, and most importantly, without their consent.[3] This reality did not disappear in the antebellum era, as exemplified by the harvesting and unethical research of Henrietta Lacks' bodily tissue, and of the numerous counts of forced sterilizations of Black women.[4] One must also not forget that in this country, "southern laws forced enslaved Black women to bear children who would build capital for enslavers."[5] So then, is it any wonder why Black women today remain distrustful of our healthcare system and its providers—especially when we continue to fail them?

WHERE WE FAIL

The CDC estimates that 50,000 women a year suffer a severe complication related to their pregnancy, and that an additional 700 women die in childbirth; as if those statistics alone were not disturbing enough: black women are three times more likely than their white counterparts to die in labor. And yet, perhaps the most unfortunate statistic: nearly 66% of those deaths are preventable.[6] In Portland, the Black Women's Birth Survey conducted by the National Association to Advance Black Birth highlighted specific examples of the system failing Black

mothers. The survey discussed that anxiety and stressors during pregnancy contribute to pregnancy complications; further, the survey discovered that 50% of black women in Portland experienced fear, racism, and/or disrespect during their hospital deliveries, and that 33% of them were concerned generally with their treatment; the researchers show that these experiences correlate with birth outcome.[7] Sadly, the survey also uncovered that Black infant mortality was nearly twice that of White infant mortality.[7]

While many of us have heard the term "implicit bias" at some point in our medical training, many fail to carry that training forward into their practice. A study by the Society for Maternal Fetal Medicine showed that 84% of providers acknowledge disparities in their own practice, but that only 29% of them believed these disparities were due to *their* implicit biases.[8] And while we are taught to practice evidenced-based medicine, there are still antiquated, false notions perpetuated in the field—namely that Black people have a higher pain tolerance, thicker skin, and stronger bones—and this directly contributes to poorer outcomes. In the perinatal period, this is evidenced by Black women receiving less pain control interventions—or having their complaints of pain dismissed altogether; this is especially unacceptable when the complaints are symptoms of an impending complication.[8]

We do not just fail on the individual level, but on the systemic level as well. Many women, not just Black women, if uninsured are enrolled in Medicaid when they discover that they are pregnant. And while this allows for coverage during the perinatal period, this coverage abruptly ends 60 days after the birth of their child(ren). This is wholly inadequate, as the risk of complications and death from the pregnancy caries on through the first year after the birth. It also does nothing for the prenatal and pre-conception period, which we know it critical for the outcome of the pregnancy. Optimizing the health of Black women before they even become

pregnant should be our goal, but we are failing. This is a multifactorial issue. In part, it is due to inadequate access to care, inadequate insurance coverage, and poor access to resources and education.[8-9] There is also the underlying component of mistrust between the Black community and the healthcare system, and understandably so. All these components contribute to the generally subpar healthcare for Black women.

WHAT WE CAN DO

We must first acknowledge that in order to improve maternal outcomes in the perinatal period, we must optimize the holistic health of the mother. Longstanding chronic illnesses, such a hypertension and diabetes, should ideally be well managed before conception in an effort to not exacerbate said illnesses. Women of child-bearing potential need access to excellent primary care services for general healthcare maintenance—this allows the medical community to intervene early on to optimize care and baseline health status. Further, we need to ensure that we are getting women enrolled in insurance, private or Medicaid, so that routine preventative medicine is in place for both mother and child. Additionally, we must advocate for Medicaid coverage that extends through the first year after birth—during a critical period in which risk of complications is higher.[10-11]

We must rebuild the trust and rapport we have with Black women and mothers by going into the communities in which they live and providing interventions such as group prenatal care. In this scenario, women who are in similar stages of their pregnancy are grouped together to provide both medical care, education, and anticipatory guidance. This type of intervention has been seen to lower complications for both mother and infant.[10]

Next, we need to *listen* and *hear* our patients. We need to take their complaints and their concerns seriously. In a study conducted in New York, Black and Latina mothers described their perinatal care as subpar—emphasizing that they felt ignored and dismissed. They report that better communication from the healthcare team would have significantly improved their delivery hospitalizations. Dismissive attitudes and poor communication, along with poor continuity of care, were identified as indices associated with poorer outcomes for mothers.[12]

The CDC recommends physicians recognize their biases—this can be supported by institutions implementing implicit bias and anti-racism training, and by holding all members of a care team responsible for advocating on their patients' behalf. Providers must take the time to build rapport with patients by getting to know more about their patients' lives to better understand their needs and tailor their care. Providers must counsel patients on return precautions and signs of perinatal emergencies, so that earlier interventions can be made.[6] We must additionally do everything in our power to have consistent follow-ups and debriefing conversations with mothers—we cannot let them fall through the cracks after delivery. Simple interventions such as nurses performing post-discharge wellness checks via phone have also been proposed as a method to improve outcomes.

We must also not forget the important role that nurses and midwives have to play. Often, nurses are the members of the team that are at the bedside the most. They are often the ones who spend the most time and build the strongest rapport with patients, so it is critical that they understand the importance of their role in reducing complications during hospital delivery stays. We have to empower them to advocate for their patients, and we as clinicians need to recognize the value that they add to a healthcare team. We need to listen to our patients' concerns, and we need to listen to the concerns that our nurses express on our patients' behalf. We must also support and

empower Black people who wish to serve as midwives and labor and delivery nurses—as having them part of the care of Black mothers during their prenatal, perinatal, and postpartum period is associated with better outcomes.[13]

CONCLUSION:

Being pregnant and Black in the United States should not afford one a higher risk for pregnancy related complications and mortality—but it does. This is a shameful, multifactorial reality in our country that is but one testament to the sequelae of chattel slavery. The field of obstetrics and gynecology is indebted to Black women. As clinicians and as nurses, we must do everything in our power to help repay this debt by ensuring equitable, high quality, culturally sensitive care in the preconception period, perinatal period, and through the postpartum period. We can achieve this by listening to our patients, taking their concerns seriously, and optimizing their general health long before childbearing. We can further act to achieve systemic change, by advocating for public policy that would close the Medicaid coverage gaps for pregnant women and mothers. The unfortunate reality is that reducing maternal complications cannot simply be achieved by changes we make on the individual level—not when systemic racism continues to plague the healthcare industry. Be that as it may, our commitment to this cause must continue to be unrelenting.

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