Addressing Bias and Disparities in the Care of Pregnant and Postpartum People: A Call-to-Action for Associates

CMEO Podcast Transcript

Monica Peek, MD, MPH, MS, FACP:

Hello and welcome to a very special CMEO Snack activity that is part of a series I am leading on Diversity, Equity, and Inclusivity with CME Outfitters. Today's CMEO Snack is entitled, *Addressing Bias and Disparities in the Care of Pregnant and Postpartum People: A Call-to-Action for Associates*. These activities are supported by an educational grant from Walmart Incorporated.

I'm Dr. Monica Peek, and I'm the Ellen H. Block Professor of Health Justice in the Department of Medicine at the University of Chicago. Here, I'm also the Associate Director at the Chicago Center for Diabetes Translation Research and the Director of Research at the MacLean Center for Clinical Medical Ethics. I'm delighted to be joined today by my distinguished colleagues, Dr. Melissa Simon and Dr. Rachel Bond. Melissa and Rachel, would you mind introducing yourselves to our audience today?

Melissa Simon, MD, MPH:

Hello, and thank you, Monica. I'm really happy to be here. I'm Melissa Simon, and I'm Vice Chair of Research in the Department of Obstetrics and Gynecology, and the George Gardner Professor of Clinical Gynecology. I've been practicing for over two decades in Obstetrics and Gynecology. I'm also the Founder and Director of the Center for Health Equity Transformation and the Chicago Cancer Health Equity Collaborative, and the Associate Director of Community Outreach and Engagement for the Robert H. Lurie Comprehensive Cancer Center at Northwestern University Feinberg School of Medicine.

Monica Peek:

Thank you, you bring a lot of expertise to our conversation today. Rachel, would you mind introducing yourself?

Rachel Bond, MD, FACC:

Hello, and thank you so much, Monica. My name is Dr. Rachel Bond and I am the System Director of the Woman's Heart Health Program at a local community hospital in Phoenix, Arizona. I also am an Assistant Professor of the Department of Internal Medicine at Creighton University School of Medicine in Phoenix. And finally, I am the Co-Chair of the Cardiovascular Disease in Women and Children's Committee for the Association of Black Cardiologists. A lot of my work has been really emphasizing education at the community level when it comes to amplifying the messaging around the Black maternal health crisis.

As a cardiologist myself, the reason I even wanted to invest in this area is because, when we look at the statistics, we know that the greatest or the leading cause of death when it comes to maternal mortality, both during pregnancy and up to one year postpartum, is cardiovascular disease. So, we as cardiologists need to have a seat at that table to really make change and really move the needle in the right direction, especially for our most vulnerable patient populations, such as the Black and Brown community, where we're seeing the highest rates, unfortunately, of very preventable conditions like cardiovascular disease.

Monica Peek:

Excellent. So, let's jump right in and start with the candid discussion about race, racism, and health care. And just acknowledge that the legacy of racism, both structural racism, meaning the differential access to goods and services and all the good things, both within healthcare and outside in society, that has impacted the way that patients are treated in health care and their health outcomes. And that is something that has been historical, but something that continues to happen today. So, I'm going to give you two quick examples, but also know that these are things that are not just something from the past.

The first is what happened to women who were enslaved, that particularly for the field of gynecology, they learned many of their surgical techniques, which are named after, you know, famous people based on the work that they did with enslaved Black women. And those procedures were done and perfected without the use of any anesthesia, pain medication, or anything, partially because these were done under the auspices of the belief that Black women did not experience pain or significant pain, and that maybe their skin was thicker, or that just for whatever reason, pain was not an issue, and that was, these are some of the myths that helped to justify slavery and brutal treatment of people that were enslaved. And this was not unique to medicine in general to have racism be, sort of, part and parcel of how it was delivered, but it was particularly common for gynecological procedures.

And then second, is the forced sterilization of women in the 30's through the 50's and 60's. And so, it was so common that they would refer to it as Mississippi appendectomy, where a lot of Black women in the South would go in for childbirth and have tubal ligations that were unknown to them, and they would realize many years later, after not having any more children, that they had been sterilized. And so, this breach of community trust when people were coming for care, and then having that trust broken, this history of experimentation, where women were repeatedly experimented on for surgical techniques, obviously, against their will and without remuneration, and without any level or measures of comfort or pain control given, these are the kinds of things that have shaped the history of gynecology and the way that we practice medicine today. These are stories that have been handed down from generation to generation for Black communities and Black women in particular, and these are experiences that are not unique to how Black women are experiencing health care in our system, currently. So, before we move on, Melissa and Rachel, is there anything you'd like to add?

Melissa Simon:

Yes, thank you, Monica. Really, the centuries of egregious maltreatment and abuse of Black persons and Native American indigenous persons and other Brown persons and minoritized persons in our country is deep, and broad, especially in health care, and in research. And we've earned the distrust based on all of this, and it's passed generation to generation, and it is time for us in health care to really earn the trust back. That's really important right now.

Rachel Bond:

One thing that I would like to add when it comes to racism as a whole is that we do know that the way that the health care system has been structured, unfortunately, is centered on several disparities. Those disparities range from not just race and ethnic, but also sex and gender disparities. And we know that at the core of these

disparities are toxic stress. What toxic stress is doing to our body is unfortunately upregulating the inflammatory system, it's upregulating our adrenaline. And by doing that, what is that actually doing to our own, our own medical health? What we know is that it's leading to premature cognitive as well as cardiovascular complications, such as earlier and earlier people coming in with strokes, earlier and earlier people coming in with heart attacks. So, I think that it's important that we acknowledge the effects of what stress does to one body, one's body, and then incorporating that into why we're seeing disproportionately higher rates of mortality and morbidity in Black mothers, and how does that centralize to the issue, which is the fact that many a times it's just the double discrimination of being not only Black, but also being a female living in the United States of America. So, I think it's important that we pause to acknowledge that.

Monica Peek:

Those are great points. And we saw during the pandemic with some of the hesitation for the Covid vaccine that a lot of people began turning the conversation around to saying, no, and why aren't the institutions trustworthy. And really putting the onus back on institutions and health care, you know, researchers and healthcare delivery systems and public health systems. We need to become more trustworthy, rather than asking people to just trust us, given the long, long history and current practices that we have.

So, Melissa, we know that racism and structural racism, interpersonal racism, impacts more than just health care, more than just the access to care, or the kinds of care that people receive once they're in the health care system. It can actually cause chronic disease. Can you talk a bit about this?

Melissa Simon:

Yes, indeed, Geronimus and others have talked about the weathering hypothesis and things where stress actually gets under your skin, and exposure to chronic acts of racism and discrimination and bias and the intersectionality of all of your identities really adds up, and it can influence your psychological responses, your biological responses, how your cells actually are created, whether they're thriving, created to thrive or not. This racism and experiences of, and other experiences of oppression and systems of oppression actually does drive health outcomes. And so, we see these inequities as basically the phenotype or the result of all of these different systems of oppression impacting people over, over centuries. And so, that's why you see on your slide, that really more than 60% of maternal deaths in this country are preventable. Actually, it's more like 4 out of every 5. And in Georgia, for example, and Arkansas and several states across the United States, Black women are 3 to 4 times more likely to die from pregnancy-related complications than their White counterparts.

Monica Peek:

And what I'm hearing you say is that it's not race that's the marker, it's racism. It's not the fact that you have brown or black skin, it's the, what that brown or black skin is putting you at risk for, the exposure that happens as a result of that, and the pathophysiologic responses to the chronic stress, and other things associated with racism. And so that's really, I think, an important thing to realize that when Black women are presenting with worse health outcomes, it's not because of their black skin, or their brown skin, it's because of things that have happened to them because of who they are. And this is a good transition for us to be now thinking about the social determinants of health, and I know that the Walmart employees have had a sort of a primer already about

social determinants of health. So, Rachel, what I'm going to ask you to do is to talk specifically about ones that may be presenting that we should be thinking about for those who are pregnant and postpartum patients, and what we can all be doing to address these issues.

Rachel Bond:

One thing that's important for us to review is that we know that 80% of our health is dictated by social determinants of health. These are where people are born, where people live, where they grow up, where they play, and where they pray. And we know that 80% of these health factors include access to affordable care, access to getting to the clinician, be it through safe transportation or safe means of transportation. We also know that many a times, these negative social determinants of health limit ability to have healthy food, where many of these patients live in food deserts. We also know that not being able to exercise outside because their communities may have high rates of violence. These are factors that we as clinicians, and even those out in the community, need to be more thoughtful of, because this is what's causing the disparities that we're seeing, and these are glaring disparities when it comes to maternal mortality and something that I do think is relevant for this particular conversation because in order for us to really move the needle and change the statistics that we're seeing, we have to think about how we could improve resources to make health care as accessible, but also as equitable as possible for many of these people, these birthing people that are considering becoming mothers.

Monica Peek:

Excellent. Thank you so much for that great explanation, Rachel. So, Melissa, we know that implicit biases impact patient experiences and customer experiences. And so, what type of stigmas exist when it comes to maternal health? Can you talk a little bit about that? And how have you identified your own biases, something I know that we're all working on? And what are you doing yourself to improve along your journey?

Melissa Simon:

So, let's start with everyone has bias. No one can say they don't have bias. It could be against somebody who is looking different in many different ways. It could be obesity, it could be someone who covers, it could be a variety of things, color of skin, sex, many different things, age. And so, we really need to first understand our biases, because when we have a bias, if we're not actively managing it and addressing it, acknowledging it, then it plays out in how we interact with people in a variety of ways. And one actually useful test to take that's anonymous that you can do online and it's free is the Implicit Association Test, the IAT, which I believe you will have access to later on after this series. In addition, you have to think about belonging. Whenever you go into a store or into someone's house or into a restaurant, or a hospital or clinic, you immediately pick up on whether or not you belong there. And you also may have history with that particular restaurant, store, or hospital or a clinic. You may you, or your friends or your family members or loved ones, may have had history, a negative history with that feeling sense of belonging, like, “I don't belong there,” or “4hey treated me badly there.”

So, it is, the onus is on all of us as members of the team, whether it’s at Walmart, or some other store or clinic or setting, to actually make people feel like they belong, like they’re welcomed, and included. And I think those types of experiences are really important to help mitigate or decrease bias in every single way. You know, it's also important to note things like pregnancy, you know. If somebody looks pregnant and they're coming into the store,

or even if they're shopping for baby items, or pregnancy clothes, it may not be for them, or they may not be pregnant at all, or they may have a pregnancy that they don't necessarily want or that it was unintended. And so, we need to be really careful about the language we use about “Congratulations”, or “Are you pregnant?” because that could actually hurt people and make them, kind of, shy away, or trigger something, like upset or mental distress.

And that even is important in my own work in the hospital. We never assume that somebody has a pregnancy that's alive, because some people coming to our labor floor may have pregnancies that have passed. So, all of those things in terms of stopping, checking our biases at the door, actively managing our biases, and actively seeking to help people feel wanted and at home, and belong. And that’s, that's part of how we can actually address bias.

Monica Peek:

You know, those are wonderful recommendations, and, you know, I had never even thought about the fact that if you see a pregnant woman, the baby may not be alive and so, you know, that's an extra thing that I learned today. And your, your comments about a sense of belonging, I think, are probably the best description that I have heard about just wrapping all of those complex terms up. It really is, do people feel at home? Do they feel like they belong in a place? And, you know, for a place like Walmart that has greeters, that is the … their, that’s their primary job is to make someone feel like they belong in that store. So, before they get to the pharmacy, or before they get to the health clinic, you know, really doing that outreach. And for populations that historically have been marginalized, going that extra mile, doing that extra step of being, you know, extra friendly and reaching out, I think would go a really long way. So, thank you really for, sort of talking about that in a way that I hadn't really heard before.

So, Rachel, I'm going to go back to you and ask you, why is it important to really be mindful of the patient voice? And what can we all learn to make an impact when it comes to maternal health, morbidity, and mortality? And when I say morbidity, that means disease, mortality, meaning death. So, when we're thinking about moms, moms being sick, moms potentially dying, how can learning about what women are saying have an impact as we practice medicine as, you know, as an entire team. So, I want you to talk about some of these patient voices, and what we can learn about that.

Rachel Bond:

Now, I can’t speak enough about the importance of being mindful of the patient’s voice. I think it’s important that we acknowledge some of the examples that some actual real-world women provided when it came to their maternal experience. And, you know, one quote, “As a Black mother myself who faced the very real fear of death when complications arose during one of my own deliveries... Knowledge is power, advocating confidently for ourselves is key and a village mentality, not only for raising children, but for also supporting mothers are necessary.”

And this is coming from a mother who also is a doula and an advocate. Doulas are professional workers who are not in the health care sector, but have that ability to advocate for patients, and we know that statistics show that Black women in particular benefit from access to doulas. Now, I bring up access because many a times people are

not able to afford doulas. One thing that at the level of even government we are lobbying for is the inclusion of making sure that insurances will provide coverage for anyone, regardless of their insurance, for somebody to have access to a community health worker, like a doula as an example.

We also know, though, that beyond that, many a times, women, especially women of color, feel that their voices are silenced. And when it comes to pregnancy, we have to acknowledge the fact that, although sometimes symptoms may be just due to pregnancy, if someone's coming into our office, if somebody is coming in and expressing that something doesn't feel right, I'm worried that something's going on, we need to take that very seriously, because women in general, we know when something's not right, and we know if something needs to be further looked into. So, I do think that we have to be doing a better job in terms of making sure we're listening to our patients, we're not silencing them. You know, there's a terminology called medical gaslighting and a lot of times, women, especially women of color, are told that it's in their head, that it's anxiety, or even that it's due to the pregnancy when a vast majority of the time it's not. And I do think that we have to do a better job at listening to our patients, and the more and more stories we hear, I think we will hopefully have the comfort in realizing that patients know their bodies better than anyone.

We should use, even, let's say, a celebrity, as an example, Serena Williams, such a powerfully known tennis player, who had challenges in even getting the medical care that she deserved, probably because of the color of her skin, and that highlights the fact that when we're looking at the Black maternal health crisis, it spans income, it spans education, it spans all of the socio-economic status. What that translates into is that somebody who is a White female, who is perhaps a high school graduate, has less likely of a chance to die during their pregnancy than a Black female who has graduated from graduate medical education, as an example. So, I think it highlights the fact that this epidemic spans socio-economic status or any socio-demographic status, as well. And I think that it goes back into the importance of listening to these mothers and listening to their voices.

Monica Peek:

Hearing patient perspectives is always really powerful. It helps to just remember the lived experience of people as they, sort of, are going through an important stage in their life. And we know that there are issues around equity for all kinds of health care, for racial and ethnic populations who've been marginalized. With this in mind, I'd like to ask both Melissa and Rachel to, if you could give us an example of a bias, one example that you've seen and how it has impacted your patients in their care in your, in your practice. Melissa, I'll start with you.

Melissa Simon:

Thank you. I've seen a lot, unfortunately. People who come who are obese, I've seen comments being made about how hard it's going to be for a patient to be moved from one bed to another because of their obesity or other, other … assumptions, such as I'm Latina, and the assumption when I'm in labor is that I don't want pain medicine. And that is also translated to some people thinking that women with darker colored skin or Black women in labor don't feel pain because they have thicker skin. That is a completely racist and discriminatory assumption.

And then finally, poverty. Poverty plays out in many ways, and people assume because someone's poor that they need to be asked the question about substance use, or other bad outcomes. And I, you know, again, it's racism

and the isms and systems of oppression at play here, and it is not … there's nothing about the color of your skin that drives whether or not you're going to abuse or use substances or experience pain or not. It's just egregiously wrong.

Monica Peek:

Absolutely. So, Rachel, if you could share a story or an example with us, that would be helpful.

Rachel Bond:

As a clinician who takes care of several, several patients, I do think it's important that we acknowledge their stories, and I have so many stories, but many of them have a lot to do with the fact that their voices may not have been listened to, and as such, I think in a positive realm, they decided to switch providers and go to a provider who they felt was more empathetic to their needs. And data does demonstrate that sometimes when you see a provider who looks like you, a provider who identifies with your cultural background, you are more likely to receive the empathy and the appropriate treatment. So, I have had many women, particularly women of color, who have reached out to me, and in doing so we've been able to work more closely and collaboratively as a team. And in doing so as well, I've been able to work with even their own obstetricians or their own other clinicians within the actual group of clinicians that are helping to care for these particular patients.

So, I do think it's valuable that we highlight the fact that there are patients that are going out, doing their homework, and trying to figure out how to self-advocate for themselves, and making sure that they're making targeted efforts on bringing people into their circle, when you think about it, their clinical circle, that are going to also advocate for them as patients. And I'm very fortunate to have a series of women that have given me the utmost opportunity to do that, which is such a privilege.

Monica Peek:

It's always important to hear or just have a few minutes of walking in a patient's shoes. So, thank you both very much for this great insight as we try to understand how we can have a better impact on our patients' lives and the health of them and their communities and the people that are around us.

I want to try and recap our main takeaways from today's program and what you can do to address health equity with an action lens. The first would be to recognize the role of historical and systemic racism on creating consumer distrust of the healthcare system.

The second is to assess your own personal bias and actively work to address it every day. Last, would be to listen with an open mind and learn what does the consumer need and/or want. And two, how can I be a resource to help consumers address any myriad of social determinants of health or unmet social needs that they have in their life at that time in this place?

So, we've created a list of resources to help you with your action plan from our program today, and I encourage you to visit these resources to learn more about what you can do to address these issues that women or that people who are facing birthing, who are persons of color, are going through. I also want to ask you to complete

the online evaluation. This is really important because we want to hear from you, what you liked, how we can improve, and potentially any additional topics that you'd like for us to address. We also have additional D&I activities that you can participate in.

So, thank you for your commitment to education on Diversity, Equity, and Inclusivity. When we know better, we can do better. So, thank you for joining us today for actively engaging to do your part to address the morbidity and mortality of mothers of color.

