Maternal Health Disparities

CMEO Podcast Transcript

Monica Peek:

Welcome to a very special podcast that is part of a series I'm leading on diversity and inclusivity with CME Outfitters. Today's CMEOCast is entitled A Call To Action: Racial Disparities in Maternal Health. I'm Dr. Monica Peek and I'm an associate professor of medicine at the University of Chicago. I would now like to welcome Dr. Joia Crear-Perry, the founder, and president of the National Birth Equity Collaborative, who has been both an academic and on the frontline advocating for black women's health equity for a very long time. Dr. Perry, I'm honored to have you joining us today, and I'm excited about the discussion ahead.

Joia Crear-Perry:

Thank you so much, Dr. Peak, for having me. I'm excited to be here.

Monica Peek:

Thank you.

Monica Peek:

Let me begin by starting with our first learning objective, which is to identify factors that are causing the crisis in maternal health outcomes in the United States. There is no denying that there's maternal health crisis in the United States and Black women are disproportionately affected. Dr. Perry, how do we get here? What can you tell us about some of the historical factors that influence present day high maternal mortality rate among Black women and also among other women of color?

Joia Crear-Perry:

You know, we do this work really frequently, and we're working with an organizations and we really have to provide a framework of how we got here historically. Although people like to leave the past in the past, we have to realize that the past often dictates how we are, where we are today, so we can't ignore the things that have happened.

Joia Crear-Perry:

For 86% of the time Black people have been in the United States of America, we were under legal oppression. Meaning that there were laws that said we could be owned, we could be sold, we had segregated hospitals, segregated schools, segregated communities, right? We didn't really, we've only had the last 14% of the time that we've been here that we've undone some of those laws, but really when you think about this time, we can't just undo the laws. Right?

Joia Crear-Perry:

In order to hold those laws together for so long, there had to be an understanding, a cultural belief, that there was a hierarchy of human value based upon skin color and that belief was codified into law. Although we've begun the process of removing some of those laws, we haven't changed that belief system. We haven't changed that idea that people are different based upon the amount of skin, the amount of melanin they produce. That's what we're working really hard to undo, and unlearn, and move forward for everyone to have justice and joy.

Joia Crear-Perry:

When we move on to think about reproductive justice, we talk about this history and the history and legacy of slavery, of Jim Crow, but really there was also a history inside of our field of obstetrics and gynecology. Many of my fellow OB-GYN never knew that the history of the Sims retractor, the retractor that we use, J. Marion Sims was a plantation doctor. On a plantation in Alabama, he practiced on Black women who were enslaved. Three that we name, mostly Lucy, Betsy, and Anarcha, but there were several others, and he did surgeries on them without any anesthesia, even though anesthesia was available, and he would cut and repair fistulas to practice surgeries so that we could do going forward.

Joia Crear-Perry:

We have to honor that there were bodies of people that were used for experimentation and so when we see that history and legacy of belief that Black birthing people don't feel pain, that comes from textbooks, that was taught. That was believed. We also know my own university, Tulane, where I trained in obstetrics and gynecology. There was a professor there named Dr. Cartwright, who created an illness for Black folks wanting to be free, right. It was called drapetomania. If a slave looked you in the eye, you could give him more lashes. If he tried to escape, you could cut off a toe. So think about how our health care system was built on this legacy of a belief of a hierarchy and it shows up in medicine, in the tools that we use, it shows up in the way that we describe and talk about patients and the care that they receive.

Monica Peek:

It's so fascinating and important that we bring in the external structural racism and beliefs into medical care and understand how we play a role in propagating these health inequities as well.

Monica Peek:

Dr. Perry, let's talk a little bit more about structural racism and the kinds of things that drive many of the social determinants of health, and how they're responsible for maternal mortality, and why it's important to be aware of these details. What does it matter to health care providers? Why should they care?

Joia Crear-Perry:

Once we really start having an honest conversation about history and how we got here, because it's not something we should run from or be afraid of. It's something that's really a part of our legacy. Then the next step is to say, "Okay, well, how does that show up in health care? What does that mean? When we say these words, social determinants of health?"

Joia Crear-Perry:

Back in 2005, I was the director of maternal child health for the City of New Orleans Health Department. Many of you, hopefully, are familiar with what was happening in New Orleans in 2005. Right? There was a hurricane. 15 years ago. The President came and flew by in an airplane, Air Force One, and waved at us. The World Health Organization actually came to town. They sat down at a hotel and as a young public health professional who was appointed by the mayor, I was able to be in that room. To sit there while they talked about this idea. That it wasn't your genes or your choices that cause bad health outcomes or poor health outcomes, but these social determinants of your health outcomes.

Joia Crear-Perry:

There are things like having access to a living wage, having availability of fresh fruits and vegetables, quality education, transportation. When you don't have those things, you have unhealthy behaviors, and then you get a disparity in the distribution of disease, illness, and well-being. This is transformative. This idea that we don't need to blame and shame people for eating more kale, but if we don't provide access to fruits and vegetables and places for children that have PE, that they're not going to have, we're going to have increases in childhood obesity. Right? We don't have childhood obesity just because children like CheeWees. Although I personally like CheeWees. We have childhood obesity, because we are creating the social determinants of health to create, to cause that issue, to not allow for children to be able to exercise.

Joia Crear-Perry:

That same thing happens when we think about maternal health. When we think about preterm birth. When we think about the work that we do as OB-GYN. But what we haven't had a conversation about in the last 15 years, although we've been leaning into talking about social determinants of health, is where they come from. Right? Why do we have differences in access to food? Why do we have differences in access to quality education? It's not innate. It's not mint. It doesn't have to be this way. It was constructed this way, because we have a power and wealth imbalance. Those are things like our labor markets, our education systems, our social safety net, our tax policy. A concrete example of this is, if you think about Medicare and Medicaid, when they were created in 1965, in order for the states in the South, where I live and where I'm from, to agree to have a benefit for poor people, they said, "Well, we have to control that." That's a power and wealth imbalance and you still see today.

Joia Crear-Perry:

Many of the states that are not expanding Medicaid are still holding onto that power. Or they're saying, in order for you to qualify for health care coverage, you must have a job. You must work to prove your worthiness to be healthy.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

That's a power and wealth imbalance.

Joia Crear-Perry:

In the U.S., they have three main root causes, and that is racism, classism, and gender oppression. Now these are words we don't use a lot in health care. These are words that we don't talk about a lot in health care. We think about ourselves as very clinical. We think about things like hysterectomy and we use words like retractors, but understanding that the work that we're doing when it comes to clinical care is deeply impacted by racism, classism, and gender oppression. You could add some more. You could add religious fundamentalism. You can add a lot of these words that come from sociology, anthropology, but we really need to learn that language inside of medicine, because our health of our patients is deeply impacted by those things.

Monica Peek:

Mm-hmm (affirmative).

Monica Peek:

You know, what I like is how you started this off by saying, these are things that we don't need to be frightened of and you're so comfortable talking about them in a way that feels so accessible to others. I appreciate that warm open spirit in which you can engage everyone in this conversation.

Joia Crear-Perry:

Yeah. I recognize that it is new for us to have these kinds of conversations and I recognize that people are nervous. I began using, even stating, the word racism six years ago. When I would do these talks people would get nervous, because they feel racism as if I'm calling them a bad name...

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

Or saying they're a mean-spirited person. It's not an individual. When I use the term racism, I'm not calling you a bad person. We have internalized racism, their idea that I have as a Black person that de-value Blackness, so this idea that that makes you a bad person, because we've all been swimming in this ocean of devaluing people based upon race, gender, geography.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

It's not a judgment on people's that way. Sorry.

Monica Peek:

Thank you.

Joia Crear-Perry:

Mm-hmm (affirmative). Thank you.

Monica Peek:

We've seen from the data and with many patients stories like that, of Serena Williams,

Joia Crear-Perry:

Mm-hmm (affirmative).

Monica Peek:

That even when there's access to the best maternal care, and all the other factors to try and even the playing field, there can be disparate care. Dr. Perry, what can you tell us about interpersonal racism and the impact that this has on maternal morbidity and mortality?

Joia Crear-Perry:

Yeah. I think that's why the different levels of racism are important for us to understand. There's structural, so when I mentioned Medicaid, that's structural, that's systems, that's really into policy. Interpersonal is something that still happens.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

Personally mediated, bias, implicit bias. All of us have biases and biases are unconscious assumptions that skew our understanding, unintentionally affect our actions, but they're also explicit bias. There are people who do really believe that there are other people who are less valuable than they are. We can't ignore that to be a fact.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

But that is not the overarching reason why we have health inequities, but it's important for us to really work on our biases. So I... Every person has bias. I have a bias. If you take the Harvard Implicit Association Test, you'll see what your biases are based upon, you can take it free online. You can see race, gender, age. Most people in United States, their biggest bias is obesity. We think if you just come in for tooth ache, we still want you to get your stomach stapled, so we have a real bias around what obesity means in the United States.

Joia Crear-Perry:

The importance for us is that the power that we hold as providers is that our biases can actually be harmful to patients. We have to work on our biases, because if we make assumptions about, for example, if a White patient comes in to be seen and you think, "Oh, well, White patients don't really have high blood pressure. They don't have preeclampsia." Then the next thing you know, the patient's blood pressure is high, and they're seizing, and have a stroke. We have many stories of that happening, because of the bias that people have about who they think should have preeclampsia or not and patients end up ill. The same thing happens the other way for Black patients, there'll be an assumption that Black people just always have high blood pressure, so we don't treat their preeclampsia and they can end up, seizing, and having a stroke, and in the ICU, so our biases have direct clinical impact on patient care.

Monica Peek:

We've talked about this very critically important problem for women of color. Now let's layer on our next learning objective, which is to outline steps to eliminate preventable maternal morbidity and mortality. We know that about 65% of maternal deaths are due to preventable causes and that there are several clinical and social factors that increase the risk burden for Black women and other women of color. Dr. Perry, you've also mentioned unlearning history to help foster respectful maternal care and equitable care. What does this look like for clinicians and how do we put that in practice?

Joia Crear-Perry:

Yeah. I realize that I did not talk a little bit about this individual versus collective accountability, so I just want to bring that into this for a second. That I'm my favorite book is Ibram Kendi's *Stamped from the Beginning*...

Monica Peek:

Yes.

Joia Crear-Perry:

The Definitive History of Racist Ideas in America. It won the American Book Award. It's an amazing historical document and I unlearned so much reading that book.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

One of the things people always ask Ibram, because he leads now the Anti-Racism Institute at Boston University and I get to work with him around maternal health, but he does a lot of work around how to be an anti-racist, and people ask him frequently, "What comes first, racist policies or racist ideas?" And he would say, "Individuals use racist ideas for their own self-interest." Politicians use it to get more political power, capitalists use it to get more money, cultural professionals use it to get more speaking engagements.

Joia Crear-Perry:

That's funny.

Joia Crear-Perry:

Like me. Right? I hope I'm not doing it for harm, but for good.

Joia Crear-Perry:

If you think about... What we have... While they're fighting for individual self-interests, what we have is collective accountability. We can see through it. We can see when people are using these words for their own self-interest. For their own ability to make money. For their own ability to hold power. And it's harming all of us, so that's important for us to really lean into our collective accountability with each other as providers, but also with our patients and our communities.

Joia Crear-Perry:

To your second point though, about really thinking about unlearning, that's one of the things I had to do to unlearn. I was taught in medical school in the late 1990s, which is not that long ago.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

In embryology class, that there were three biological races, Mongoloid, Caucasoid, and Negroid. Although I back then was still an organizer and we organized to have the professor fired who said those things, I remember his face and how stunned he was that we didn't believe that that was science. He'd been teaching that for decades, so that tells me that many people who were practicing medicine across my home state were learning that race is biological. That Black people have different skin. We have different pelvises. We have different kidneys.

Joia Crear-Perry:

When we see racial health disparities, what they hear when I'm talking, "Is of course y'all are different. You have different kidneys, different lungs, different skin." That was taught in textbooks. We have to unlearn that, because that was never true. There's no difference between, there's only one human race and there is no biological basis of race. Race is a social and political construct. I have no different kidneys, no different lungs, no different skin.

Joia Crear-Perry:

When we think about health inequities in maternal health and as an OB-GYN, we don't see the differences in outcomes when it comes to clinical outcomes by race, because we have different biologic biology. We see the difference, because of how we're treated. How we're seen. How we're valued. If you see things like, people not being heard, not being listened to, or things like if Black people are more likely to have jobs that don't have paid leave, by data, then we're more likely to not be able to come to your doctor's appointment, twice a week, to have fetal monitoring. Then you write that off as non-compliant, but we're having to choose between feeding our family, because there is no paid leave or come into your doctor's appointment. That is a false choice that policy creates that we shouldn't have to make in order for us to thrive and to survive.

Joia Crear-Perry:

It really... We've been really thinking about how respectful maternity care, which is a project they're working on with the American College of OB-GYN, with funding through the Robert Wood Johnson Foundation and Johns Hopkins School of Public Health, to really listen to and learn how would respectful maternity care show up in the United States. What it would look like for us to unlearn these bad things. Like there's a different pelvis. I was taught that Black women have android pelvis, White women having gynecoid pelvis. This idea that the amount of melanin that you produce changes your bone structure. Right? The history and legacy of eugenics shows up in how we practice medicine today. Even when we unlearn those ideas, it's still hard for people to stop doing them.

Joia Crear-Perry:

You might've seen recently, we stopped utilizing the VBAC calculator, the person who put it together as asking people to stop use it, because this idea that you can, based upon race, Black and Brown people have higher rates of C-section, you put that into a calculator. What you're doing is then codifying racism. You're saying yes, because people are more likely to have a C-section after they have a failed... After they have a vaginal... After they have a C-section the first time, they are going to fail an attempt to have another vaginal delivery. That therefore we shouldn't even just try.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

We could just go ahead and not even try with them. There's nothing, there's no biological reason for that.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

That's just all about bias, and choice, and proximity. There's no data to support that there's a reason to do that by race.

Joia Crear-Perry:

Those are the kinds of things that we really have to unlearn and undo. They're deeply embedded inside of our science. I was just going to say that part of the reason it was so hard in the beginning to get people to stop using the calculator, because I'm sure some people will still try to, it's because they still here, when we say Black women have a higher rates of C-section, they believe that they need, that we have some biological difference and we don't.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

There is no biological difference among the races.

Monica Peek:

That's so fascinating to me, just the prevalence of these beliefs in this current day and age.

Joia Crear-Perry:

Yeah. Yep.

Monica Peek:

But...

Joia Crear-Perry:

And they're more subtle.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

The thing about devaluation, there was a time when J. Marion Sims was working that he didn't have to be subtle. He could say "These women, they don't feel pain" and people would kind of agree,

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

Because they really believe we were not fully human. We were two-thirds human, right?

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

In the Constitution. Now it's not like there's a lecture and a slide that says Black people don't feel pain.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

The way culture , it's just subtly still a belief that people hold and when you ask medical students or when you do research around it people still hold that belief. You don't need to lecture it. You don't need to put it in a PowerPoint.

Monica Peek:

Right.

Joia Crear-Perry:

It's just a belief that's still held.

Monica Peek:

It's still in the air floating around that...

Joia Crear-Perry:

Exactly.

Monica Peek:

That somehow people are still breathing.

Joia Crear-Perry:

Yes, exactly.

Monica Peek:

Mm-hmm (affirmative).

Monica Peek:

Dr. Perry, can you talk also about holistic care?

Joia Crear-Perry:

Yeah.

Monica Peek:

What can you tell us about this and how do clinicians and the community create a model of more holistic care?

Joia Crear-Perry:

Well, this is really building on that respectful maternity care that I mentioned.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

With this research, we interviewed Black birthing people around the United States to see what would respectful maternity care look like for them. They said things like, “They want empathy.”

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

“They want to be trusted.” We talk a lot about trust building, but we’re always asking the patients to trust us.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

Do we trust patients? Every time we write the word non-compliant in the chart, what does that say about our trust in the patient, and their choices, and why they’re not there? If we couldn’t write non-complaint and we had to actually ask them, why they weren’t there and write that down, “We don’t have paid leave. We don’t have childcare.” That would be very different. Anyway. Having respectful care is really the core in order for us to get to holistic care, right?

Joia Crear-Perry:

To get to this where we have the mom, and the family, and the birthing person surrounded by people who love and value them. Birthing is a communal event. My father’s an ophthalmologist, you don’t need community to have a cataract surgery, right? That’s very clinical. You need an operating room, you need a surgeon. Birthing is not that. It’s not the same thing. We need to really reexamine how we think about having holistic care, allowing people to birth in the ways with whom they wish.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

How they wish, because that entry into the world is such an important moment and we don’t want it to start with trauma...

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

And harm. Really having community health workers, making sure that we have Doulas, that we have Midwives, that we have a team, a care team. That we have the birthing person support people there. All of that is so important to decrease your risk of C-section and increase your risk of vaginal birth. We have data to support that.

Monica Peek:

Mm-hmm (affirmative).

Joia Crear-Perry:

That's really, when we say holistic care, we mean putting the mom and the baby in the middle and ensuring that our... It's not a hierarchy, that we're all together as a team supporting the dyad that's in the middle.

Joia Crear-Perry:

If you want to be actively anti-racist, which I sure all of you do. Then all that simply means is you understand there's nothing broken about Black people. That there have been cultural beliefs and policy that have been trying to break us for a long time, but they we're all human. There's only one human race and we're all in this together, so how do we support each other for well-being, and for justice, and radical Black joy.

Monica Peek:

Thank you so much, Dr. Perry. It is always a pleasure to hear you, and your wisdom, and your expertise. This brings us to the takeaway goals that each of us can play a part in implementing to help end the maternal health crisis in the United States. These are SMART goals, which stands for specific, measurable, attainable, relevant, and timely goals. For example, measure and recognize bias and social determinants of maternal health, applied best practices to screen for risk factors and provide holistic reproductive maternal care for African-American women, develop care plans that focus on respectful maternity care, and include discussions with the patients on their specific health needs, and implement effective and timely clinical interventions to prevent major causes of mortality, maternal morbidity, and mortality.

Monica Peek:

I also want to encourage everyone to visit CME Outfitters dot com backslash diversity and inclusion hub, to access a number of additional activities on this very important topic of diversity and inclusivity in health care. We'll be adding new content every month and we really want to hear from you, our audience, on what you need so we can make a real impact on these very important issues.

Monica Peek:

Again, thank you so much Dr. Crear-Perry for your input today and thank you for our audience, for all your work in providing equitable and holistic care to all patients around the globe.