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## NATIONAL PERINATAL ASSOCIATION

### STUDENT SOCIETY NEWSLETTER

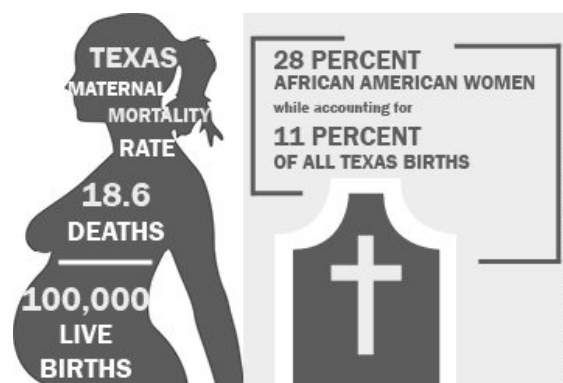
## Op-Ed: Racial Disparities in Perinatal Morbidity and Mortality in the United States

C. Cody Miller, MS4, and Ealing Tuan, MS3

In 2016, a study published in *Obstetrics & Gynecology* on maternal morbidity and mortality in the United States shook the foundations of beliefs in the safety and effectiveness of the American healthcare system. The study found a nationally (excluding California and Texas) averaged maternal mortality rate (MMR; defined as number of deaths per 100,000 live births) of 23.8, a 26.6% increase from 2000-2014 while all other developed nations globally experienced reductions in their MMR.<sup>1</sup> Now, increasing awareness has brought to light a new aspect of our perinatal healthcare woes – or rather, a historical aspect.

After all, the problem of racial inequity in perinatal mortality and morbidity is nothing new. By the time JAMA published an article on the matter in 1999, previous studies had already attempted to explain racial discrepancies in maternal mortality.<sup>2</sup> Nearly twenty years later, the matter irrefutably persists with disturbingly little improvement. Even in 2010, Black women were still over three times more likely than white women to die in the peripartum period.<sup>3</sup> Studies have shown that black women in the United States are 60% more likely than white women to suffer from preeclampsia or eclampsia<sup>4</sup>, 88% more likely to have a postpartum hemorrhage<sup>5</sup>, and 48% more likely to undergo cesarean section.<sup>6</sup> Even when accounting for known differences in educational attainment, black women still fare worse; a black woman with a college degree or higher is still more than twice as likely to suffer severe maternal morbidity than a white woman who never graduated high school.<sup>7</sup> All of the aforementioned findings are from studies published within the past decade.

Infants are by no means insulated from these disparities. Although medical advances have precipitated an overall decrease in US infant mortality, from 1950 to 2005, the African American infant mortality rate rose from 1.6 to 2.4 times the white infant mortality rate.<sup>10, 11</sup> JAMA Pediatrics published a study in March 2018 that examined nearly 596,000 very preterm births across 40 New York City hospitals. Among the many contributing factors assessed (including mother's race, socioeconomic status, and highest level of education), the impact of hospital of birth on



### Fast Facts:

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These numbers are **unacceptable**. Something has to change.

infant mortality was second only to a given infant's inherent health risk. Unsurprisingly, Black and non-white Hispanic very-preterm birth infants were more likely than their white peers to be born at these hospitals that were associated with higher risk-adjusted rates of neonatal morbidity and mortality.<sup>12</sup>

These egregious disparities in outcomes between racial groups in US perinatal healthcare are unacceptable. In 2015, the American Congress of Obstetricians and Gynecologists (ACOG) published a committee opinion that recognized more than a third of all women in the US as members of a racial or ethnic minority demographic, and the opinion called for immediate efforts to reduce racial inequities in MMR.<sup>8</sup> However, academic literature and professional society recommendations have not proven effective in the last two decades at addressing racial inequity in perinatal healthcare. Real, actionable measures must be taken at the levels of patient education, practitioners, and healthcare policy, to assure all expecting mothers and their newborns receive high-quality care.

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## Medical School Highlight: Schweitzer Fellowship

*Soumya Gogia is a current MS2 at BCM in the MD/MPH track. She is doing a Schweitzer Fellowship in postpartum depression along with fellow MS2 Peter Yun. Here she describes the inspiration for this project and her hopes for the future of postpartum care.*

Throughout my undergraduate career, I had the opportunity to work at Almost Home, a shelter in St. Louis for pregnant teenagers. During my first few months there, I developed a very close relationship with a young woman staying there. I watched her feelings about welcoming her baby into the world transition from sheer joy and excitement to a deep depression, and, ultimately, psychosis. I watched her bounce from doctor to doctor without finding solace in any treatment provided, and I experienced the heartbreaking impact on her and her loved ones.

I can't even count how many times she wished to confide in someone who would truly understand what she was going through. And as much as I cared about my friend, there was so little I could do,

especially as a young college student who had very little idea of what it meant to be a mother who was struggling. While I did my best to be supportive, I ultimately felt powerless and as though I had let her down.

When I moved to Houston this year and started school at both Baylor as a MD candidate and UTHealth as an MPH candidate, I was inspired to work on a postpartum depression policy brief through the Clinic to Capitol elective in the hopes of influencing policy that would expand options for mothers who suffer as my dear friend did. In my research for the course, I was unbelievably excited to find that Texas has taken steps (inspired by a brief written by BCM students!) to increase recognition of postpartum depression by allowing pediatricians to be reimbursed for its screening!

Unfortunately, I also learned that this increased recognition has not led to appropriate treatment and care for many mothers, especially minority women – a demographic often opposed to antidepressant therapy. Additionally, resources are ultimately only available to those with a diagnosis of postpartum depression, and this cutoff overlooks a

crucial demographic of women who may be on the border of that diagnosis or whose mental health is nonetheless affected by significant postpartum stressors.

Wanting to do something – anything – to help these women, my classmate, Peter Yun, and I started planning a Schweitzer Fellows project aimed at addressing these potential gaps in postpartum care. After significant research and conversations with OB/Gyns, reproductive psychiatrists, public health professionals, and patients themselves, we settled on starting a peer support group aimed at reducing the stressors that minority women face postpartum. We have begun our needs assessment process by surveying both currently and recently pregnant women at a Harris Health System clinic in Houston. In these surveys, we ask the women what support systems are in place for them at home during the crucial perinatal period and what the clinic could do to better support them. We also gauge their interest for our support groups and elicit potential discussion topics from them, which have included contraception, daycare, and postpartum depression. While group meetings have not yet begun, we hope to conduct support group meetings with a combination of discussion and activities, all while we assess outcomes using the maternal efficacy, perceived stress, and Edinburgh Postpartum Depression scales. On top of that, we will reflect on our experiences, alongside the women we serve, by keeping journals. And in the end, we will hopefully make a difference in their lives, their families, and our communities.

## OB/GYN Clerkship: Medical Student Reflections

*Christina Hagan, MS3*

Getting ready for my first clinical clerkship as a second-year medical student, I expected my Obstetrics & Gynecology rotation to be something like this: learn to integrate into a clinical team efficiently, continue to work on forming comprehensive differentials, assessments and plans, and of course, the classic goal of mastering pelvic exams. But as soon as I was scrubbed into two cesarean sections and a bilateral tubal ligation on my first day of labor and delivery at the county hospital, I knew those expectations would be shattered during what promised to be an exciting rotation!

Through the diverse settings of L&D, a high-risk obstetrics clinic, the gynecology surgery service, and a community OB/GYN clinic, I was enamored by the variety of an OB/GYN practice. Vaginal deliveries, C-sections, prenatal care, contraceptive counseling, well woman exams, LEEPS, D&Cs and hysterectomies, were just some of the things I was fortunate to observe and even assist in the care of a diverse age demographic, from teenagers to elderly women. I realized my initial expectations severely underestimated the variety in this specialty. I remember the awe on a mother's face at seeing her baby on ultrasound for the first time, and I remember my own wonder at being handed a baby as it took its first breath during a C-section.

And then sometimes, there was despair – such as when we had to tell a patient she'd suffered a miscarriage. I stood amidst her tragedy wondering, "What do I do?" I quickly learned my role as the medical student was to find the box of

tissues, but the OB/GYN physicians' compassionate responses to the patient modeled the role I would have as a physician. They displayed not only strong intellect and skill as they ran between clinics, consults, and the OR, but also the strength and empathy to rejoice with one patient and mourn with the next. They set the bar high for the doctor I aim to become one day. I finish this rotation reluctantly, as I know the experiences I had were invaluable and will shape my journey to becoming a physician.

### **Hannah Chen, MS3**

*"A quién se parece el bebé?"-- Who does the baby look like?*

While gently cradling her newborn, the mother smiled as she responded confidently that there was a shared likeness, to which the father readily agreed.

This conversation came halfway through my labor and delivery sub-rotation, reflecting my growing language proficiency as I built upon my Spanish foundation to form a framework comprised of both basic L&D terminology and colloquial conversation starters that fostered a connection with the patient. More than gathering 'Gs and Ps' as part of her medical history, I found it just as meaningful to elicit her life history -- what the name of their child would be, who chose it, and who else in the family was eagerly awaiting the child's arrival. While this exchange would not be documented in her progress notes or discharge summary, she and I would both record it for ourselves as a memory formed in the wee hours of a special morning.

Beyond the hustle and bustle of L&D, I also loved being a part of the weeks of

eager anticipation leading up to delivery. Every Wednesday morning, I got to follow my preceptor to see her third trimester patients. Despite the unpredictable nature of the delivery process, these weekly appointments occurred like clockwork. Through these visits, I learned more about each patient, her hopes ("that he looks like me this time!"), fears ("that I can finish my project AND get my nails done before it's time.") and stories while concurrently developing my ability to measure fundal height and fetal heart rates. At the same time, I was also learning from my preceptor, who not only provided reassurance and guidance for each patient, but also made every effort to be at their deliveries, even after a long night of being on call. This close relationship empowered her patients and modeled for me what it means to be a physician.

Coming into my very first rotation with little more than my white coat and a prayer that I would not drop any babies, I did not know what to expect. Eight short weeks later, I have not only developed my OB/GYN clinical and surgical skills, but also nurtured a desire to pursue the specialty in the future. In the meantime, I will continue to learn from both patients and physicians alike on my second, third, fourth, and all subsequent rotations.



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