



Institute for
Healthcare
Improvement

The Role of Racism as a Core Patient Safety Issue

*Three things leaders can do to understand
the contributing causes of maternal
mortality, including racism.*

In February 2019, the Johns Hopkins Bloomberg School of Public Health hosted a special symposium titled, “The Fierce Urgency of Now,” in honor of Shalon Irving, PhD, a JHBSPH alumna, who passed away unexpectedly in 2017 just weeks after giving birth to her first daughter, Soleil. Irving was black, and the circumstances of her death were, tragically, far too common. The symposium was both a way to shine a brighter light on health inequities and a tribute to Irving’s lifelong work to eradicate unjust health disparities.

Maternal mortality rates in the United States have more than doubled between 1991 and 2014, according to the Centers for Disease Control and Prevention. A 2018 Commonwealth Fund comparison of 11 similarly high-income nations found that mothers in the U.S. were the most likely to die from pregnancy-related complications.

Maternal mortality among American black women is an even greater problem—a “fierce and urgent problem,” to borrow the words from the Johns Hopkins symposium. Black women in the U.S. are three to four times more likely to die from pregnancy-related complications than white women. This

inequity is decades old, and now is the time to end it.

Serena Williams and Shalon Irving

Due to high-profile cases like the one suffered by tennis champion Serena Williams in 2017, both academia and the media are starting to pay more attention. Williams experienced shortness of breath one day after giving birth. Her history of blood clots led to her concern about a possible pulmonary embolism. Despite her medical history and clear communication of symptoms to a hospital nurse, Williams had to insist on the CT scan that revealed the clots in her lungs. Her candor in sharing her story brought more attention to pregnancy-related health risks for women, especially black women. She survived, but thousands of others, like Irving, do not.

In the weeks following the birth of Soleil, Irving’s blood pressure frequently spiked, and she suffered headaches and had swelling in her legs. The incision from her C-section wasn’t healing properly. She was concerned enough to visit her healthcare providers on many occasions. Despite a series of tests, she was repeatedly sent home without adequate attention to what was wrong. Three weeks after giving

birth, she collapsed in her home and died.

Though it is true that black women in the U.S. disproportionately suffer the medical and social conditions associated with higher rates of complications and maternal mortality—poverty being one of these conditions—among black women, racism is also playing a major role in maternal mortality. The difficulty of talking about and directly addressing racism is hindering progress. A 2016 study by the New York City Department of Health showed that a black woman in New York City with a college degree was three times more likely to die from pregnancy-related complications than a white woman without a high school diploma.

Both Williams and Irving had access to healthcare in major urban areas in which safe and high-quality care is routinely delivered. Both women were aware of their own health histories and the unique risks to black women, yet they endured preventable complications. Education, income and social status are not enough protection for black mothers.

Race Is Not a Risk Factor, Racism Is
The contributors to maternal mortality, particularly among black women,

are deeply rooted in our society. The experiences of people of color in our health systems reveal that implicit and explicit bias and structural racism are driving health inequities like maternal mortality. Joia Crear-Perry, MD, FACOG, founder and president of the National Birth Equity Collaborative, adviser to the Black Mamas Matter Alliance, and recent presenter on this topic to the United Nations Office of the High Commissioner of Human Rights, helps us understand by teaching us that “Race is not a risk factor, racism is.”

The Better Maternal Outcomes Initiative, supported through a grant from Merck for Mothers and facilitated by the Institute for Healthcare Improvement, is a recent effort to

improve outcomes for women and babies in the U.S. In addition to spreading the use of evidence-based care practices to reduce complications, the aims of the initiative include partnering with black women, healthcare providers and community organizations to better understand and address factors to reduce inequities and improve health outcomes. What’s particularly promising is the explicit focus on reducing health inequities by co-designing improvement efforts. The initiative engages black women who have experienced pregnancy and birth, and uses this expertise to drive improvement in women’s health and healthcare.

If we are to reduce and ultimately eliminate inequities in maternal

health, healthcare leaders can begin by doing three things:

1. ***Listen and learn:*** We know that listening to patients and their families is core to any improvement effort. It’s even more important in efforts to address maternal health inequities. Leaders can partner with black women so we can learn together how to improve maternal health. Healthcare systems in the Better Maternal Outcomes Initiative are actively listening to and honoring black women’s stories about their experiences in childbirth, and using those stories to co-design system-level improvements to increase equity, dignity and safety for black women.

2. **Acknowledge and address implicit bias:** Even though most healthcare organizations have no intention of causing discrimination, the experiences of patients teaches us that implicit bias and structural racism are common sources of harm. Health systems can include in their diversity and inclusion training programs ways for the workforce to recognize implicit biases, provide tools to address care inequities, ensure access to clinical and social supports, and standardize clinician responses to obstetric complications.

3. **Support collection of standardized data:** The Preventing Maternal Deaths Act (H.R.

1318) seeks to reduce variation in collecting and tracking maternal health data. Healthcare leaders can insist on and aid this standardization effort. Good data collection and analysis will help us understand if changes are leading to improvements in outcomes. Leaders can also standardize the engagement of women, particularly women of color, and their families, with lived experience of pregnancy and birth. As referenced, their stories and experiences are perhaps the most important data of all.

It's uncomfortable to talk about racism, and even more harmful to experience it. It's uncomfortable to

look deeply within and identify our biases. More often than not, though, being a leader is about doing the uncomfortable things. ▲



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