BIOETHICS IN FILM: FROM SCREEN TO SEMINAR

Aftershock

APRIL 12, 2023
11:30 AM ET
Dr. Shalon Irving (1981-2017)
Maternal Mortality in the U.S. Far Outstrips That of Other Industrialized Nations

<table>
<thead>
<tr>
<th>Country</th>
<th>Rate per 100,000 Live Births</th>
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</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>23.8</td>
</tr>
<tr>
<td>France</td>
<td>8.7</td>
</tr>
<tr>
<td>Canada</td>
<td>8.6</td>
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<tr>
<td>UK</td>
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<tr>
<td>Australia</td>
<td>4.8</td>
</tr>
<tr>
<td>Switzerland</td>
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<tr>
<td>Sweden</td>
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<tr>
<td>Germany</td>
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<tr>
<td>Netherlands</td>
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<tr>
<td>Norway</td>
<td>1.8</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1.7</td>
</tr>
</tbody>
</table>

*Deaths per 100,000 live births

Maternal Mortality Rates, by race and Hispanic origin: United States, 2018-2021

Statistically significant increase from previous year ($p < 0.05$).

Maternal Mortality Rates, by race and Hispanic origin: United States, 2018-2021

Statistically significant increase from previous year ($p < 0.05$).


Egypt – 17
Ecuador – 66
Libya – 72
Brazil – 72
Colombia – 75
Algeria – 78
Zambia – 135
Proportion of pregnancy-related deaths and live births by Race/Ethnicity, NYS MMRC, 2018

Source: NYS MMR and NYS Vital Statistics
Proportion of pregnancy-related deaths and live births by Race/Ethnicity, NYS MMRC, 2018
Proportion of pregnancy-related deaths and live births by Race/Ethnicity, NYS MMRC, 2018

Source: NYS MMR and NYS Vital Statistics
Proportion of pregnancy-related deaths and live births by Race/Ethnicity, NYS MMRC, 2018

Source: NYS MMR and NYS Vital Statistics
Average Black/White Disparity Has Been 9.4 times Higher For Black v. White Mothers

Black/White Disparity, Pregnancy-Related Mortality Ratio, 2001-2018

Ratio Black:White PRMR

Average = 9.4 times higher
Its Racism, NOT Race
Figure 1: Pathways to Racial and Ethnic Disparities in Severe Maternal Morbidity & Mortality

- **Preconception Care**
- **Postpartum Care**
- **Antenatal Care**
- **Delivery & Hospital Care**

**Outcomes**
- Severe Maternal Morbidity & Mortality

**Health status**: comorbidities (e.g., HTN, DM, obesity, depression), pregnancy complications

**Racism & Discrimination**
- **Patient Factors**
  - Socio-demographics: age, education, poverty, insurance, marital status, employment, language, literacy, food insecurity, disability, gender, sexual orientation, body weight
  - Knowledge, beliefs, health behaviors
  - Psychosocial: stress, self-efficacy, social support

- **Community/Neighborhood**
  - Community, social network
  - Neighborhood: crime, poverty, built environment, housing, environmental exposure, interpersonal violence

- **Provider Factors**
  - Knowledge, experience, implicit bias, cultural competence, communication

- **System Factors**
  - Access to high quality care, transportation, structural racism, policy

Black Maternal Health in the 21st Century
April 12, 2023

Danielle Laraque-Arena, MD, FAAP
Professor of Clinical Epidemiology and Pediatrics, Mailman School of Public Health and Vagelos College of Physicians and Surgeons, Columbia University
Senior Research Scientist, New York Academy of Medicine
Founder and Co-Chair the Women’s Health Research & Wellbeing Workgroup, NYAM
Co-Chair Governor’s Task Force on Maternal Mortality and Disparate Racial Outcomes (2018-2019)
President & Professor Emerita, SUNY Upstate Medical University
I have no financial conflicts to disclose
Timeline of US Maternal Mortality*
Deaths/100,000 live births

1930’s ~1,000/100,000

1969 68%

1998**

2018 2019 2020 2021

*Black/NH 37.3 44.0 55.3 69.9
White/NH 14.9 17.9 19.1 26.6
Hispanic 11.8 12.6 18.2 28.0
US overall 17.4 20.1 23.8 32.9

68%

HD ratio remains 2.45-2.89, MM for Black women compared to white women

Increases steadily

*National Center for Health Statistics; https://www.cdc.gov/nchs/products/index.htm. Maternal Mortality: Death while pregnant or within 42 days of the end of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. WHO, ratio per 100,000

Maternal Health Disparities

Black/White Disparity, Pregnancy-Related Mortality Ratio, 2001-2018

Ratio Black:White PRMR

Average = 9.4 times higher
Maternal Mortality

50

About 50 people die during pregnancy, at birth or within one year from the end of pregnancy.

About 40% (20) of these are complicated or aggravated by pregnancy.

Approximately 60% (30) are preventable.
What must we do to address preventable pregnancy-related death?

Awareness & Action

• Positional statement (Who am I?)
• Knowing history and epidemiology
• Establishing the frame for action (scientific vs justice/or both)
• Moving beyond talk
Fathers and Partners

• Brief review of PubMed literature with key words *maternal death and the role of fathers*  
  – 62 results  
  • 7 articles only dealt directly with the impact of maternal death on fathers  
  • Titles: “Fathers Matter”  
    “Overlooked and underserved: Widowed fathers with dependent children:”  
  • Understudied and under-researched  
  • Families matter
Figure 17.3: Socially Accountable Education: An Equity Proposition*

Co-defined Health Needs

Co-defined health impact (outcomes)

Competencies

Curriculum Co-learning

Co-defined Assessment

Community Assessment

Quality Individual & Population Data

Iterative Feedback Flexibility Transparency

*Laraque-Arena, 2019/2021/2023
Apply the Evidence

Center for Medicare & Medicaid Innovation (CMMI) results (2013-2017): Strong Start for Mothers and Newborns Initiative

• Three models of care tested that each allow incorporation of midwives and community-based workers (doulas, CHW)
  – Provision of prenatal care at group visits (centering)
  – Use of birth centers instead of hospitals
  – Maternity care homes
None of these models were shown to systematically result in worse outcomes or higher costs than a control group of similar pregnancies not participating in these models of care.
Two models were found to improve health outcomes and lowering costs.
Key Concepts in Sustainability and Scaling*

*Building trust

- Horizontal – next unit in the change process
- Depth – adding to existing innovations
- Vertical – adoption by different jurisdictions
Institutional/Societal accountability

- Innovate models of care
- Evaluate effectiveness in the improvement of outcomes
- Scale up
- Continue to evolve
- Full system shift
What must we do

• Decolonize care
• Use medical interventions appropriately (understand the medicalization of maternal care and its impact)
• Dismantle structural racism
• Address gendered perception of roles
• Establish health and health care as a human right
• Regain our humanity
“AFTERSHOCK”
BLACK WOMEN AND OBSTETRIC RACISM

Dana-Ain Davis, MPH, PhD.
Queens College and Graduate Center, City University of New York
What is Obstetric racism? Obstetric racism is comprised of beliefs and practices levelled against the reproducing Black body that sit at the intersections of obstetric violence and medical racism. It is the mechanism and practice of subordination to which Black women and people’s reproduction are subjected that track along the histories of anti-black racism based on ideas of difference that have been worked out through the hierarchization of humanity as is contemporarily a remnant of the afterlife of racial science. (Davis, 2018).
"They kept asking if she was taking drugs" Shawnee Benton Gibson, Shamony’s mother.

"Who we are and what we look like" Omari, Shamony’s partner.

"They don’t care" Mustafa Shabazz.

"They said it was pregnancy-related issues" Bruce McIntyre, Amber Rose’s partner.

“If you are Black you are less likely to get the support for a vaginal birth” Helena Grant, Midwife at NYU.

“There was negligence and incompetence” Bruce McIntyre.
OBSTETRIC RACISM
Dâna-Ain Davis, MPH, Ph.D.

1. Diagnostic Lapses
2. Neglect, Dismissiveness, or Disrespect
3. Intentionally Causing Pain
4. Coercion
5. Ceremonies of Degradation
6. Medical Abuse
7. Wild Card
OBSTETRIC RACISM

DIAGNOSTIC LAPSE
Dána-Ain Davis, MPH, Ph.D.

When a clinician’s uninterrogated belief that Blackness is pathological leads them to de-emphasize or exaggerate or ignore a patient’s symptoms resulting in an inappropriate or lapsed diagnosis.

NEGLECT, DISMISSIVENESS, OR DISRESPECT
Dána-Ain Davis, MPH, Ph.D.

When medical professionals ignore or dismiss a person’s expressed need for reproductive help or care and/or treats them with disdain.
OBSTETRIC RACISM

INTENTIONALLY CAUSING PAIN
Dána-An Davis, MPH, Ph.D.

When medical professionals fail to appropriately manage pain, which may be rooted in racialized beliefs about pain immunity and as well as the absence of empathy for Black people’s physical suffering, leading to lack of internal motivation to alleviate or reduce Black suffering.

COERCION
Dána-An Davis, MPH, Ph.D.

When medical professionals perform procedures without consent and/or intimidate patients to make decisions.
OBSTETRIC RACISM

CEREMONIES OF DEGRADATION
Diana-Ain Davis, MPH, Ph.D.

The ritualistic ways in which patients are humiliated or shamed and includes a sense of being sized up to determine the worthiness of the patient or their support person(s) who may be viewed as a threat. In response, medical staff may deploy security, police, social services or psychiatry to ensure compliance or to remove the “threatening” person.

MEDICAL ABUSE
Diana-Ain Davis, MPH, Ph.D.

Can occur when medical professionals engage in experimentation and/or (repetitive) behavior that is motivated not by concern for the patient but serves to validate the clinician’s self-worth and upholds their domination over the patient.
BIOETHICS IN FILM: FROM SCREEN TO SEMINAR
FALL | WINTER | SPRING
2023 - 2024
ETHICS GRAND ROUNDS

MEDICALIZING AND CRIMINALIZING MENTAL HEALTH

VIRTUAL EVENT | MAY 2ND 2023, 12-1:30PM ET

Kimberly Sue, MD, PhD
Division of General Internal Medicine, Yale School of Medicine

Leah G. Pope, PhD
New York State Psychiatric Institute and Columbia University

Fay Owens
Urban Justice Center Mental Health Project

Sandra Soo-Jin Lee, PhD
Moderator, Division of Ethics, Columbia University
Visual Storytelling in ELSI Research
April 14, 2023 at 12pm ET/9am PT

Elizabeth Gross Cohn, PhD, RN, FAAN
City University of New York,
Columbia University

Gary Ashwal, MA
Booster Shot Media

Sara Ackerman, PhD, MPH
University of California - San Francisco

Moderated by