IF NOT NOW, WHEN?

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ABSTRACT

Maternal Health requires a bioethical evaluation to thoroughly address and reduce the troubling statistics and events of pregnancy-related complications and maternal mortality. Maternal mortality affects African American women three to four times more than any other race, therefore presenting race as a factor. Types of experienced racism and the overall scientific pathway are explored in relation to the health of African-American women. Race-related stress and its association with adverse maternal health outcomes is an important issue to consider when evaluating the maternal health complications. In addition, addressing the result of unethical inequalities in the healthcare system in combination with other societal contributions is essential when trying to recognize its impact on the experience of pregnancy. This thesis explores the impact of racism on maternal outcomes and health of African-American mothers, beyond the commonly understood influences of other socio-economic factors.

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CHAPTER 1: INTRODUCTION

Serena Williams and Kira Johnson, two different women who lived two different lives, share shocking experiences that emphasize racial disparities and health inequity in maternal health. Their unforgettable stories display the lack of fair care, consistent racism and the difficult patient-physician relationship that exists between the healthcare system, healthcare providers and African American Women. Serena Williams, who experienced complications during her pregnancy, and Kira Johnson, who unfortunately passed away after giving birth, two women with opposite socioeconomic statuses, both encountered an undesirable pregnancy experience. An experience that perhaps was caused by racial bias during their hospital stay. Both women had their cries and pain ignored a common issue for African American women who seek medical assistance. The stereotype of black women being able to handle pain on a higher scale compared to their counterparts has caused many ethical concerns in medicine currently and historically (Stallings, 2018). The comparison of these two cases has two things in common, that they were both African American women, and that they both did not receive the care that they deserved and needed. “This was not just a medical tragedy, this was a medical catastrophe,” said Charles Johnson during an interview about his wife’s encounter (Johnson, 2018). This quote is relatable for both. Unconscious racial bias and/or implicit bias was displayed throughout the experiences of Serena Williams and Kira Johnson and was likely the reason for the unfortunate outcomes that commonly affect women of color across all borders.

Pregnancy can be one of the most beautiful experiences that a woman goes through in life, a time in which a woman is a creator and the home of an amazing creation. Understanding inequity in Maternal Health is important in efforts to improve the health of women and children, as they are what makes the expansion of generations, hence making it an important public health issue. The development of research and publications that have touched on the topic of negative maternal and infant outcomes within the African American community has also brought attention to the concern of maternal mortality. Maternal mortality is defined as a death that occurs to a

woman as a direct result of obstetric complications or indirectly with a pregnancy-induced exacerbation of pre-existing medical conditions, but not for incidental or accidental causes (GBD 2015 Maternal Mortality Collaborators 2016). The CDC has recorded that about 700 women die in the United States per year due to pregnancy or delivery complications, with African American women being three to four times more likely to die from childbirth than their counterparts. Although research and recent unfortunate events have been brought to the attention of the government and health professionals, the United States, which is considered a "developed country," continues to have higher rates of maternal mortality than underdeveloped countries. The rates of maternal mortality have left individuals surprised and national organizations determined to discover the cause of such disturbing statistics.

Beyond reported mortality rates, there is an extensive list of disparities that have a long-lasting effect in maternal and child health of African Americans and have been presented statistically. For example, between 2013 and 2015, about 54 black women died for every 100,000 births compared to about 15 white women in the state of New York (Julion, 2018). This recent reporting of maternal mortality displays the continuation of unaddressed disparities in the medical system, particularly for African American women. During pregnancy, women have a possibility of developing cardiovascular diseases which could end immediately after birth or persist as a life-long disease. In a study that examined maternal cardiovascular mortality in Illinois during the years of 2002 and 2011, data showed that cardiovascular complications are the cause of more than 8.2 deaths per 100,000 live births. Dr. Briller also reports that non-Hispanic black women are four times more likely to die from cardiomyopathy (diseases of the heart muscles) compared to non-Hispanic white women. Lastly, it has been reported that black women of lower socioeconomic status are more likely to be recommended birth control, particularly an intrauterine device (IUD) compared to white women. The increased rate of IUD recommendations for black women suggests there is a provider bias towards minority

populations. Most research that has attempted to address the inequalities amongst this data have focused more on maternal living location, education, and economic status, not race as a common social inequality. In this thesis, I will focus on the influence of racism and stress on adverse maternal health outcomes. A few factors that I hypothesize to play a major role are different forms of racial bias, lack of health communication, and injustices within the healthcare system. It is crucial to address inequalities and disparities embedded in the healthcare system towards the African American race, particularly women. Pregnancy can be one of the most beautiful experiences that a woman goes through in life, but the desired experience of a successful and healthy pregnancy is not always granted to African American women and this unethical situation is the motivation for this thesis.

CHAPTER 2: DEFINING RACISM

Although maternal mortality is viewed as an obstetrical concern, there are societal influences as well. Racism is an institutionalized system of oppression that designates negative value to people based on race and/or ethnicity (Prather 2016). This system has a strong effect on the health and wellness of the African American race but sadly continues to be overlooked as a contributor especially when it plays a significant role in the treatment of patients. Have you ever thought about how meaningful your answers to the questions about what your race is or what your ethnicity is? Surprisingly, many people fail to separate the two, combining them into one characteristic mainly through the perception of the observer. In understanding health-related differences, potential influential factors and addressing any biases within the healthcare system, a distinction between the description of race and ethnicity must be explained. Race is a biological foundation that leads to socially constructed characterizations within similar groups of people. For example, race is display commonly as Asian, Black or African American, White, American Indian or Alaska Native, and Native Hawaiian or Pacific Islander limiting those who choose to categorize themselves as more than one race into a single identifier. In the US, ethnicity, on the other hand, is seen as two categories Hispanic or Latino and non-Hispanic Latino. It is typically viewed as placement into a broader category based on heritage and/or national origin (Kaplan, 2003). As the understanding of the three terms racism, race, and ethnicity progresses, it is possible to visualize the ways of discriminating from most subtle and indirect to severely threatening to an individual's health on many levels. The Socio-ecological Model (SEM) is a concept used to expand health promotion by recognizing complex challenges from a more comprehensive perspective. This model breaks down the multiple levels of influential factors that hold an effect on behaviors and overall health outcomes. In the article "The Impact of Racism on the Sexual and Reproductive Health of African American Women," Dr. Cynthia Prather uses this model to explain multi-leveled racism and its effect on the health outcomes of African American

women. In efforts to distinguish between the multi-leveled racism that a black woman may experience, the theoretical framework presented by Dr. Camara Jones is relevant. Dr. Jones provides a tool that efficiently conceptualizes racism in undesired health outcomes and disparities. She displays the three types of racism: institutional, personally mediated and internalized. Institutional racism means "differential access to the goods, services, and opportunities of society by race" (Jones 2000). Many opportunities and services are viewed as an individual and/or human right but seen as a privilege by many people who practice race associated discrimination of basic human rights and needs. Systematic racism falls under the guidance of institutional racism. Systematic policies and procedures have led many professionals, especially health professionals, of organizations and institutions to possess direct bias attitudes and to provide unfair healthcare. Women have reported feeling unheard and unseen in the medical field for being viewed as unable to afford care and able to withstand pain. This mistreatment has caused many trust issues between health professionals and black women. Unfortunately, reliable measurement of experiences (excluding self-reported) has not been developed causing researchers to have a hard time developing efficient studies that contain accurate experimental variables and representable conclusions. Although there have been attempts to address institutional racism through research, recent relatable and unfortunate events present the issue better in real-time. Some refer to institutional racism as a form of violence, particularly violence against women. For example, Simone Landrum reflects both the relation between institutional racism and unfair healthcare treatments and the black maternal and infant mortality rates in the United States. Landrum a mother of two, experienced shocking headaches during her pregnancy. When she spoke about her constant headaches (which in turn accompanied additional complications such as swollen feet and face) to her physician, he automatically dismissed it with a recommendation for Tylenol. Months later, Simone reported the intensifying symptoms, but her pain was overlooked to where it remained absent from her medical records.

She stated, “It was like he threw me away,” when she reflected on her conversation with her physician about potential delivery dates. Simone delivered a stillborn via cesarean section, a result due to a possible untreated case of preeclampsia. Simone’s experience of neglect from her providers is an example of institutional racism and the experiences of African-American women in the healthcare system.

African American women have historically experienced sexual violence, exploitation, discrimination and painful medical experimentations all of which previously impacted their health and have in turn impacted the health outcomes of the current generations of women. Some of these biases and mistreatments stem from historical embodiment in many common practices. For example, the historical events of enslaved African American women being used as subjects in experimental procedures by the “father of modern gynecology” Dr. James Marion Sims have contributed to institutionalized racism. He performed painful and unjust experiments on the bodies of enslaved black women to eventually perfect his surgical techniques (Prather, et al., 2018). Dr. Sims went on to perform these experimental surgical techniques until he perfected his skills, even leaving one woman to endure the painful experience about 30 times. The pain of these enslaved black women was continuously overlooked by the notion that black people could tolerate pain on a higher level compared to their counterparts (Hoffman, Trawalter, Axt, & Oliver, 2016). Nevertheless, black women have contributed to the development of many medical practices and procedures and the precision of instruments such as the speculum (Holland, 2017). Similar to past instances, black women remain hurt by the medical system, a system whose purpose is to maintain the health of individuals. The lack of fair maintenance of women’s health amongst African-American women affirms institutionalized racism.

Personally mediated racism is developed through attitudes and actions of discrimination and prejudices caused by race-based assumptions and stereotypes. Personally mediated racism

occurs when healthcare providers' preconceived notions about racial groups result in providing substandard healthcare to racial/ethnic minorities. As it can occur with or without a premeditated motive, it further connects to the ideas of implicit and explicit bias. The implicit bias, which is at the foundation of all three types of racism, can be recognized as an indirect and unconscious action or thought. Healthcare providers along with other individuals commonly hold implicit bias which ultimately leads to health disparities. Assumptions such as the previously stated "high pain tolerance" concept are said to be prominently held amongst individuals in the healthcare community has played a major role in the lack of health equity, particularly in pain treatments and interventions. On the other hand, explicit bias is referred to as conscious attitudes and beliefs held about a person, or a group of people and will more than likely stem from feeling fear. This fear can come from present or past threats in addition to experienced violence which in result may create boundaries amongst different racial/ethnic groups. The actions of personally mediated racism are regulated by societal norms which are defined as unwritten rules of behavior and motives accepted by a group or society.

Internalized racism is the acceptance of negative messages about abilities and intrinsic worth by members of the stigmatized races (Jones 2000). With the three types of experienced racism, it is likely that an individual will embody and accept the negativity that continues to be projected onto them. The confirmation and acceptance of the negative stereotypes are typically followed by a lack of self-worth and self-confidence. In the article "The Impact of Racism on the Sexual and Reproductive Health of African American Women," the authors address the relevance of racism in women's health. They suggest that internalized racism can impact sexual and reproductive health by promoting psychological distress, substance use, and physical health conditions that contribute to pregnancy-related complications (Prather, Fuller, Marshall, & Jeffries, 2016). Internalized racism along with historical racism can also gear towards the development of negative self-perceptions. With the help of Dr. Camara Jones' theoretical

framework of addressing racism in healthcare, and the socioecological model developed by scientists from the Centers for Disease Control and Prevention (CDC) addressing the connection of racism and adverse health outcomes (Fig. 1), it is clearly shown that racism plays an essential role in health disparities and inequity. In figure 1, the doctors explain a model which presents the social determinants of health, breaking it down from a broader view to a more detailed view. The model displays the impact of historical context, society, neighborhood/community, family/interpersonal supports, and individuals in a multileveled context. The four emphasized factors each contains the influence of one of the three types of racism. The theoretical model helps with the understanding that along with other commonly and continuously addressed factors that shape the health of an entire population, racism is also a factor. Bringing attention to the effects of social behaviors such as racism, as a mechanism of forcing individuals to self-reflect with a different perspective and newly gained knowledge will allow for a more interpersonal change. Making personal actions and thoughts a priority while understanding the effects on the community could result in more conscious efforts and actions. With there being three types of experienced racism, it is not uncommon for people to naturally hold biases, but how these biases are presented and projected on the stress and health outcomes of women of child-bearing age is the main concern.

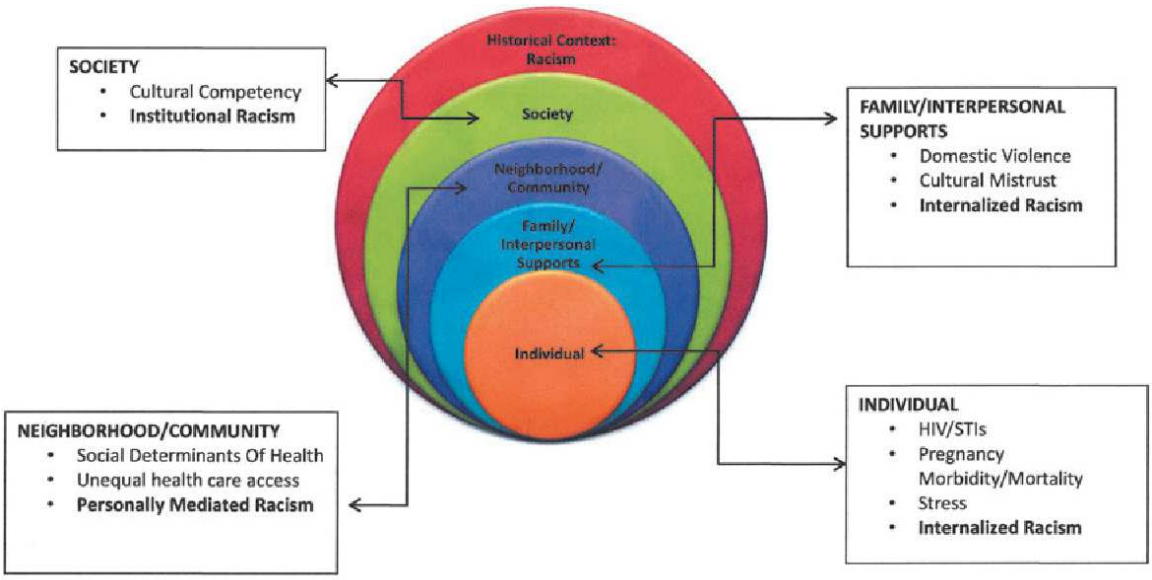

Figure 1: A socioecological framework adopted by Doctors Prather, Fuller, Marshall, and Jeffries used to identify the influence of racism on African American women and sexual reproductive health influences outcomes.

CHAPTER 3: CASES OF MATERNAL HEALTH OUTCOMES

It has been proven that socioeconomic factors such as occupation, income, and education level play a role in the outcome of pregnancy. In the article "Explaining Racial Disparities in Adverse Birth Outcomes," Rosenthal and Lobel emphasize that socioeconomic status and prenatal health behaviors are not the sole contributors to the rates of negative birth outcomes in African American women (Rosenthal & Lobel, 2011). Even, Rosenthal and Lobel also state "With increased education, the racial disparity in adverse birth outcomes actually increase" (Rosenthal & Lobel, 2011: 978). It is assumed that with higher education come better careers which in turn lead to higher income levels, but unfortunately, that is not the case. For instance, an African American woman that has an amazing scholastic background and exceeds professionally will experience more stress throughout her tenure than her counterparts. Thinking in terms of imposter syndrome, a continuous doubt about one's achievements and capabilities, black women experience this more as they advance in life. African American women are taught to be strong and resilient and told that they must be twice as good and qualified in positions, whether academically or career-wise, to succeed. This idea brings on additional stress that could impact their health. Racism exists across other demographic variables which is through the most recent news of Serena Williams and Kira Johnson. The cases of Serena Williams and Kira Johnson have demonstrated the lack of health equity through the experience of two mothers from two different socioeconomic classes, with a common denominator of being a pregnant African American woman.

Serena Williams, a 36-year-old (at the time of pregnancy) professional tennis player, experienced a troubling and life-threatening delivery with her first child. Williams, who has a known history of blood clot formation that continues to be treated with the use of blood thinners, knew that the birth of her daughter would not be easy once she discovered that she would have to undergo an undesired cesarean section. Williams, her husband, and her doula agreed that with her

history of blood clots, a vaginal birth would be ideal in efforts to minimize her complications. This decision later changed once the safety of her child's life along with her life was threatened. A few days, after the birth of her daughter, Alexis Olympia, Williams began to experience the shortness of breath and consistent coughing all the which are the results of a pulmonary embolism. She immediately notified her nurses about the complications that occurred and immediately requested heparin, and a Computed Tomography (CT) Scan, based on the treatment of her previous events of blood clots. At first, her requests were ignored, and an ultrasound was performed, instead revealing no issues or concerns. Eventually, the medical team obeyed Williams suggestion of a CT scan and confirmed blood clots. The blood clots were located in her lungs, which instantly caused a more complicated situation. In a documentary following William's pregnancy, she stated: "with as many issues and scares as I have had, I think I have learned pretty well how to listen to my body." With Serena Williams' ability to understand and truly know her body, she automatically knew that something was wrong. Unfortunately, that is not the case for many women.

April 13, 2016, Kira Johnson died at 39 years old after giving birth to her second son Langston via a cesarean section. Kira, whose health was never questioned and who routinely followed all the prenatal expectations, had an unexpected turn hours after giving birth. During Johnson's cesarean section procedure, a laceration in her bladder caused massive internal bleeding and continued for more than ten hours before the hospital staff took action. Charles Johnson, Kira's husband, noticed that there was an excessive amount of blood in her catheter and immediately notified the nurses. After more than four hours, Kira and her husband finally received the attention that they had continued to cry out for, but once the medical team took her into the procedure room, the team realized it was too late. Johnson died due to internal bleeding which was later confirmed as hemorrhagic shock. Hemorrhagic shock is defined as severe blood loss which leads to inadequate oxygen delivery and if left untreated, death quickly follows. The

cases of Williams and Johnson deserve significant attention because they provide real-life experiences of two different African American women, reinforcing racism in maternal health, affects a community of women whatever their socio-economic background.

CHAPTER 4: ADVERSE OUTCOMES AS A FACTOR OF RACISM

The problematic functioning of the healthcare system needs to be thoroughly addressed, beginning with healthcare being defined as how we provide services necessary to treat disease and to promote health. Services range from specific interventions to medical office services and care, all of which are sought by individuals in need. First, the lack of diversity amongst providers has created a division in the different races and cultures. The American Medical Association has reported that among obstetricians and gynecologists in office-based practices, 75% are white men, 18% white women and only 2% are black women. The lack of diversity leads to a decrease of a patient and provider relationship since the physicians are not equally representing the community in need, and creating a gap of communication and trust (Stallings, 2018). It is important for physicians to represent the population that they are more than likely to serve in an effort of reducing inequalities within communication and fair knowledge. Furthermore, I believe the current healthcare system, lacks a patient-centered focus which is essential for the growth of the patient and the healthcare system. Patients should feel that their needs are the priority of a health professional or system. Having a patient-centered focus approach, more accurate services, and treatments will be available for set individual factors which are impacting a patient's health. According to Figure 2, factors that impact the health of patients are affected by many socio-economic components which make up 40% of factors besides medical care that affect a patient's health. While the additional components that make up the 60% are important and should be focused on, the highest significant percentile (socio-economic factors) needs to be addressed without restrictions. Besides addressing the lack of health equity, access to resources, and the need for a greater amount of attention and prioritization for patients, race as a dynamic factor should also be researched and discussed.

More recently, attention and efforts have been put towards promoting research that directly addresses the inequalities in maternal healthcare and women's health overall in hopes to

make a change. Previous research primarily focused on socioeconomic and sociodemographic factors as common causes of adverse outcomes. For example, there are concerns about education, trust between patient-physician, pre and post medical reliability, and the ability to afford set resources. Social determinants of health are a complex topic to understand and address. It entails multiple aspects of an individual's life: housing, lifestyle, economics, and accessibility to resources, all of which vary from person to person making it difficult to put a set perspective on the role of social determinants and the relation to the health of populations. Figure 2 presents, factors beyond medical care which contribute to a patient's health but does not accurately provide all possible factors. Research has reported that poor access to both prenatal and postnatal care as well as inadequate medical treatment, all contribute to the increase of maternal complications. These complications can be the result of racism performed by health professionals and/or the healthcare system and can ultimately lead to chronic stress. Stress is defined as a multidimensional construct involving exposure to a stressor, the appraisal of its threat, and the cognitive, emotional, behavioral and physiological responses corresponding to that appraisal (Nuru-Jeter, et al, 2008). Experiences infused with racism can lead to various negative maternal outcomes from premature labor and chronic hypertension to preeclampsia (which yield many cardiovascular issues) and sadly, maternal mortality. A study was conducted by Collins and his colleagues to explore the relationship between racial discrimination during pregnancy and low birth weights within African American mothers (Collins, et al., 2000). Through the analysis of the questionnaires distributed, the team discovered that there is a link between racial experiences during pregnancy, and the outcome of low birth weight of infants. With maternal mortality in African American women being one of the largest racial disparities, the findings of this research should not be taken lightly. When racism is the "stressor," a diverse combination of responses (physically, mentally, and psychologically) is created especially in maternal health outcomes of African American women.

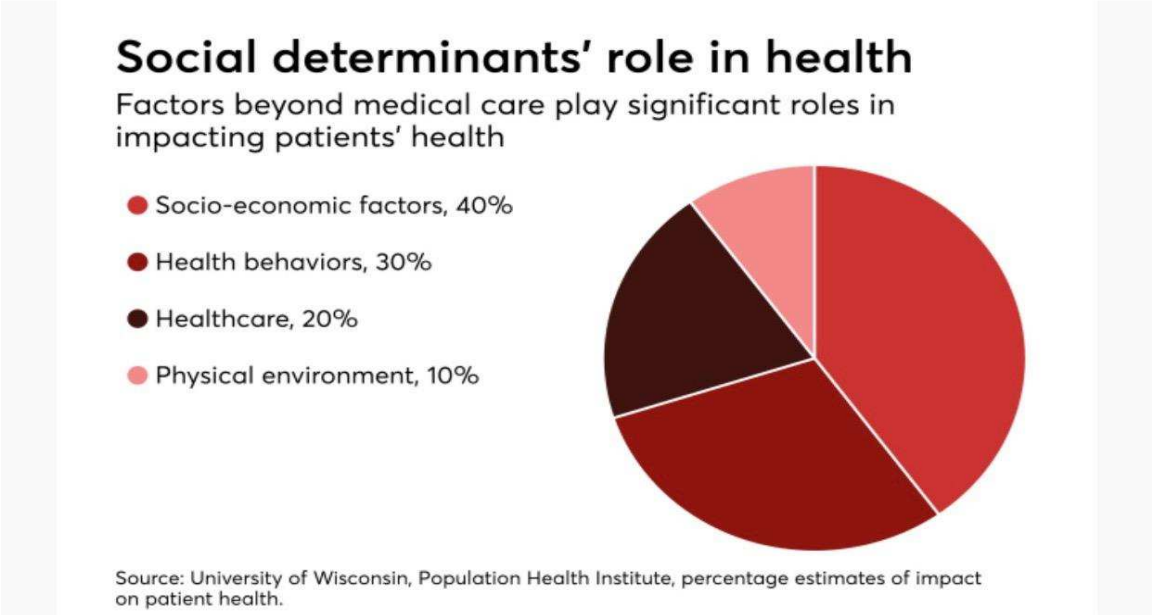

Figure 2: Social determinants' role in health (Driver 2019)

CHAPTER 5: THE SCIENTIFIC PATHWAY OF RACISM

To better understand the effect of racial stress on the body, a scientific pathway can be presented of the corticotropin-releasing hormone (CRH) as being accelerated by physiological stress. The corticotropin-releasing hormone is the main element that drives the body's response to stress and has many powers, such as the ability to increase anxiety. After stress, the hypothalamus releases a corticotropin-releasing hormone (CRH) which travels to the anterior pituitary, where it stimulates the release of adrenocorticotropic hormone (ACTH) (Thomson 2012). The hypothalamus is an area in the brain that controls body temperature and hunger, meanwhile, the anterior pituitary is a gland located in the head that secretes hormones impacting growth and sexual development during the transmission of ACTH. Steroids are released during the transmission to assist with the management of stress.

In pregnancy, the placenta releases CRH into both the maternal and fetal bloodstream. Many studies have shown that an increase of CRH levels in the placenta relates to preterm births (Ramirez, Watson, Brinkman, Challis, & G., 1998; Ruiz, et al., 2016). Thus, the determination of fetal growth can be accomplished through testing CRH levels in maternal blood. In addition to low birth weights, the acceleration of the corticotropin-releasing hormone can result in additional adverse outcomes, especially those leading to cardiovascular problems. In an article called "The Biological Clock and Vascular Disease Application to Pregnancy," Karoutsos, and the team explains a biological clock and its influence on physiological processes and hormone secretion (Karoutsos, Karoutsos, & Karoutsou, 2017). In figure 3, it is shown how an increase of CRH expression in the placenta mediates pre-eclampsia, leading to the influence of CRH on other cardiovascular abnormalities. This diagram provides a visual image of how stress relates to pre-eclampsia, and how it could potentially aid in both the understanding of adverse birth outcomes for both patients' and doctors' understanding of adverse birth outcomes.

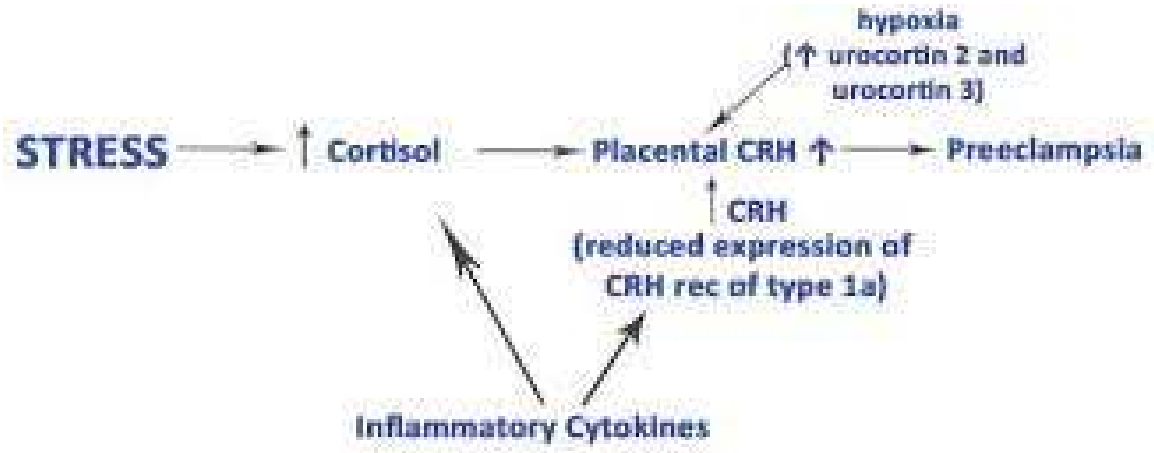

Figure 3: The Physiological Pathway Of Stress.

Racism creates a threat to the well-being of African American women, especially their mental health. In addition to the secretion of the corticotropin-releasing hormone leading to low-birth weights and pre-eclampsia, it also has a possible physiological yield to postpartum depression. Postpartum depression is common and has serious implications for the mother and her newborn. Dr. Yim and colleagues explored the relationship between the elevation of CRH and its possible effect on the increase of postpartum depression (Yim, et al, 2009). Through a longitudinal cohort study which involved the participation of pregnant women, a collection of blood samples at different gestational ages and the assessment of a questionnaire that provided the team with depressive symptoms was performed. The results of this study demonstrated the relevance of placental corticotropin-releasing hormone (pCRH) and its ability to predict postpartum depression symptoms. At a gestational age of 25 weeks, the team determined that testing pCRH levels could be a sufficient way of testing for symptoms it was determined that pCRH levels in women with postpartum depression were notably higher between the gestational ages of 23 and 26 weeks. Dr. Yim and his colleagues determined that the range between 23 and 26 weeks of gestational age is a significant pregnancy point to test for postpartum depression.

With this information, testing for specific symptoms and illnesses will be more efficient and effective for the health of both the mother and baby. Although there is an assumption that depression and CRH having a relation, they have not yet been clinically finalized as having a role amongst each other, therefore, the theory of the two being connected should continue to be researched. As the scientific pathway of stress ignites, additional societal contribution and their effects on maternal health cannot be forgotten.

CHAPTER 6: SOCIETAL CONTRIBUTIONS TO THE MENTAL HEALTH OF AFRICAN AMERICAN WOMEN

"I consider a woman who brings a child every two years more profitable than the best man on the farm," a quote by Thomas Jefferson (Yardley, 2012). Jefferson's quote displays the harsh reality of the embedded idea of a male's view on "what a woman is," and the social stress put onto the bodies of women. This quote also expresses the accepted belief women having the inability to conceive and reproduce yielding to the idea that a woman is not doing her purposeful duty. Infertility is a disease that is not fully understood but continuously impacts the black community, in fact, married black women have almost twice the odds of infertility than their counterparts. The unfortunate case of infertility is among various other social implications that affect the mental health of African American women of childbearing age. To reflect back on the types of racism, internalized racism could be one of the most severe and direct types. As stated before, internalized racism is the acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth. Most African American women experience their first racial encounter at a younger age when their mental stability is much more vulnerable and absorbent to what is presented to them (McGuire & Miranda, 2008). The internalization of experiences and stereotypes along with the creation of a long-range of undesirable mental health issues will easily occur. The acceptance of these negative messages will cause poor self-worth and self-confidence, resulting in a list of unexpected outcomes for personal growth, relationship longevity, health, etc. In addition to the early onset of racial experiences, the concept of being born into racial and/or ethnic segregation cannot be overlooked. For instance, African-American women have a higher chance of witnessing chronic diseases, early deaths, and other life-changing health conditions, which could give them the perception that those instances resemble what their health will be as years continue. The risk of younger African American women conforming to the negative stereotypes about their race could eventually lead

them into a downward spiral mentally. Ultimately resulting in the acceptance of "the cards they are drawn." In maternal health, physiological and psychological effects of race-based stress could affect both the mother and infant. Medically, this could lead to the adverse outcomes previously spoken about while psychologically leading to the lack of self-worth and self-confidence, with an unintentional transfer of experience from mother to infant. This causes an intergenerational spiral of internalized racism, a slippery slope.

CHAPTER 7: FIELD OF BIOETHICS

The continuation of addressing ethical issues surrounding the health and protection of women is essential. The embodiment of the main principles of bioethics as being respect for persons, beneficence, and justice could expand the range of an individual's knowledge, improve the practice and policies of the health system, and eventually make the United States a safer place for African American mothers. The main principles of bioethics present a patient-driven approach to decision-making.

If more physicians practice with these bioethical principles then more patients would be accurately treated based on their needs, with the help and understanding of cultural and background information. More importantly, in maternal health, a patient-centered approach would allow mothers to have more dignity in the laboring of their babies. Maternal health deserves a critical analysis of the ethical principles and foundations of how the healthcare system responds, especially to maternal decisions. The concept of "doctor knows best" can be eliminated as a result of bioethical tools and principles being more accessible and provided in various training. The thought of "doctors knowing best" has ended in an influence on racial bias and race-related stress in adverse maternal health outcomes, possibly being caused by the lack of diversity in the healthcare system. As previously stated, doctors have provided information to mothers in their assumption of who can or cannot afford specific resources. These assumptions have led to a knowledge gap in healthcare and to the unenviable statistic of African American women being three to four times more likely to die from childbirth than their counterparts. Unfortunately, these racially biased assumptions can, in turn, play a role in the decision-making of women, and the respect for their informed consents and refusals.

Professor Patricia King states "Confronting race is critical in uncovering the ways we interpret human similarity and human difference, hierarchies, and power in the practice of medicine and research" (King 153). The confronting of racism relies on the field of bioethics to

successfully breakdown both the interpretation of humans and the practical power of medicine. What will be discovered is a lack of respect for the autonomy and agency of a patient and more of a power dominant role played by physicians. Respecting the autonomy and agency of a patient and his/her self-determination is a start to improving the lives of patients and having a patient-centered approach to medicine. Autonomy, which is defined as self-governance, while agency is having the free will to make decisions less encumbered by negative social determinants. The two terms, autonomy and agency in healthcare is important for the dignity of the patient. Mothers should have the opportunity to decide how they give birth, but that is not always the case. For situations such as the Rinat Dray case, how women go about the biological process of labor, is commonly decided based on what the doctor suggests as the best option. Addressing the lack of diversity of physicians does not always mean the lack of racial representation, but in this case, the lack of cultural understanding and maternal autonomy negatively affects maternal outcomes. The enforcing of bioethical principles should be continuously addressed from the beginning of a physician's career to the end. Starting prior to individuals becoming physicians or even starting medical school, the earlier, it is taught the more embedded it will be in the performance of physicians.

CHAPTER 8: CONCLUSIONS AND FUTURE SUGGESTIONS

Addressing race-based stress implications and additional inequalities in maternal health will be a long-term task but tackling maternal mortality with specific interventions and research to reduce the events and statistics might be a good place to start. First, in reference to the previous discussion of the thought process and responsibility of health professionals along with the health care system, the notion “We know what works” needs to be eliminated. In fact, if this notion was found to be true, the health of African American mothers would not be at such a high risk. In a 2016 article titled “Strategies for reducing maternal mortality: getting on with what works” the authors present a few possible beneficial interventions. Campbell and Graham, present types of interventions that could create a possible change within maternal health outcomes. They introduce Health center intrapartum care, described as “basic emergency care." This model of care would provide a watchful eye on women from the time they are in labor until the time of delivery. In addition, a midwife would be present that will provide a combination of local services to pregnant women in the case of an emergency. The advantages of this strategy include providing close and timely observations as well as a socially positive experience for both mother and baby. The disadvantages being that there would be complications for the availability of emergency obstetric care services especially when this technique is not seen as being the traditional standard of care. Another strategy Campbell and Graham suggested was providing skilled at the home attendant (Campbell, Graham, & Lancet Maternal Survival Series steering group, 2006). The use of an at-home attendant would be beneficial, especially for mothers that do not have reliable transportation to medical facilities due to reasons ranging from income to housing locations being distant from

medical resources. Another positive of this method would be to have the needs of the mother as the center of care which has been notably successful in efforts to lower maternal mortality ratios in countries such as Malaysia and the Netherlands (Campbell, Graham, & Lancet Maternal Survival Series steering group 2006). Although these techniques are presented with an international and a more remote view, the understanding of maternal needs and the adaptation to providing the most efficient medical services is a dominant concept that should be projected on the work of all health professionals. Campbell and Graham agree that although there are options for single interventions, these interventions alone cannot address different maternal mortality causes (Campbell, Graham, & Lancet Maternal Survival Series steering group 2006).

Racial bias and its effects on maternal health, along with its extreme statistical rates, need to be directly and powerfully addressed. Health professionals have an obligation to address both their coworkers and workplace of any unjust actions. Effective training on how to address these situations considering both parties should be provided continuously. Honestly, speaking, training should include a curriculum that thoroughly explains what injustice is, what racism is and the types of scenarios in which these issues may occur. Similarly, more institutions and organizations should make Maternal Health, particularly the quality of healthcare mothers receive, as an important initiative in their research, missions, and actions. On a governmental level, health policies and standard of care should be accessible on a need-based and fair circumstance, not based on wealth, class or race. Lastly, improving the distribution of knowledge equally amongst every and all patients in an attempt to decrease the knowledge gap should be implemented. For example, it has been noted that African American women are seen as having fewer

economic resources to seek and pay for help, thus more providers eliminate information during discussions that they presume the patient cannot afford (Weiner 2001). However, those same providers may supply all the needed information to other races, causing an expansion in the medical knowledge gap. Meeting the patient where he/she is and providing supplemental information needed to improve the health of the individuals while remembering that each patient has their own story, will create a sufficient change in healthcare.

Putting patients at the center of health resources in addition to other important factors needed for a successful healthcare system is a necessary approach. Without patients, there would be no health care system and without mothers, there is no current expansion of generations. This idea leads to a questionable theory: are more negative cases addressing the adverse outcomes of African American maternal health shedding light on the opinion of the expansion of black children? As an African American woman, when I read the statistics of maternal mortality, I automatically connect it to "my" life. The women who are dying from these preventable causes could be my mother, my sister, or my friend. These instances inspired me to truly understand the foundation of the issue and find ways to improve it. I also sometimes think: will I become a statistic? This question being the main reason for my hesitation of bringing another life into the world, a moment that should be so beautiful, but could slowly turn into a nightmare. There is a common comment amongst the African American community, which states bringing an African American child into the world, is dangerous. Dangerous for the child, the mother, and the community. There have been way too many deaths of African American children

that have gone without justice, and now it includes the lives of mothers prior to giving birth.

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