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Invited Editorial

Ethnicity and death in childbirth

According to the World Health Organization, maternal mortality in the United States is a national crisis [1]. That is, it is significantly higher than in most other adequately resourced countries such as the United Kingdom, member states of the European Union, Canada and Australia. And the COVID-19 pandemic has brought health disparities in the United States—a product of institutionalized, systemic racism and sexism—into public awareness in ways that are unprecedented. Although the United States aspires to be a beacon in so many humanitarian areas, that light is dimmed when it comes to maternal morbidity and mortality, especially, as noted, when compared with most of our industrialized counterparts [2]. While these disparities, and the institutions and systems that support them, are not new, we are paying attention in ways that we have not previously. Paying attention matters, but it is not enough. There are genuine concerns about how far we can move the needle on this issue relying on current efforts alone.

History is a critical guide, and we ought to consider representation of the issue over generations and among oppressed populations [3]. In what ways have we charted maternal death through major historical periods? Among native women? During slavery? Through the World Wars and periods of mass immigration? Did we identify the reasons for maternal deaths at these junctures? Did we talk about specific populations of women, about where and how these deaths were happening? We have always known that death is a part of life. Our human condition challenges us to accept this grim reality while we also identify the causes of its unnecessary appearances. But changes in medical practice alone will not address the roots of preventable and tragic deaths. We will never eliminate all incidents of maternal death—indeed, tragedy happens in ways that are sometimes out of our control—but we can make a difference now and for generations to come.

Consider these scenarios:

Scenario One: Fearful from prior hospital experiences when her pain was disregarded and her stay required family members to care for her infant son, a patient minimizes a crushing chest pain until she collapses. When she arrives at the hospital she is brain dead.

Scenario Two: A woman stops her breast cancer treatment early, feeling well and wanting to have children. She takes hormonal medications that could potentially stimulate a recurrence of her breast cancer. She successfully delivers her child but dies nine months later due to recurrence and metastasis of her cancer.

Scenario Three: A pregnant person dies as a passenger in a car driven by her partner. She and her partner have substance use disorder and they are involved in a motor vehicle accident while she is thirty-five weeks pregnant. They were returning from a prenatal appointment thirty miles from her home due to a lack of high-risk care in her community.

Scenario Four: A pregnant person known to be anemic progresses through her uncomplicated pregnancy until labor and delivery, when, despite her normal delivery, she experiences hemorrhaging. The hospital does not have the resources to respond in a timely fashion and she dies from excessive bleeding.

There are many more such cases in which the death of the mother has its roots in systemic racism. Systemic racism impacts how we value women's lives, how women value their own lives, and how it affects the environments in which we raise our children.

The end result of systemic racism cuts across rural and urban centers, and generates shared health threats [3]. Approximately 40% of all Indigenous people are rural residents and they face heightened risks of severe maternal morbidity and mortality [4]. Pregnancy-related death due to cardiac complications or hypertension as well as pregnancy-associated deaths due to community and interpersonal violence are the leading causes of death among Indigenous and African American women across geographies. We must address the medical aspects but also the social determinants as we look at maternal mortality among oppressed populations. We simply cannot move one without moving the others.

If we value all women, a more holistic view is warranted. We must consider systems of inequity, studying challenges and identifying opportunities to improve maternal health in context. We need a collective action plan: the work of "undoing" racism and sexism must not be the burden of oppressed people. Dr. Camara Phyllis Jones elucidates the allegories of race and racism—institutionalized, personal-mediated, internalized—and calls us to name these and other systems of inequities when we see them [5]. Can we identify racist and sexist ideologies in our workplaces, in schools, financial institutions, neighborhoods, even our grocery stores? Each locale contributes to whether or not a woman will die in childbirth or as a new mother.

Can we each do our part to root out systemic racism and sexism at its source, just as we would take the drastic measure to cut off the breast of a woman with an increased risk of breast cancer? If we know such excision could save lives, will we make the hard choices? How are we willing to act and to organize?

When the US calls for "maternal justice" with particular attention to Indigenous and African American persons, we must step back. We must look at our own institutional structures and complicity in oppressive systems. We can't limit our efforts to putting out small fires in our day-to-day work. We are poised at this moment to do so much or nothing at all. Globally, we all must ask the question: In what ways are you cast in this dramatic production, where the stakes are life or death?

Contributors

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