Listening to Each Other: Improving Communication Between Provider and Patient

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Introduction

Disparities in maternal mortality (MM) and severe maternal morbidity (SMM) are striking. In New York City (NYC), the pregnancy-related mortality rate for Black non-Latina women is nine times higher than for White non-Latina women.[1] Rates for Latinas, Asians and Pacific Islanders are twice that for White non-Latina women. You have the opportunity to make sure that every person who is pregnant or postpartum has the information they need to have the safest possible pregnancy.

Research is ongoing to expose the reasons for the disparities and establish how to best address them. Systemic racism — racial biases across institutions and society that advantage White people and disadvantage people of color — influences every social determinant of health (the conditions in which people live, learn, work and play), including health care. Quality of care, access to care and the health impacts of stressors from systemic racism have all been identified as contributors to disparities.[2] By being aware of this, your practice can be a positive point of contact through the care and resources you provide, help influence the health of every individual, and improve health outcomes in the surrounding community.

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1 New York City Department of Health and Mental Hygiene. Pregnancy-Associated Mortality, New York City, 2011-2015. Long Island City, NY. February 2020. https://www.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report-2011-2015.pdf

2 AHRQ. Patient Safety Primer: Maternal Safety. AHRQ website. Updated September 2019. https://psnet.ahrq.gov/primer/maternal-safety

Know That You Are Trusted

Your patients listen to you. The Listening to Mothers III: Pregnancy and Birth nationwide survey asked 2,400 mothers who had recently given birth about their knowledge, attitudes, beliefs and experiences around pregnancy and childbirth. Eighty percent said their maternity care provider was a very trustworthy or completely trustworthy source of information.[3] That is far higher than even the next most trustworthy source, childbirth classes, at only 55%.

Communicating With Your Patients

Seventy-eight percent of respondents in the Listening to Mothers III survey had an obstetrician as their prenatal care provider. Nine percent saw family physicians and 8% saw midwives. Percentages for primary birth attendant were similar: 70% had obstetricians, 6% had family physicians and 10% had midwives (7% unknown).[4]

It is important to make sure your patients:

- Understand their care
- Get their questions answered
- Get the follow-up they need

Even the best of us do not achieve these goals 100% of the time. This guide may be useful for understanding where communication can be misinterpreted and what that may mean for your patients.

3 Declercq ER, Sakala C, Corry MP, Applebaum S, Herrlich A. Listening to Mothers[SM] III: Pregnancy and Birth. New York: Childbirth Connection, May 2013. https://www.nationalpartnership.org/our-work/resources/health-care/maternity/listening-to-mothers-iii-pregnancy-and-birth-2013.pdf.

4 Declercq ER, Sakala C, Corry MP, Applebaum S, Herrlich A. Major findings of Listening to Mothers III: Pregnancy and Birth. *J Perinat Educ*. 23(1):9-16. doi:10.1891/1058-1243.23.1.9

Encourage Asking Questions

Do patients feel comfortable asking questions?

The following words come from focus groups with NYC women who experienced SMM:

> "[I was told] well, that's one of the symptoms of '[condition],' or whatever. It wasn't until four and a half days later when I mentioned it again. And now it was a very severe problem."[5]

> "My doctor still hasn't told me what happened. I don't know if she doesn't want me to know."[5]

We want our patients to have all the information they need, yet in the Listening to Mothers survey, a substantial number of women (about 40% each of White non-Hispanic, Black non-Hispanic and Hispanic/Latina respondents) had held back from asking a question at their prenatal visits.[6]

5 Wang E, Glazer KB, Sofaer S, Balbierz A, Howell EA. Racial and ethnic disparities in severe maternal morbidity: A qualitative study of women's experiences of peripartum care. *Women's Health Issues*. 2020 Oct 14;S1049-3867(20)30100-6. doi:10.1016/j.whi.2020.09.002

6 Cheng ER, Carroll AE, Iverson RE. Communications between pregnant women and maternity care clinicians. *Jama Netw Open*. 2020;3(5):e206636. doi:10.1001/jamanetworkopen.2020.6636

Why? Twenty-one percent did not feel comfortable saying they wanted a treatment option that was different than what their maternity care provider recommended. Twenty-three percent were afraid they would be perceived as difficult. Thirty percent thought the person providing their maternity care seemed rushed.[6]

The survey also found that patients would hold back from asking a question when a provider usually or always used medical words that they did not understand.[6]

What helped? When a provider consistently answered all of their questions and encouraged them to ask questions.[6]

Recognize Racial Discrimination and Your Own Implicit Biases

Racial discrimination has been linked to poorer birth outcomes for women of color.[7] Even if we try as individuals to give each person the best medical care, the systems we work in can still subject our patients to discrimination and bias.

The Impact of Discrimination

In the Listening to Mothers survey, nearly a quarter of respondents felt they had been treated poorly during their hospital stay for reasons that implied bias.[3,8] Black and Hispanic women were more likely than White women to have perceived discrimination according to race, ethnicity, language or culture.[9] Overall, almost 14% of respondents perceived this type of discrimination.

How might this affect health outcomes? About half of all MM occurs in the postpartum period, with a third of deaths occurring seven or more days after delivery.[10] Women who perceived discrimination during their hospital stay to give birth were less likely to attend a postpartum visit.[8]

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7 Dominguez TP. Race, racism, and racial disparities in adverse birth outcomes. *Clin Obstet Gynecol*. 2008 Jun;51(2):360-70. doi:10.1097/GRF.0b013e31816f28de

8 Attanasio L, Kozhiimannil KB. Health care engagement and follow-up after perceived discrimination in maternity care. *Med Care*. 2017;55(9);830-833 doi:10.1097/MLR.0000000000000773.

9 Attanasio L, Kozhiimannil KB. Patient-reported communication quality and perceived discrimination in maternity care. *Med Care*. 2015;53(10):863-871 doi:10.1097/MLR.0000000000000411.

10 Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017. *MMWR Morb Mortal Wkly Rep 2019*;68:423–429. doi.10.15585/mmwr.mm6818e1

What other types of biases were identified? Sixteen percent of patients felt their health insurance situation negatively impacted their treatment. Twenty percent perceived that a difference of opinion with their caregivers about the right care for themselves or their babies led to being treated poorly.[3]

Implicit Bias

Implicit bias refers to one's automatic, instant associations of stereotypes or attitudes toward particular groups. Interviews with women of color who had recently given birth highlight examples of what they experienced as implicit bias in health care settings: surprise that a Black woman had a college degree, an assumption that a lighter-skinned woman was more financially secure, more time and patience being given to some people than others.[11]

At the individual level, the Implicit Association Test (IAT) is a tool that may help people uncover their own biases and reflect on their interactions. An IAT can have value in the medical setting, as there is evidence for an association between implicit bias on an IAT and poorer quality communication between patients and health care providers.[12]

As we become increasingly aware of systemic racism, we can work to combat it. The same is true for our own implicit biases. You can find more information about the IAT by searching online for "Implicit Association Test."

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11 Altman MR, Oseguera T, Mclemore MR, Kantrowitz-Gordon I, Franck LS, Lyndon A. Information and power: Women of color's experiences interacting with health care providers in pregnancy and birth. *Soc Sci Med*. 2019;238:112491. doi:10.1016/j.socscimed.2019.112491

12 Maina IW, Belton TD, Ginzberg S, Singh A, Johnson TJ. A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. *Soc Sci Med*. 2018;199;219-229 doi:10.1016/j.socscimed.2017.05.009.

Take Steps at Your Practice

As you care for each of your patients, especially those in groups with high MM and SMM, consider the following:

- Do you encourage your patients to ask all of their questions?
- If there is not enough time during a given visit, do your patients know how to follow up with you to get answers?
- Will your patients recognize serious problems during pregnancy and postpartum, so they will know when to call you or go to the emergency room?
- Do you check with your patients to make sure they understand the information you share with them? The teach-back technique is one way to do this: Invite your patient to explain it back to you in their own words.[13]
- Does your practice have the same outcomes for patients who are White, Black, Latina or Asian? If not, can you trace anything in your practice or hospital system that could account for the difference? Is there something you or your staff can do to help create more equitable outcomes?
- Can you identify any biases, implicit (unconscious) or explicit (conscious), impacting care at your practice?

The Center for Disease Control's HEAR HER campaign encourages providers to engage in open conversation to address patients' concerns during and after pregnancy and help them to understand urgent pregnancy-related warning signs. For more information and resources, visit cdc.gov/hearher.

13 The SHARE Approach—Using the Teach-Back Technique: A Reference Guide for Health Care Providers. September 2020. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/health-literacy/professional-training/shared-decision/tool/resource-6.html

Establish a Quality Improvement Pathway

If you find that your practice has different outcomes for people of different races or ethnicities, you can try a quality improvement approach to gather more information.

Consider tracing your patients' experience through your system. Follow them through all their possible encounters during visits to the office, during a hospital stay to give birth and during postpartum follow-up. This includes interactions with health care providers, staff, insurance and billing, and other key steps in obtaining and receiving care. What works well? Where do you see opportunities for improvement?

And, importantly, does everyone, regardless of their race, ethnicity, language, culture and financial situation, have the same experience at each step in their care? If so, is that working equally well for everyone, or would some of your patients do better with additional options or support? Are there places or situations impacted by biases or are there breakdowns in communication? What barriers do you see your patients facing, and who do you see being the most affected?

Once you have identified the challenges, you can begin to address them. Follow up on the changes you make to see how well they are working, continue monitoring outcomes and make your practice part of the solution.


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