Society for Maternal-Fetal Medicine Special Statement: Race in maternal-fetal medicine research- Dispelling myths and taking an accurate, antiracist approach

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Profound inequities in maternal and infant outcomes based on race exist, and the maternal-fetal medicine community has an important role in eliminating these disparities. Accurately employing race and ethnicity as social constructs within research that guides clinical practice is essential to achieving health equity. We must abandon commonly propagated myths that race is a surrogate for genetics or economic status and that data are exempt from potential bias. These myths can lead to harmful misconceptions that exacerbate racial disparities in maternal and infant health outcomes. Furthermore, these myths obscure racism as the true underlying etiology of racial disparities. Understanding that race is a social construct and using an antiracist approach to research are essential in combating racism and eliminating unacceptable disparities in maternal and infant health. This document provides specific suggestions to approach the research process with an antiracist framework.

Key words: antiracism, health disparity, health equity, health inequity, intersectionality, racism

Introduction

The burdens of maternal and infant morbidity and mortality are among the most extreme and consistently documented health disparities.[1,2] Maternal-fetal medicine (MFM) sub-specialists have a central role in providing culturally competent clinical care and uncovering evidence-based methods to mitigate disparities through research. Although race is a commonly collected and reported data element, it may not be evident how or why health outcomes are affected by race.[3] In overt and subtle ways throughout medical research, race is often presented as a construct based on genetics.[4–7] Approaching race as a genetic construct leaves researchers vulnerable to inaccurate methods of data collection and misleading interpretations of findings that can perpetuate racial disparities and obscure systemic antiracist changes necessary to eliminate disparities.[8–10]

Persistent health disparities, including maternal mortality, and recent events, such as the murders of George Floyd, Breonna Taylor, and many others, have thrust race and the ramifications of racism into the forefront of a national conversation. This ongoing conversation highlights the necessity to ensure an accurate and evidence-based approach to race in data collection and interpretation in research.

Adoption of such an approach is essential for MFMs to fulfill their critical roles as clinicians, educators, and scientists.

Definitions and Disclaimers

The language and terminology used to report race and ethnicity in medical and scientific articles must be accurate, clear, and precise and must reflect fairness, equity, and consistency.[11] *Race* is a culturally defined category based on an individual's physical characteristics such as hair texture, facial features, and skin color (Table 1).[12] *Ethnicity* is distinct from race and denotes a grouping based on shared language, religion, or other cultural practices. *Ancestry* is defined as the line of genetic, inherited descent[13] and is thus distinct from both race and ethnicity. Distinguishing these constructs is critical to understanding the etiology of health inequities and uncovering pathways to eliminate health disparities.

Although *disparity* and *inequity* are ubiquitous terms in the medical literature, precise definitions are often lacking. National and international organizations, including the Institute of Medicine[14] and World Health Organization,[15] have offered varied definitions of these terms. Common to all definitions is the central idea that a disparity or inequity goes beyond a measurable difference in health outcomes and describes a negative health impact on individuals because of their lived experiences in a marginalized group.[16] In the setting of race, groups marginalized most

TABLE 1
Definitions of key terms

Term[a]	Definition
Race	A culturally defined category based on an individual's physical characteristics such as hair texture, facial features, and skin color
Ethnicity	A category based on shared cultural practices that may include language, religion, or other customs
Ancestry	The line of genetic descent and inherited traits
Health disparity	A measurable difference in healthcare outcomes that is due to differential treatment based on membership within a marginalized group
Health inequity	Unjust healthcare experiences or outcomes that are due to differential treatment based on membership within a marginalized group
Racism	Negative lived experiences at the interpersonal, institutional, or societal level that stem from biases based solely on physical characteristics
Prejudice	Biased beliefs held by an individual or propagated throughout a group or society about any person or groups founded on stereotypes
Discrimination	Biased behavior exhibited by an individual, group, or society toward a person or specific group of persons based on stereotypes
Intersectionality	Interplay between multiple aspects of an individual's identity (eg, race, sex, gender, ability)
Antiracism	Actively combating racism and racist ideas at the individual, interpersonal, policy, and societal levels

[a] Many of these terms have multiple definitions that can be found throughout the literature. The definitions used in the current document are presented.

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often include Black and Indigenous (American Indian and Alaska Native) groups, people collectively termed "people of color." Economic disadvantages and chronic health morbidities disproportionately affect people and communities of color and can contribute to causal pathways leading to racial disparities; yet, the root cause of disparities is differential treatment, commonly termed racism. *Racism* can be defined as negative lived experiences resulting from prejudice (ie, biased beliefs) and discrimination (ie, biased actions) at the interpersonal, institutional, and societal levels that stem from biases experienced based solely on physical characteristics such as skin color.[17] Importantly, racism that leads to racial disparities cannot be explained by anything else inherent about the individual. *Antiracism* is an active opposition to policies and practices based on racist ideologies. The term *health inequity* builds on the concept of racist treatment, leading to differences in outcomes. Health inequity is the lack of health equity, the state in which all persons have a "fair and just opportunity to be as healthy as possible."[18] *Health equity* is both a process, including the assignment of metrics, and a set of values through which progress toward eliminating inequities occurs.[14,16,19,20] The term *health disparity* has been used in the literature since the 1990s to describe adverse health outcomes that affect groups of people that experience systemic social and economic obstacles because of discrimination and exclusion.[21] In the realm of research, health disparities are the "metrics by which we measure progress towards health equity."[16]

As we discuss race and its role in research, it is important to acknowledge that biases affect multiple communities, and disparities exist on the basis of aspects of a person's identity beyond race, such as sexuality, gender, and ability. In addition, the interplay between multiple dimensions of an individual's identity, commonly termed *intersectionality*,[22] can substantially influence a patient's experience with medical care. One very important and often overlooked area of intersectionality is between race and gender identity. We will intentionally use the term *birthing individuals* throughout this document rather than *women* to be inclusive across all individuals who give birth. All of these elements of an individual's identity are critically important and worthy of deep discussion. Because of the frequency with which racial data are used and the impact of racism on healthcare disparities throughout medicine, the current document focuses on an accurate scientific conceptualization of race and an approach toward antiracism.

We provide a pragmatic approach to conceptualizing race in research by challenging the commonly held myths that (1) race can be equated with genetics, (2) economic disadvantage completely explains racial disparities, and (3) data are free of bias. MFM researchers have an important role in promoting antiracism by framing research questions and interpreting data with an understanding that racism, rather than race, is the key factor leading to health disparities.

Debunking myths
Myth #1: Race = genetics. Is race a proxy for a person's genetics?

There is abundant evidence demonstrating that race is a social construct, which means that the definition, importance, and implications of race are based on cultural norms.[23] Racial categorizations are based on physical

characteristics such as hair texture, facial features, and skin color.[12] Although these physical characteristics are genetically determined, the boundaries that define one racial group compared with another are socially and arbitrarily defined. Because of the arbitrary nature of racial categorizations, an individual's racial identity reveals little about their genetics.

There is markedly minimal genetic variation among humans. From genetic studies, it is well established that approximately 0.1% of DNA varies among individual humans.[24] This equates to approximately 1 in 1000–1500 nucleotides. Despite the limited variation within the genetic code, there are numerous examples in medicine where variation in a single nucleotide creates dramatic changes in a person's health. Diseases such as sickle cell anemia, beta-thalassemia, and cystic fibrosis arise from a single nucleotide polymorphism (SNP). Although SNPs and the physical characteristics that may correlate with an individual's racial identity are genetically determined, the phenotypic characteristics that determine an individual's lived experiences with race cannot reliably predict which genetic variants they have inherited.[4,25] In other words, a person's inherited genetics, known as their ancestry, may correlate with their physical features; however, arbitrary racial categories are poor predictors of an individual's genetics or ancestral background.[26]

One clear reason racial categorizations are poor predictors of genetics is the variation of racial categories between cultures and over time.[8,9,27] In the antebellum South, various state laws considered a person "White" if they possessed less than one-eighth or one-quarter African ancestry.[27] During the 20th century, racial categorizations in America changed as the "one-drop rule" was widely adopted. As the name suggests, the "one-drop rule" assigned Black race, and therefore, inferior rights, to any person who had any known African ancestry.[28] The fluidity with which boundaries around specific racial groups are defined renders race an imprecise and potentially harmful surrogate for genetics within medical research.[29,30] It is particularly dangerous to suggest that medical treatments or surgical approaches should be assigned on the basis of race.

Although race is not an appropriate surrogate for genetics, the social impact of race has profound implications on lived experiences, which in turn have profound implications on health and disease.[14,31,32] A substantial body of literature explores the biological pathways by which chronic stress leads to "weathering" on the body that manifests in perturbations of the hypothalamic-pituitary axis, known as the "allostatic load."[33–37] Increases in allostatic load have deleterious consequences for human reproduction, including links to in utero imprinting that may alter long-term health.[36,38–40] Separating the biological impact of racism from the existence of scientifically reproducible genetic differences is critical to moving beyond the antiquated concept of inherent deficiencies within marginalized populations (Figure 1, A). We must discard the harmful genetic framework and adopt a just, accurate framework that centers racism—and the unequal foundation it creates—as the root cause of health inequities (Figure 1, B).

In summary, racial categorizations are based on socially constructed definitions with no biological or genetic basis. Researchers should not use race as a surrogate for biology or genetic differences, and racism should be considered a root cause for any differences in outcomes based on race.

Myth #2: Race = economic status. Are racial disparities explained by economic disadvantage?

Economic status and the social determinants of health (SDOH), including education, housing, and employment, are critically important contributors to racial disparities in maternal and infant health outcomes. The link between economic status and health outcomes is deeply rooted in racist policies. People of color have been intentionally excluded from social programs that promoted education and homeownership among White individuals.[41] After World War II, the GI Bill paved the way for former soldiers to advance through federally funded subsidies for education and mortgages. Black service members were intentionally and systematically denied access to the GI Bill benefits.[41,42] Furthermore, Black families were systematically denied mortgages based on "redlining," a practice in which home loans were denied in predominantly Black neighborhoods.[41] Numerous adverse health outcomes, including preterm birth, remain more common in communities historically affected by redlining.[43,44]

Although historical and contemporary systemic racism translates to large income disparities, many health disparities are not entirely explained by economic status or SDOH.[14] For example, the Black race remains associated with an increased risk of maternal death and severe maternal morbidity after controlling for economic status and SDOH.[1] In the United States, Black birthing individuals are up to 3 times more likely to die from a pregnancy-related cause than White birthing individuals.[45] Among college-educated birthing individuals, the disparity is even wider: college-educated Black birthing individuals are 5 times more likely to die from pregnancy-related mortality than college-educated White birthing individuals.[45,46]

Accurately conceptualizing race in the setting of research requires investigators to understand the association between race, economic status, and other SDOH. Researchers must also recognize that race has considerable associations with health outcomes even when members of a marginalized group have achieved high education or income levels.[14,19,20,47] Racism and health inequities may be experienced even when economic disadvantage is not present.

In summary, the root cause of racial disparities in health outcomes is differential treatment based solely on physical characteristics, which is known as racism. Economic

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FIGURE 1
Comparison of 2 conceptualizations of equality vs equity
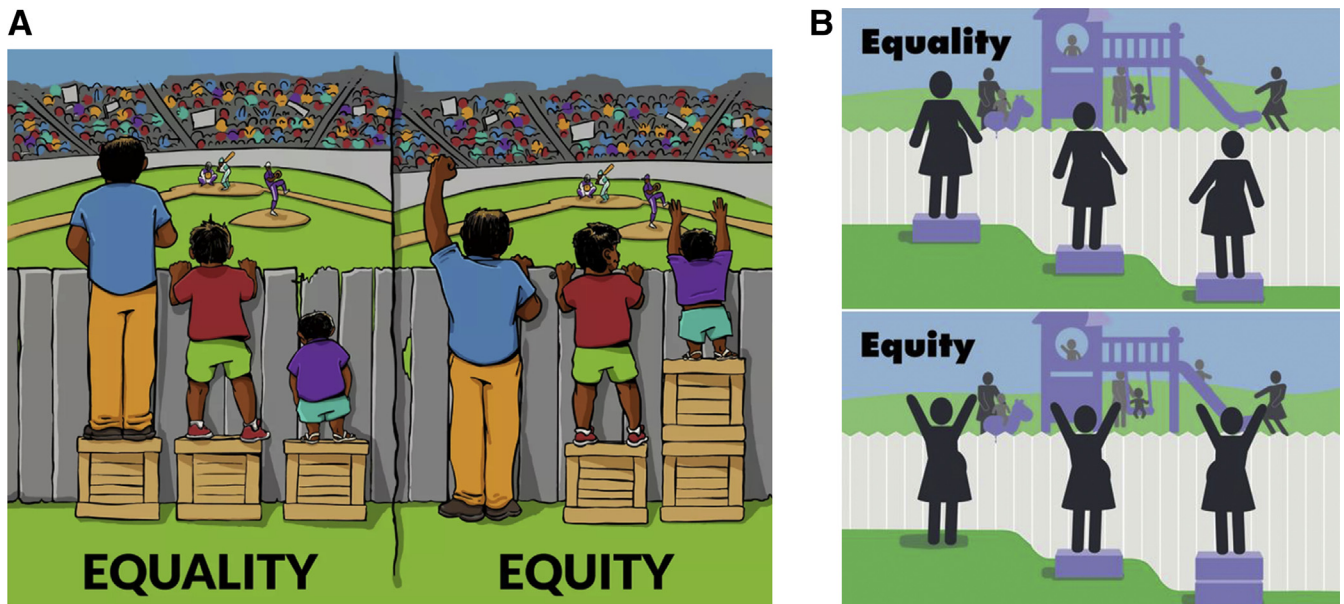
A, The disadvantages as individuals of different heights. This imagery incorrectly conceptualizes inequities as inherent deficiencies within an individual or specific groups that experience disadvantage. Available from: Interaction Institute for Social Change | Artist: Angus Maguire. Available at: interactioninstitute.org and madewithangus.com. **B**, A more accurate image of inherently equal individuals (ie, they are equal height); however, due to racism, their environments are unequal, leading to inequitable outcomes. The ultimate origin of the unequal environments is racism. We must shift our focus away from fixing individuals or communities that experience inequities and instead focus on ending racism and the inequities that have resulted from racism. Reprinted, with permission, from The Society for Maternal-Fetal Medicine. Available at https://www.smfm.org/equity.

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disadvantage may be a manifestation of racism and a mechanism leading to racial disparities, but even in the setting of high economic status, people of color may experience other manifestations of racism, leading to poor outcomes.

Myth #3: Data are colorblind. Is it possible for data to perpetuate racist ideas?

Data within medical literature are often cited as empirical evidence that race is a genetic categorization leading to biological differences. For example, many prominent obstetrical texts report that Black individuals are more likely to have an anthropoid pelvis, which is less favorable for vaginal delivery, leading to the increased rate of cesarean delivery in Black birthing individuals.[48] Such data are often viewed as unbiased truths observed in nature. However, careful examination reveals that these "biologically based race differences" are grounded in observations made using unclear definitions of racial categorizations. In fact, the "data" underlying these so-called differences in pelvic shapes are based on literature popularized in the 1920s, and it is unclear what inclusion criteria the researchers used to define "Black" or any other race.[49–51] Without reproducible biological criteria for the racial categorizations in these studies, the conclusions must be viewed with skepticism.

In addition, much of the data used to document biological differences based on race were collected with the goal of proving the genetic inferiority of enslaved people.[52–55] For example, Samuel Cartwright was a physician—researcher in the antebellum South who conducted numerous medical experiments on enslaved people, as he sought to scientifically prove that slavery was justified and humane given their genetic inferiority.[9,55] Some of Dr Cartwright's most famous work reports that enslaved people had inferior lung function compared with their White counterparts.[9,55] These historical data, rooted in racist ideology, form the basis for the present-day medical practice of adjusting pulmonary function test results based on race.

There are numerous examples of similar race-based interpretations of medical tests,[5,52,55] including the vaginal birth after cesarean (VBAC) prediction model. By diminishing the predicted success of "trial of labor after cesarean" among Black and Hispanic birthing individuals, the prior VBAC prediction model reinforced and perpetuated biases that drive increased cesarean rates among Black and Hispanic birthing individuals. It is essential for clinicians and researchers to critically appraise any claims of a connection between race and clinical or health outcomes when the researchers fail to connect the socially constructed nature of

race to the outcome. By definition, the racial categories used to compare groups in these analyses were based on socially constructed designations that have never been proven to be biologically based. Therefore, the data and conclusions drawn from these data that may seem to be a colorblind statement of facts are based on an inaccurate racist ideology that can lead to dangerous and medically inaccurate conclusions.

In summary, claims equating race with biology are ubiquitous in medicine. It is essential that MFM researchers critically appraise the data that underlie medical practice, reject the data falsely equating race and biology, and conduct future research with an antiracist approach.

A Call for Accuracy and Antiracism in MFM Research

One of the most dangerous conclusions drawn from inaccurate claims of biological differences based on race is that healthcare disparities stem from genetic, and therefore, unmodifiable factors. Although there are numerous examples of medical research equating race with genetics that obfuscate racism as the root cause of disparities, many scientists, sociologists, and public health experts have long identified racism as a root cause of racial disparities. In the 2002 landmark Institute of Medicine report aptly titled "Unequal Treatment," the constellation of injustices within the societal structure, institutional systems, and biased interpersonal interactions are identified as manifestations of racism.[56,57] The American Public Health Association declared racism an "ongoing public health crisis" and defines racism as "a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which we call "race"), that unfairly disadvantages some individuals and communities and unfairly advantages other individuals and communities."[58] A clear understanding of race as a social construct and racism as a root cause of disparities demands a reevaluation of our canonical research and demonstrates the necessity for antiracism going forward.[59]

A Practical Guide to Antiracism in MFM Research

Antiracism is simply "the commitment to fight racism wherever you find it, including in yourself."[60] Contemporary definitions of racism incorporate discrimination at the individual, institutional, and system levels that can be overt or subtle (Figure 2).[17] An antiracist research framework includes a contemporary definition of racism and empowers researchers to mitigate bias throughout the research process from the formulation of a research question through the dissemination of research findings.[59]

How should data on race be collected?

As with any data used in research, racial data must be collected in a careful, scientifically rigorous fashion. The
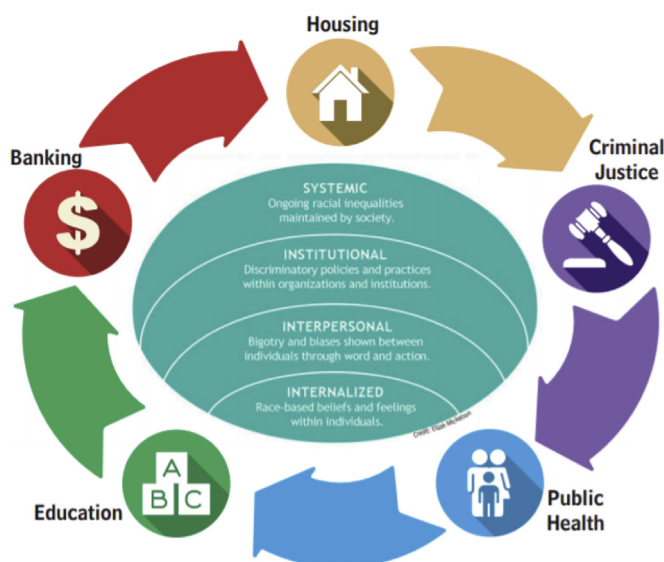
Reprinted, with permission, from Morgan et al.[57]

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National Institutes of Health (NIH) have established basic standards for collecting and reporting racial data in research.[61] The NIH recommends the following: researchers collect data on race based on self-report, include a minimum of 5 categories (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and White), allow the option to select multiple categories, and separate race from ethnicity. According to the NIH recommendations, ethnicity is categorized as Hispanic/Latino and Not Hispanic/Latino.

These basic guidelines have provided a framework for consistency, allowing for meta-analyses and comparisons across research studies. However, these basic guidelines are often insufficient in the setting of a culturally specific research question about the lived experiences of a specific group. For example, the Hispanic ethnicity includes a broad array of diverse people groups with unique experiences that provide valuable context for a research question or interpretation of findings. The array of diversity within specific racial and ethnic groups that must be considered is far beyond the scope of this document. It is critical that researchers examining specific groups educate themselves about cultural nuances and partner with experts and community members.

When collecting racial and ethnicity data, researchers should refrain from aggregating groups solely for convenience. Although statistical analytics may require aggregations of small numbers, it is important to report how and why specific groups were aggregated.[11] The aggregation or elimination of groups with small numbers may preclude

future meta-analyses that might reveal important findings about understudied groups, such as American Indian and Alaska Native individuals.

How should race be conceptualized when a research question is developed?

As with any other research data, it is essential to carefully consider if, how, and why race is important to the research question. Consulting published guidelines[62] and clarifying whether the research question is informed by race, ethnicity, or ancestry are critical. Research questions that focus on genetic and biological constructs are best informed by ancestry data such as family history, country of origin, and genetic markers rather than race. In contrast, questions that incorporate participants' lived experiences may be better informed by race and ethnicity data.

Tailored research questions about disparities or experiences within marginalized groups require careful consideration, and numerous published resources contain detailed guidance.[63–65] The Public Health Critical Race Praxis (PHCR) provides a semistructured process integrating rigorous research methodology with the critical race theory (CRT).[59] CRT is a decentralized group of core tenets with origins in legal scholarship. Examples of core CRT tenets include that racism is (1) "ordinary" and "commonplace" and thus challenging to address because it is pervasive throughout society and rarely acknowledged unless egregious, (2) beneficial materially and psychologically to individuals in the majority, and (3) a product of purely socially constructed race groups.[66] The PHCR challenges researchers to uncover and acknowledge one's own racial biases and how these biases may affect hypotheses, data collection, and measurements.

Furthermore, the PHCR advises researchers to measure constructs that quantify the structural elements of racism rather than simply stratifying by race. For example, in Ford et al's work applying the PHCR to the Human Immunodeficiency Virus Testing, Linkage, and Retention in Care study, the researchers used multilevel modeling to estimate the effects of "racialized context of care" variables (eg, the racial demographics of a clinic) relative to the study's outcome measures while controlling for a participant's self-identified race. Through these methods, Ford et al[67] examined the populations at risk based on specific racism exposures.

PHCR also prioritizes the perspectives of marginalized persons. Consultation or collaboration with members of marginalized communities is an underutilized yet essential component of rigorous health equity research that begins with framing research questions and data collection using innovative and culturally responsive methods.[68]

What is the role of diverse research teams in research?

Data from the business sector clearly demonstrate that diverse teams perform more effectively and generate more innovative solutions to problems.[69–71] Data also suggest that recruiting and retaining diverse talent within a research team enhances the final research product.[30,70,71] Programs that cultivate diverse talent across the clinical and research pipelines, including students, clinical and research trainees, and research faculty, are critical to advancing MFM research. Specifically, programs tailored to increasing the participation of historically marginalized groups including Black, Indigenous, and other people of color as well as sexual and gender minorities in the research process are urgently needed. In addition, diverse experiences across training backgrounds inclusive of nursing, midwifery, advanced practice clinicians, and social scientists are also central to maximizing successful research teams.

Although the benefits of diverse research teams are well documented, there is an urgent need for a systemic approach to cultivate and support diverse research teams. Cultural sensitivity and bias training for the research team is an important initial step toward creating an environment for diverse researchers across the pipeline to thrive.[72]

What are best practices for recruiting diverse research participants?

Racial and ethnic minorities are historically underrepresented in research studies. Mistrust in the healthcare system and legacies of atrocities such as the infamous Tuskegee Syphilis Study are often cited as reasons for the underrepresentation.[73] More recent studies, particularly investigations within obstetrics, suggest that participants in minority groups are equally willing to participate in research.[74] Techniques initially developed to improve equitable clinical care may promote diverse recruitment, such as equitable community partnerships, ensuring culturally sensitive recruitment materials, study questionnaires, and recruitment locations.[75] Diverse multidisciplinary research teams may also help identify gaps in recruiting strategies that less diverse teams may not appreciate.

How can communities be engaged in research?

Engaging communities affected by racism and inequitable outcomes is a core element of an antiracist research agenda.[32,59,68,76,77] The Centers for Disease Control and Prevention defines community engagement as "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people."[78] Community engagement can be operationalized by engagement with organized groups, institutions, or individuals.[78] The level of community involvement can range from outreach (in which there is minimal community involvement and the goal is the dissemination of information from researchers to the community) to shared leadership (in which community members are involved in all aspects of the research process)[78] (Figure 3). Although differing the levels of engagement along this continuum may be appropriate depending on the

FIGURE 3
NIH principles of community engagement
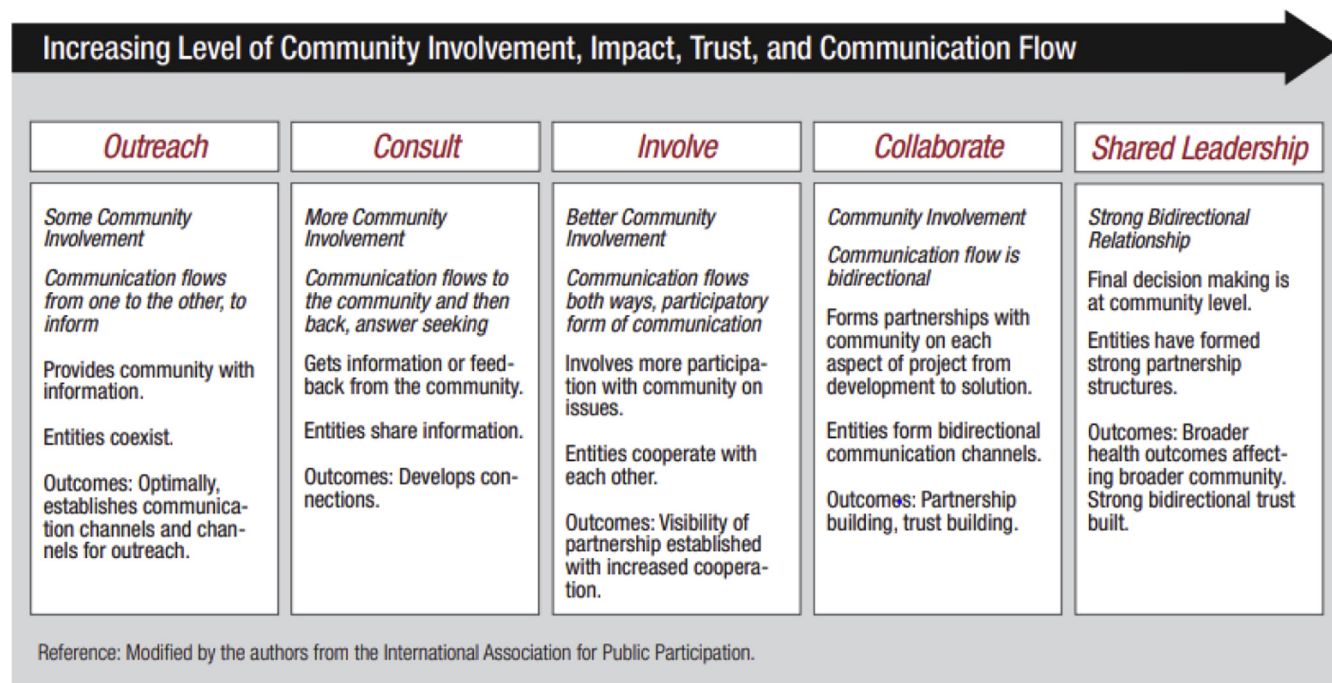
Available from Clinical and Translational Science Awards Consortium Community Engagement Key Function Committee Task Force on the Principles of Community Engagement.[78]

NIH, National Institutes of Health.

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research question, sustainable efforts to narrow the disparities in maternal outcomes will be strengthened by increasing levels of community engagement.

What is research justice?

Along with increased community engagement, sustainable innovations are dependent on a commitment to research justice.[76] Research justice is a framework based on the understanding that marginalized communities often have limited political power to access funding and resources for data collection and interpretation.[76] Yet, marginalized groups possess the experiential and cultural knowledge essential to asking innovative questions, capturing appropriate data, and performing nuanced data interpretation.[76] The vision of research justice is an equitable structure in which communities control research agendas, data collection, and dissemination of findings. Currently, academic centers, many of which are saturated in racist systems and ideology, control much of the scientific research field.[32,77] Research justice seeks to reframe the power structure to ensure that communities have the resources to produce, analyze, and disseminate research using rigorous and reproducible methodology.[76,77] Academic centers, researchers, and clinicians play an integral role in realizing the research justice vision.

How can research be evaluated with an antiracist approach?

Much of the research guiding current obstetrical practice was conducted with an antiquated understanding of race and without an appreciation for the effect of systemic racism on health outcomes. Addressing the disparities in obstetrical outcomes requires reevaluating the literature using an antiracist framework. The antiracist approach to conducting research has important implications for consuming and applying previously conducted research. Research that suggests clinical practice or risk stratification based on race must be reevaluated. Currently, important initiatives are underway to reevaluate clinical tools that include race as a biological variable. The VBAC prediction calculator was recently republished to exclude race and ethnicity. The updated prediction model maintains predictive accuracy, yet no longer has the propensity to exacerbate health disparities.[79] Similar efforts are underway to remove race and ethnicity from other calculators such as glomerular filtration rate and pulmonary function testing. Furthermore, there are evaluation tools such as the prediction model risk of bias assessment tool that aid researchers in systematically evaluating the risk of bias in the data included in a systematic review or prediction model.[80,81] These

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TABLE 2
Action items for approaching race in maternal-fetal medicine research

1. Race data collection checklist	1a. Race data are collected from participants based on self-report.
	1b. At a minimum, the following NIH race categories are used: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and White.
	1c. Participants can select all race categories that apply.
2. Guidelines for asking an antiracist research question	2a. Consider seeking expert consultation during the initial research planning to ensure that the research question is clearly defined and avoids assumptions of race as a proxy for genetics or other inherent qualities.
	2b. Research questions centered on genetics and biology are best informed by ancestry. Ancestry may be assessed by family history, country of origin, and genetic markers.
	2c. There may be an important role in collecting data on race for research questions informed by a participant's lived experiences.
3. Practical steps to develop a diverse research team	3a. Participate in efforts to cultivate and recruit diverse research teams, including community-engaged pipeline programs.
	3b. Consider engaging team members with diverse experience across training backgrounds.
	3c. Ensure that all research team members have basic bias, inclusivity, and antiracism training.
4. Steps to promote community engagement and research justice	4a. Efforts to mitigate disparities should include communities impacted by disproportionate outcomes.
	4b. Equitable partnerships should incorporate research justice principles, including allocation of financial resources, ownership of data, and dissemination of research findings.

NIH, National Institutes of Health.

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initiatives are an important step forward toward a more antiracist approach to medicine.

In summary, researchers and reviewers can take practical steps to ensure that race is used accurately, research questions and findings avoid promoting racism, and communities most affected by health disparities are represented to promote accelerated progress (Table 2).

Conclusion

Some notable racial health disparities in outcomes across the life course intersect with the clinical and research mission of MFM. The MFM community has an important role in promoting systemic change by insisting on the appropriate use of race in the research we conduct and apply in clinical care. We can require that researchers collect, analyze, and distribute data using antiracist strategies to stop the perpetuation of racist ideology. We can require that funders and journals critique studies using an antiracist framework. We can require equitable power-sharing with communities affected by disparate health outcomes. Martin Luther King Jr famously said, "The arc of the moral universe is long, but it bends towards justice."[82] Similarly, there is a long history of racism and injustice throughout medicine. Yet, through persistent and intentional efforts, research can become more equitable, and we can eliminate racial disparities in health outcomes, including maternal health. ■

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