The US reports the highest rate of maternal mortality (MM) of all developed nations: the OECD average is ~10.9 per 100k, whereas the US rate is about ~22.3 per 100k (Tikkanen 2022). Now imagine that one of the world's greatest athletes nearly dies while giving birth. That was Serena Williams in 2017, when she developed life-threatening blood clots after delivery and struggled to get doctors to take her symptoms seriously despite repeatedly advocating for herself. This frightening ordeal reveals how even wealth and status may not protect someone from a poor maternal health outcome. Unfortunately, Serena's story is not uncommon. Upon further inspection of the US MM rate, one will find that black women are disproportionately represented in this statistic.

Maternal mortality, defined as death during pregnancy or within 6 weeks of the end of pregnancy due to pregnancy-related causes, is a crucial marker of health equity (CDC, 2025). In the United States, the rates of MM in black women are approximately three times higher than those of their white counterparts, irrespective of income and education levels (Anderer, 2025). This startling statistic, exposing profound racial disparity, reflects a violation of equity; one's fundamental right to access and attain the best quality of health care and outcomes, regardless of their social determinants of health (SDOH). Unlike other high-income nations, the mortality rate in the U.S. continues to show an alarming upward trend, disproportionately affecting Black women. The drivers of these disparities involve deeply systemic issues surrounding race, biases, and barriers to quality healthcare.

Reproductive justice emphasizes access to safe clinical care, the right to bodily autonomy, and freedom from racial discrimination in health care settings (Altman et al., 2020). The persistent occurrence of preventable maternal deaths within marginalized populations highlights a kind of health care that is out of touch with these principles. It is ethically imperative that measures are taken to eliminate the existing disparities in maternal outcomes. Addressing these disparities requires both clinical and structural reform with multidisciplinary participation at all levels of healthcare.

So, why do black women face higher mortality rates? What are the medical issues and barriers to care? How deeply entrenched is injustice in our healthcare system*?* What interventions have proven to protect these women? And as new PAs, how can we save lives, advocate for patients, and mitigate this breach of equity and justice?

While black women may have a higher risk of chronic disease upon entering pregnancy, studies show that over 60% of maternal deaths are considered preventable. These chronic diseases, such as hypertension, obesity, and DMII, increase the risk of complications like pre-eclampsia, CV events, infection, and C-sections, all of which can contribute to mortality. Research shows that cesarean rates are disproportionately higher in Black populations, and cesarean-related complications account for three of the six leading causes of MM (Saluja 271). Delivering high-quality care for these women demands a strong patient-provider relationship and the integration of services to manage potential complex issues. Yet it is still far too common to hear of "scattered" or "traumatic" experiences and feelings of being "misled" and "alone" amongst focus groups of black mothers (Glazer & Howell, 2021). This signifies the inadequacies of care coordination and the often dismissive treatment black women face. The impact of such inadequate care is compounded by the higher rates of cardiomyopathies, hypertensive crises, and severe maternal morbidity (SMM) in the form of organ failure, eclampsia, and septicemia. Mental health must also be considered as an often-overlooked but essential component of care, especially in black women. The "weathering hypothesis," describing the cumulative stress of discrimination that black women have historically faced, has been associated with distrust of the medical system, stress surrounding health education, and poorer health outcomes. Women who experience SMM are at high risk for postpartum psychiatric illness and substance use disorder within 1 year of delivery, which has been linked to death by self-harm or overdose (Glazer & Howell, 2021).

For PAs to serve this population, a deep understanding of the systemic causes driving MM disparities is equally essential to delivering ethically responsible and equitable care. One key contributing

factor is structural discrimination, referring to systemic policies or practices that, intentionally or not, negatively affect specific groups. Women of color have historically been clustered into communities that are not equipped to provide adequate maternal care. For example, in NYC, Black women are twice as likely as white women to deliver in the city's highest risk (upper tertile) hospitals. They also face an eightfold higher risk of MM. These striking statistics show how inequities in hospital quality and access can play a major role in the racial disparities seen in maternal outcomes; some studies even suggest that differences in delivery hospitals may account for up to 48% of the black-white disparity in MM. Even among black women with higher education, their MM rates remain 5 times higher than their white counterparts (Glazer & Howell, 2021). This underscores a sad reality: the current system is failing black women, and that failure cuts across SES and individual choices. The US also ranks second to last in its utilization of midwives among developed nations. Studies have found that countries with a higher ratio of midwives to OB/GYN specialists have lower rates of maternal mortality. The OB/GYN to midwives ratio in the US is 11:4 vs. the ratio in Norway, which is 12:53; unlike the US's ~22.3 maternal deaths per 100k, Norway has reported many years of 0 deaths since the year 2000 (Tikkanen 2022).

The United States's longstanding history of systemic racism continues to permeate both our society and the healthcare system, and it is clear that black women and women of color bear a disproportionate weight of the load (Ogunwole & Starks, 2024). While the failure of justice and equity are noticeable, it is important to examine the nuanced ways in which these inequities play out daily. One critical aspect of this ethical principle is testimonial injustice, when a patient's experiences and symptoms are discredited or dismissed by healthcare providers. This form of injustice plays a significant role in the inadequate care and poor outcomes faced by many Black women during pregnancy and childbirth (Ogunwole & Starks, 2024). Harmful stereotypes surrounding black patients and their experiences of pain have led many providers to discredit their complaints or prescribe them less pain medication. This poses an ethical dilemma when Black women explain their symptoms to providers, and

it is brushed under the rug or dismissed. This is dangerous because it leads to errors that could have been prevented, and in the OB/GYN specialty, delayed interventions can ultimately result in death. Understandably, a dismissive patient-provider relationship can cause patients to stop seeking care, further erode trust in the healthcare system, and perpetuate the ongoing denial of justice.

Another layer of injustice is based on the power imbalance seen daily in clinical settings. The culture of medicine stems from a hierarchy not only between interprofessional relations but also between patients and providers. Traditionally, under paternalism, providers are automatically placed in charge of the visit, giving them full authority over a patient's health, creating a difference in power dynamics. Providers may fail to recognize that they are omitting a patient from the decision-making process due to their subconscious bias, and this does not allow the patient to advocate for themselves (Ogunwole & Starks, 2024). When a patient's voice is not heard, equitable care is impossible. Combined with an underlying distrust of US healthcare, due to historical abuses such as the tuskeegee syphilis studies, maintaining a therapeutic relationship demands openness, sensitivity, and advocacy for patients. Justice is also denied when there is limited/no access to care. An unfortunate example of injustice was the recent overturning of Roe v Wade, taking away women's right to get an abortion; studies have found a 33% increase in maternal deaths among Black women in the years following this decision. The historic court decision is just one example of the barriers created by our society. Others include systemic racism, housing instability, limited employment opportunities, and unequal access to education, all of which limit marginalized women's access to proper prenatal and obstetric care. A system that provides care based on SDOH rather than medical needs is unjust and leads to the type of health inequities that we are seeing today (Ogunwole & Starks, 2024).

As we wait for systemic change in our healthcare, at-risk populations remain in danger, especially women of color. In response, individuals and communities have stepped in to create change from the ground up. One such intervention is expanding community access to doulas and midwives. Ultimately,

the key to equity and ending racial disparity lies in improving the quality of our healthcare system. Some interventions that address systemic barriers are maternal care bundles and reducing provider biases. They have been proven to reduce MM, improve patient-provider relationships, and advance equity.

As previously stated, the US ranks 2nd to last amongst developed nations in the utilization of doulas and midwives (Tikkanen 2022). A randomized control trial found that utilizing doulas for at-risk women of color led to a 12% reduction in C-section rates (a key risk factor for MM) and an 11.5% increase in rates of breastfeeding (Mottl-Santiago 466-476). These doulas, often from the same community and of similar cultural background, provided support from prenatal through postpartum. They taught the signs of labor, offered emotional support, helped with paperwork, and, crucially, empowered women to advocate for themselves in clinical settings. This empowerment targets two major barriers to equity faced by women of color: testimonial injustice and power imbalances in clinical settings (Ogunwole E72-83). These women became better equipped to assert themselves when dismissed by providers, able to say, “No, I’ve worked with my doula, these are my symptoms, and I know what I’m talking about.” Doulas’ careful monitoring during the postpartum period, in which ~20% of mortality occurs due to complications such as eclampsia and cardiomyopathy, has been associated with seeking care earlier and improved outcomes (Mottl-Santiago 466-476). These data support that expanding the availability of doulas and midwives will protect at-risk mothers. Some of the other systemic issues leading to MM may have a more insidious and complicated network of barriers: underlying bias leading to harmful clinical decisions and poor quality of care in some clinical settings.

While sometimes misunderstood, the principle of implicit bias becomes evident in high-stress environments when providers rely on automatic or subconscious processes to make rapid medical decisions. In these near-automatic moments, unconscious stereotypes can influence judgment, leading to dismissiveness, misdiagnosis, or unequal treatment (Saluja 270–273). Implicit bias directly contributes to the previously mentioned “testimonial injustice,” in which black women's objections are discredited,

leading to more complications and death (Ogunwole & Starks, 2024). When providers aren't listening to or treating patients fairly, not only do outcomes worsen, but the foundational trust at the heart of the healthcare relationship begins to erode, contributing to the previously mentioned "weathering hypothesis" (Glazer & Howell, 2021). Training PAs to be compassionate and ethically grounded, hiring a diverse workforce, conducting regular team debriefings, and implementing implicit bias training can create an environment where black women can trust the healthcare system. One criticism of these "soft skill" interventions is that it can be difficult to quantify their direct impact on clinical outcomes through randomized controlled trials. However, as mentioned, studies show that implicit provider bias against patients can lead to worse outcomes and increased MM disparities. What if there were an intervention that could reduce this harmful disparity regardless of the biases of the provider?

A study from Davidson and colleagues aimed to determine the impact of quality improvement care bundles at Baylor College of Medicine in Houston, Texas. The goal of the care bundle, termed "TexasAIM Obstetric Hemorrhage Pt Safety Bundle," is to reduce MM by standardizing risk factor assessment (ex, anemia, prior hemorrhage, and black ethnicity), blood loss thresholds, and vital sign instabilities. Then, certain interventions and protocols would be implemented based on whether a patient met the newly established standardized criteria. The main complication measured was severe maternal morbidity due to hemorrhaging (SMM-H), a major cause of maternal mortality. There was a reduction in SMM-H of 45.5% to 31.6% amongst black patients. Davidson and colleagues determined that the impact of the care bundle was statistically significant, so much so that it completely erased the disparity in SMM-H between white and black mothers, while causing a 22% reduction hospital-wide (Davidson 670 - 678). This intervention addresses so many of the ethical challenges that black women face today. By listing "Black Race" as a hemorrhage risk factor, the bundle demonstrates cultural competency by recognizing a well-documented disparity and intentionally accounting for it in its clinical framework. Standardizing clinical metrics works to flatten the effect of provider bias and combat

testimonial injustice by creating clear intervention points: “If the patient meets these specific criteria, it is time to act.” As previously mentioned, Black women in NYC are twice as likely as white women to deliver in the city’s highest-risk hospitals (Glazer & Howell, 2021). By nationally implementing maternal care bundles such as the one at Baylor, we can improve the quality of care at low-performing hospitals, tackle structural discrimination, and reduce the MM disparity among black women.

For new PAs, the world of healthcare may seem overwhelming, but by holding strong ethical ground, leading with empathy, and following guidelines, we can maintain strong patient-provider relationships and find holistic solutions. An entry in the AMA Journal of Ethics titled “Advancing Health Equity by Avoiding Judgmentalism and Contextualizing Care” emphasizes the importance of avoiding certain cognitive biases, such as the Fundamental Attribution Error (FAE) and the Just World Fallacy (JWF) (Weiner E91-E96). The FAE explains how providers may attribute shortcomings of patients to personality traits instead of real-life circumstances. This type of bias directly contributes to testimonial injustice and clinical power structures that disproportionately affect black women. The article outlines an antidote for judgment, which is contextualizing the patient's backstory, a crucial step in empathizing with patients of low SES. Low SES patients may rely on public transportation, lack strong support systems, or have higher rates of mental illness. A good PA will listen to their patient and find solutions that make care accessible for the patient. PAs need to avoid the JWF when building a relationship with mothers who have chronic conditions; Instead of thinking “if these mothers took better care of themselves, they wouldn't be in this position,” PAs should understand that bad things can happen to good people; certain communities lack access to healthy food and some patients working multiple jobs may rely on take-out. New PAs have the ethical responsibility to listen, advocate, and lead the systematic changes necessary to ensure that no woman, regardless of her race, dies from preventable causes. Though a miracle, childbirth is a complicated, emotional journey that can leave a woman vulnerable and needing to lean on the support structures around her. PAs can be that support if we listen with our hearts.

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