MEND

MEND Study Report
"Always more moving and always more memorable": The potential of patient stories to advance birth equity

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There is an urgent need to reduce racial and ethnic inequities in United States healthcare, especially in perinatal care, where the maternal morbidity rate for Black women is nearly three times the rate for white women.[1] Equipping healthcare workers with the knowledge and skills required to provide equitable care is one of multiple interventions needed to close this gap.[2] Medical education and healthcare policy leaders have increasingly proposed clinician implicit bias training (IBT) as a way to achieve this goal,[3] and multiple states now require it as part of continuing professional development.[4] However, scholars have not identified IBT approaches able to achieve sustained practice change or more equitable clinical outcomes.[2] In light of the growing utilization of IBT, it is imperative to explore novel approaches and stakeholder insights regarding how to enhance IBT efficacy.

Social-psychological research has highlighted the utility of stories in promoting behavior change.[5] Moreover, narrative approaches to advancing equity, which involve cycles of storytelling, listening, and reflection, are gaining attention.[6,7] Some storytelling-based antibias interventions have achieved high learner engagement and self-reported reductions in stigma.[8,9] However, we find little scholarship investigating the role of narrative in clinician IBT nor the mechanisms by which it could advance health equity. Here we present perinatal clinicians' perspectives on the benefits of integrating real patient stories into IBT—a stakeholder-supported[10] but understudied approach to advancing birth equity.

Methods

This clinician-focused inquiry is one arm of the larger MEND study, a community-engaged study exploring stakeholder views on how to optimize IBT to improve care and outcomes for Black women and birthing people.[10] Our institution's Institutional Review Board approved all study activities (#21-33289), and oral informed consent was obtained from participants. We recruited multi-disciplinary English-speaking perinatal clinicians from two hospitals in Northern California (community, safety-net), purposively sampling for variation in training backgrounds, clinician roles, and self-identified demographics. 20 out of 28 invited candidates participated in interviews.

<u>Interviews</u>

A sociologist with expertise in qualitative methods (SG) conducted one-on-one, in-depth phone interviews between August 2021-March 2022. She used a semi-structured interview guide that was pilot-tested prior to interviews (see Appendix B). Majority of interviews lasted 50-60 minutes. The interviewer took detailed notes during the interview and presented her understanding of these data back to the respondent for approval. With respondent permission, she digitally recorded all interviews and had them professionally transcribed. Identifying information was removed before analysis. Respondents received $50 for participation.

Analysis

Over multiple discussions, coders with social science (SG) and clinical (FM, AW) training employed iterative rounds of inductive and deductive thematic analysis to identify and characterize respondents' IBT recommendations. The authors presented their findings to community advisors (LJ, JH, BP) who affirmed the analysis. Additional steps to promote rigor in data collection and interpretation are detailed in Appendix A.

Results

The 20 perinatal clinician interviewees were diverse in self-identified race and clinical role (Table 1). Responding to open-ended questions, 15 recommended the inclusion of *"real"* or true-to-life patient stories in IBT (Table 2). In the words of a Black lactation consultant, *"There should be…real life examples of, like, providers that have caused harm."* A Black physician elaborated, *"What would be impactful for my colleagues would be patient experiences…examples of what good patient experiences were and how they were allowed dignity in their pregnancy and their childbirth and then what bad experiences look like…"* A subset of 6 clinicians recommended that these stories be drawn from incidents at their own facility, hereafter referred to as "site-specific" content. Several expressed that patient narratives are more persuasive than statistics about inequities.

Most of the respondents shared ideas about how including real patient stories would make IBT more impactful. We identified three themes among these. First, clinicians felt stories could help them empathize with patient experiences of biased care and acknowledge that racism affects patient outcomes. A *"real situation"* said a white physician, could help them *"think about, like, how racism may have played a part."* A white social worker recalled that in a past training *"an African American woman who delivered here [talked] about her experience and how she was treated, and I think [IBT should have] something like that."* She elaborated: *"Instead of just throwing stats at people,"* training should *"connect with someone to make them think and inspire change."* A white registered nurse echoed this belief: *"I think when people hear…a story, I think that changes it more than just statistical facts that you're hearing…If you heard actual situations and stories, or people have come and talked to you about their experiences firsthand, it's always more moving and always more memorable."*

Second, respondents described that real patient stories could foster clinician recognition of biased or racist care as a problem in their own institution. A white certified nurse-midwife (CNM), for example, reflected, *"Sometimes people…think, 'Oh, that doesn't happen here.' But if you heard from patients who gave birth here six months ago and told you that this is what their experience was…you have to believe them."* A white clinical social worker recommended sharing patient accounts that are *"specific to our hospital, giving specifics, so that it was real, like, that [care inequities] are happening."*

Third, respondents expressed that real patient stories could inspire clinician self-reflection about the harm they may personally perpetuate, potentially illuminating their role in delivering biased care. For instance, a multiracial physician felt that being *"confronted with that reality"*

would allow clinicians to reflect on their actions and decisions from a specific clinical situation. A white CNM shared that *"cases of people we took care of"* would *"provide a mirror where we can really see how we in real-time are potentially causing harm."* Similarly, a Black lactation consultant explained, *"sometimes you can, like, not associate that you're causing harm to real people."* However, *"if we identified, you know, five people who had been affected by implicit bias. And then those five people told their stories, [providers] would know, 'Oh, that was my client…That was my patient'…It'd be more impactful that way, to know like, 'Yes, doctor, you are causing harm to people, even though you might not have thought that you were doing so.'"*

Discussion

Unprompted, a majority of the 20 Northern California hospital-based perinatal clinicians we interviewed identified real patient stories as key to impactful IBT. Site-specific stories may be particularly powerful content for these trainings. Clinicians expressed that real stories may foster clinician understanding and acknowledgment of biased care in their own facilities and/or practices. Greater clinician exposure to patient narratives may thus advance the well-documented wishes of Black women and birthing people of color for more understanding, respect, and humanization from providers.[11]

To the best of our knowledge, this is the first investigation to characterize how patient stories could enhance IBT. Social-psychological frameworks have suggested the potential of narrative-based antiracism interventions to promote reflection, perspective-taking, and affective empathy.[2,12] Our findings align with these theorized impacts, as well as with research showing that anecdotal evidence is more persuasive than statistical evidence in health-related decision making.[13] Our findings indicate the promise of narrative-based interventions for bias reduction by revealing clinician appreciation for them and identifying plausible mechanisms for their impact. Similar mechanisms may be at play in promoting respectful maternity care—a complementary target.[14]

Notably, the presentation of real patient stories to healthcare professionals can enact counter-storytelling, a methodology grounded in Critical Race Theory. By deploying the personal narratives of historically silenced groups, counter-storytelling is theorized to validate the storyteller's experience, expose injustices, and help healthcare workers recognize systems of oppression in their work.[15] Fostering this recognition may be a critical element of ongoing antiracism/antibias education activities for healthcare workers, given the history and ongoing effects of racism in healthcare.[2]

Our findings are drawn from a modest study in one California region. Other limitations are the lack of variation in gender among interviewees and selection bias. Though we attempted to recruit individuals critical of antibias work, the vast majority of participants were supportive. Nevertheless, the widespread and unprompted nomination of real patient stories within the sample—across diverse clinical roles and dissimilar hospitals—suggests the potential of this approach.

Future efforts should explore the acceptability and ethical use of real patient stories and study the effects of such stories on healthcare practitioners and clinical outcomes in diverse clinical contexts. There are important ethical considerations concerning integrating patient stories into IBT; for example, stories of racist care could retraumatize patients or compromise patient privacy. Notably, several patients participating in our larger study—all Black women with a recent hospital birth—expressed interest in sharing their personal stories for IBT content, indicating acceptability for some patients.[10] Community-led interdisciplinary work is needed to investigate potential benefits and harms and, if appropriate, develop guidance regarding privacy protections, mitigation and monitoring of adverse events, and appropriate patient compensation, among other considerations.

Conclusion

Multidisciplinary perinatal clinicians suggest that the inclusion of real, site-specific patient stories is a promising approach to enhance the impact of implicit bias training. Reproductive health educators and health system leaders should investigate the ethics and feasibility of integrating such stories into implicit bias training curricula.

Table 1. Demographic Characteristics of Interviewees (self-reported; N=20)

Characteristic	n (%)
Role	
Physician	6 (30)
Registered Nurse	5 (25)
Certified Nurse-Midwife	6 (30)
Lactation Consultant	1 (5)
Social Worker	2 (10)
Race	
Asian, Native Hawaiian or Pacific Islander, Other*	1 (5)
Asian, White	1 (5)
Black or African American	4 (20)
White	12 (60)
White, Other	2 (10)
Gender Identity	
Woman	20 (100)
Hospital type	
Community	10 (50)
Safety net	10 (50)

*Interviewees were given the option to select "Other" as a racial designation without providing further explanation.

Table 2. Example quotations[a]

Theme	Quotes
Calls for inclusion of real patient stories in clinician implicit bias training (IBT)	I think what would be impactful for my colleagues would be patient experiences…Examples of **what good patient experiences were** and how they were allowed dignity in their pregnancy and their childbirth and then **what bad experiences look like.** *(Black MD)*
	We remember those things, you know, **first person accounts.** *(white RN)*
Real stories could foster clinician empathy with patient experiences of racist/biased care & acknowledgement that racism/bias affects patient outcomes	I think specific examples of how Black women have died…is actually really powerful…perhaps the most powerful would be finding the providers who were actually involved and getting them to talk about it…**It's really helpful for people to have a real situation to kind of identify with…and then think about, like, how racism may have played a part.** *(white MD)*
	[In a past training] they got…an African American woman who delivered here to talk about her experience and how she was treated, and **I think [IBT should have] something like that…** Instead of just throwing stats at people…**You have to…connect with someone** to make them think and inspire change. *(white clinical social worker)*
	I think when people hear…a story, I think that changes it more than just statistical facts that you're hearing…If you heard actual situations and stories, or people have come and talk to you about their experiences firsthand, it's always more moving and always more memorable…I think that definitely would make a difference. *(white RN)*
Real stories could help clinicians accept that racism/bias is a problem at their own facilities	I think that would be really interesting if, like, **specific to our hospital,** giving specifics, so that it was real, like, that [care inequities] are happening…That's a real, actual thing. *(white clinical social worker)*
	I think it would be **so valuable for staff to hear from patients they've actually seen** who are saying, 'This was my experience.'…I think sometimes people take [IBT] and they think, 'Oh, that doesn't happen here.' **But if you heard from patients who gave birth here 6 months ago and told you that this is what their experience was…you have to believe them.**" *(white CNM)*

Real stories could increase clinician self-reflection about their role in racist/biased care	'In this specific scenario, **was there something differently that I could have done or that I might have done if it was a different person?**'…[IBT should be] **tied to patient examples or real-life experiences so that it would help put this theoretical thing in context**…I don't think anyone… would say, 'I actively made this decision or said this thing about a patient because of their race,' but **if confronted with that reality or shown that scenario and said, 'How do you think that race would play into this?' It might be a little bit more realistic.** *(multiracial MD)*
	I really feel like hearing the narrative or the person that is impacted by implicit bias, bias, and racism, I think those stories are sometimes more impactful and can create change than any, you know, one hour little training…Because sometimes you can, like, not associate that you're causing harm to real people…If we identified, you know, five people **who had been affected by implicit bias. And then those five people told their stories**, **[providers] would know, "Oh, that was my client…**That was my patient"…It'd be more impactful that way, **to know like, 'Yes, doctor, you are causing harm to people, even though you might not have thought that you were doing so**.' *(Black board-certified lactation consultant)*
	"I wonder if we were to look at cases of people we took care of rather than have it be hypothetical. I think it would…**provide a mirror where we can really see how we in real-time are potentially causing harm.**" *(white CNM)*

[a]CNM denotes certified nurse midwife; MD denotes medical doctor; RN denotes registered nurse. Authors applied bolding to quotation sections of particular relevance to the associated theme.

Appendix A. Summary of methods per Consolidated Criteria For Reporting Qualitative Studies (COREQ).[16]

The methods description below refers exclusively to the interview branch of the MEND study (Multi-Stakeholder Engagement with State Policies to Advance Antiracism in Maternal Health),[10] which generated the data presented above. *The broader study also included focus groups with individuals from the community intended to benefit from Senate Bill 464—Black women and birthing people—as well as socio-legal analysis with an interdisciplinary team. Those latter methods are not presented here.*

No	Item	Guide questions/description
Domain 1: Research team and reflexivity		
Personal characteristics		
1.	Interviewer	PhD sociologist
2.	Credentials	PhD
3.	Occupation	Assistant professor, researcher
4.	Gender	Woman
5.	Experience and training	Doctoral-level training in sociology with intensive expertise with collecting and analyzing in-depth interview data.
Relationship with participants		
6.	Relationship established	The relationship commenced with study recruitment and lasted for the duration of the interview.
7.	Participant knowledge of the interviewer	Participants understood the interviewers' goals, which were the goals of the study: To learn about challenges to and recommendations for clinician implicit bias training as required by CA Senate Bill 464 (SB464), with the goal of improving care and clinical outcomes for Black women and birthing people.

No	Item	Guide questions/description
8.	Interviewer characteristics	Beyond her interest to contribute to scientific knowledge, the interviewer identified and reported no personal characteristics that we believe would contribute to bias in the interview encounter. The interviewer clarified that she had no formal relationship to the institution where clinician respondents worked.
Domain 2: study design		
Theoretical framework		
9.	Methodological orientation and Theory	We ground this descriptive qualitative study[17] in subtle/critical realism, acknowledging (a) subjectivity in respondents' and analysts' understandings and descriptions of reality and the socially-constructed nature of reality; and (b) the existence of a reality that analysts can work toward understanding through thoughtful study design, data collection, and triangulation in analysis. Additionally, the study draws on tools and concepts from implementation science to try to understand and characterize the adoption, adaptation, and potential impact of novel antibias and/or antiracism interventions.
Participant selection		
10.	Sampling	Purposive sampling of clinician respondents who provide hospital-based perinatal care in Northern California, in order to interview individuals in different roles in perinatal care units. Clinicians were eligible if they self-identified as providing perinatal care in a hospital; one or more of the facilities where they worked was one of our study sites; were over 18 years old; and identified they could participate in an English-language interview.

No	Item	Guide questions/description
		As more individuals expressed interest than we had time or funding to interview, we conducted purposive sampling by inviting individuals representing: • Varied training backgrounds and clinical roles (physicians [MDs], registered nurses [RNs], certified nurse midwives [CNMs], social workers [SWs], International Board Certified Lactation Consultants [IBCLCs], and medical assistants [MAs]). • Varied demographic characteristics in order to attempt to maximize diversity of race, gender and ethnicity in the sample. The candidate pool unfortunately had very little variation in ethnicity or gender, which is reflected in our final sample. • Varied dates of contact with our study: We expected that individuals most enthusiastic about and interested in antibias/antiracism interventions would be among those who responded most quickly to our study invitations. We therefore extended the recruitment period over months, and across multiple waves of study advertisement/recruitment, in order to also try to recruit individuals who were likely less passionate or interested in these topics. We believe this gave us access to a broader range of perspectives and experiences than if we had recruited only the first/early phase of volunteers.
11.	Method of approach	How were participants approached? After receiving permission from departmental leaders at each facility, the principal investigator (SBG) sent an email with information about the study, eligibility criteria, and study activities, which departmental leadership forwarded to perinatal staff and clinician email lists. Interested candidates could email the PI directly or could follow a link to an online screener and contact form. The PI contacted them directly to provide more information and invite them to participate. Candidates were given the

No	Item	Guide questions/description
		option of scheduling directly with the PI or using a scheduling website (Calendly) to self-schedule. Nearly all used Calendly.
12.	Sample size	20 perinatal clinicians
13.	Non-participation	39 individuals expressed interest via email or online screener and provided their contact information to the PI. 6 of those 39 individuals were not eligible for the study because: • they did not work in a hospital-based perinatal setting (4); • they worked at a hospital where MEND had not initiated recruitment (1); or • they contacted the study after recruitment had concluded (1). Of the 33 who were eligible, the PI employed purposive sampling to invite 28 to participate in an interview. 20 of 28 invited individuals were ultimately interviewed, yielding a participation rate among invited candidates of 71%. Proximate reasons for non-participation included PI's inability to make contact with the candidate for scheduling (7), potentially indicating candidates' lack of continued interest or lack of time. 1 individual self-scheduled an interview but did not attend and could not be contacted to reschedule.
Setting		
14.	Setting of data collection	Semi-structured in-depth interviews were conducted via phone. Participants were asked to take the call in a private location.

No	Item	Guide questions/description
15.	Presence of non-participants	The interviewer observed no non-participants; interviewees reported none.
16.	Description of sample	Interviews were conducted August 2021 to March 2022. The sample was diverse in self-identified race and clinical role; all identified as women (n = 20; see Supplement 1, above).
Data collection		
17.	Interview guide	The interviewer used a semi-structured interview guide that had been developed and pilot-tested prior to interviews. Additionally, to enhance study rigor and the validity of the data, the interviewer took detailed notes on key topics during the interview and presented her understanding of these data back to the respondent at the end of the interview for the respondent to clarify, correct, and/or affirm. These key topics focused on specific challenges and recommendations for clinician implicit bias training. See Appendix B below.
18.	Repeat interviews	There were no repeat interviews.
19.	Audio/visual recording	With respondent permission we digitally recorded all interviews and had them professionally transcribed. Identifying information was removed before analysis.
20.	Field notes	Field notes were taken during the interviews and included among study data. The interviewer created structured analytic case summaries for each interview that reflected the respondent's

No	Item	Guide questions/description
		perspectives and experiences on challenges, opportunities, and recommendations for clinician IBT, among other topics.
21.	Duration	Interviews ranged from 44 – 80 recorded minutes, with the majority between 50 and 60 minutes (mean = 56).
22.	Data saturation	The research team discussed data saturation, specifically whether we had collected enough data to answer our main questions, at multiple points throughout the project. The insights for which we sought to reach saturation concerned domains of challenges to and recommendations for clinician implicit bias training. We feel we have reached saturation on these points.
23.	Transcripts returned	We did not return transcripts to participants. However, as described above (#17), the PI/interviewer checked her understanding of key points with each interviewee.
Domain 3: analysis and findings		
Data analysis		
24.	Number of data coders	For the analysis described in the attached paper, there were 3 coders: FM, AW, SBG. For the indexing of topics in the larger study's corpus of data, there were 3 coders: SBG and 2 individuals recognized in the acknowledgments, SZ and EC.
25.	Description of the coding tree	The major codes developed for the broader study that were relevant to this paper were: • Recommendations for improving IBT • Challenges to IBT being impactful • Comments related to humanizing or the humanization of patients

No	Item	Guide questions/description
		FM, AW, and SBG used these codes to extract data for the inductive analysis described below.
26.	Derivation of themes	Early on, SBG noticed that multiple participants had brought up the patient stories when discussing recommendations for implicit bias training. FM, AW, and SBG reviewed focused data output (see #25) to investigate this phenomenon. They reread excerpts numerous times, wrote analytic notes[18], and reviewed notes and output collectively. There was universal agreement among authors that the recommendation of real patient stories to improve IBT – e.g., to improve the effectiveness or impact of IBT for improving care or clinical outcomes for Black women and birthing people – was a robust theme, and universal agreement about which respondents voiced this recommendation. Over the course of multiple discussions, these authors (FM, AW, SBG) inductively developed and refined their characterization of subthemes regarding how respondents described patient stories would improve IBT, reduce bias/racism, and/or advance birth equity. We looked for disconfirming evidence to assess and hone our interpretation.[19, 20] The authors presented their analysis, the three subthemes, and a wide range of data to community advisor collaborators (LJ, JH, BP) who agreed with and affirmed their analysis. An audit trail was maintained throughout to capture analytic processes and decisions.
27.	Software	Atlas.ti and Excel
28.	Participant checking	Participant checking of key insights, including the recommendation that IBT include patient stories, occurred during the interview as described above (#17).

No	Item	Guide questions/description
Reporting		
29.	Quotations presented	*Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number* We included participant quotations to illustrate themes and findings in Table 2 of the report. Quotes from participants are accompanied by respondent self-identified race and clinical role (e.g., physician, registered nurse).
30.	Data and findings consistent	*Was there consistency between the data presented and the findings?* Yes
31.	Clarity of major themes	*Were major themes clearly presented in the findings?* Yes
32.	Clarity of minor themes	*Is there a description of diverse cases or discussion of minor themes?* Yes

Appendix B . Interview Guide, with associated probes, for Perinatal Clinician Participants in the MEND study

1. Interviewee context
    - In a couple sentences please tell me about a typical day for you in the hospital. What you do and who do you see?
    - About how long have you been at this hospital?
    - How long have you been a clinician?

2. Implicit Bias Training
    - Today we're going to be talking primarily about implicit bias training (IBT) for perinatal care providers.
    - Are you familiar with this term? What do you know about IBT?
    - For the purposes of this conversation, we will consider implicit bias to be unconscious prejudices, attitudes, and stereotypes that individuals may have about certain people or groups. IBT tries to reduce these biases.
    - What are a few words or feelings that come to mind when you think about IBT?
    - Have you heard about the California bill SB464? What do you know about it?
        - In advance of our meeting I sent an overview of the new state policy, SB464. I'll take a moment to review key aspects of it with you… [Review handout]

3. Feelings about the new legislation
    - How do you feel about SB464's IBT requirement?
        - In your experience [or when you imagine yourself doing it] what do you think has been [will be] a difficult or uncomfortable part of this training?
    - Has your hospital told you how you and your colleagues should fulfill the IBT that SB464 requires?
    - Will you [continue to] participate in these trainings? Why or why not? What will your involvement look like?

4. How responsive clinicians think SB464 is to the needs of Black women and birthing people and the factors that could improve their clinical outcomes
    - When you think about this hospital, do you feel clinician bias affects clinical outcomes for Black women and birthing people? How?
    - Do you think racism—either individual or structural—affects care outcomes for Black birthing patients? How?
    - I'm going to ask you two survey-type questions and then ask you to talk through your answers:
        - How much do you think that the SB464-mandated IBT will improve clinicians' relationships with Black women and birthing people at your hospital?
        - How much do you think that the SB464-mandated IBT will improve the clinical outcomes of Black women and birthing people at your hospital

- Have you heard about a time when a Black birthing patient had a negative experience or clinical outcome at your hospital? What do you think caused it?

5. Feasibility and effectiveness of SB464
    - Reflecting on your past experiences with IBT or similar training, what are some ways you feel it did not "work"? How or why did it not improve patient care or outcomes?
    - When you think about IBT for your hospital, what could go wrong? What are the challenges? In what ways might it fail to improve the care or outcomes of Black women and birthing people?
    - Reflecting on your past experiences with IBT, what are some ways you feel it "worked"? How did it improve patient care or outcomes?
    - When you think about IBT at your hospital, what might help it to improve care for Black women and birthing people? What would this look like?
        - What could your hospital or colleagues do to help it succeed?
        - Is there anything else you would you recommend?
    - How, if at all, do you feel that these trainings have affected you or your practice? How do you feel it has affected your colleagues? The labor & delivery floor overall?
    - If you were going to measure (or evaluate) the effects of IBT, what would be important to measure?
    - I'd like to check the notes I took about what we're considering the challenges, opportunities, and recommendations of IBT with you… [Check interpretation]

6. Recommendations to improve care outcomes for Black women and birthing people
    - Thinking more broadly here, when you think about labor & delivery leadership, hospital leadership, or state lawmakers, what recommendations do you have for improving clinical outcomes for Black women and birthing people?
    - Do you have any other advice for hospital or labor & delivery leadership as they begin to implement these IBT trainings?
    - What advice do you have for hospitals or labor & delivery leadership who want to improve clinical outcomes for Black women and birthing people?
    - What advice do you have for state lawmakers who want to improve clinical outcomes for Black women and birthing people?

7. Closed-ended questions
    - Please think about the IBT that Senate Bill 464 (SB464) requires perinatal providers to do.
    - Overall, how much do you think this training will improve relationships between clinicians and Black women and birthing people in California? □ A lot □ Somewhat □ A little □ Not at all
    - Overall, how much do you think this training will decrease maternal morbidity (serious injury) and mortality (death) for Black women and birthing people in California? □ A lot □ Somewhat □ A little □ Not at all

- How much do you agree or disagree with the following? I want to participate in SB464 IBT □ Strongly disagree □ Disagree □ Neither agree or disagree □ Agree □ Strongly agree. □ I'm not sure

8. Additional relevant information or recommendations
    - What else should I have asked you about this topic?
    - Is there anything we haven't addressed that you think is important to discuss?

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