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COMMENTARY

BIRTH ISSUES IN PERINATAL CARE WILEY

Applying a critical race lens to relationship-centered care in pregnancy and childbirth: An antidote to structural racism

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Achieving racial equity in childbirth care is critical to the health and well-being of our nation. Black infants are more than twice as likely as White infants to die before reaching their first birthday, and Black individuals who experience reproduction are 3-4 times more likely to experience a complication or death related to childbirth.[1] These inequities are one clear manifestation of structural racism—a form of racism that lacks an identifiable perpetrator but is instead the codification and legalization of society's unequal allocation of resources and opportunity based on an established racial hierarchy.[2,3] Clinical care during pregnancy and childbirth is an important determinant of perinatal-infant outcomes; however, for Black birthing people, care in the medical context does not consistently meet their clinical needs.[4] In addition, racial discrimination and experiences of interpersonal racism such as implicit racial bias and microaggressions during clinical encounters create disproportionate barriers to high-quality, respectful, patient-centered care experienced by Black people.[5-8] Perinatal care, as currently designed and delivered in most settings in the United States, has proven woefully inadequate for addressing structural and interpersonal racism in the day-to-day experiences of Black birthing people and in their encounters with the health care system.[8-11] Health care services that are grounded in relationships that acknowledge dynamics of power and that foster mutual respect may help shift pernicious patterns of racial inequity in perinatal care and childbirth.

The patient-clinician relationship is central to achieving high-quality perinatal care. Indeed, relationships provide the context for many important functions and activities in health care.[12] Relationship-centered care—a theoretical concept introduced in 2006 by Beach and colleagues, can be defined as care in which all participants appreciate the importance of their relationships with one another.[12] To date, few scholars have explored this concept, and despite a considerable body of relationship-centered care literature devoted to prenatal and perinatal care, there is very little written about what constitutes relationship-centered care specifically for Black birthing people.[13] Racial identity and experiences of racism influence the care Black birthing people desire—this suggests that meaningful care for this population needs to incorporate not only a relationship-centered care approach, but also anti-racism–based theoretical approaches that focus specifically on the experiences of Black parenthood.[10,14]

This call to action describes Beach and colleague's four principles of relationship-centered care through a critical race lens in the context of pregnancy and childbirth care. Taken together, the two concepts—relationship-centered care and critical race theory—have the potential to powerfully reduce racism's impact on childbirth outcomes for Black birthing individuals, infants, and families.

1 | A CRITICAL RACE LENS

To improve clinician-patient interactions for those at greatest risk for adverse maternal and infant outcomes, a critical race framework must undergird relationship-centered care processes. Critical race theory recognizes that racism is ingrained in American society and identifies that American

institutions and power structures are based on White supremacy and perpetuate the marginalization of people of color.[15,16] A critical race framework in relationship-centered care puts Black pregnant individuals in the role of "expert" about their own bodies and desires, alongside their clinician who is expert in medical diagnoses and care. Relationship-centered care contends that all illnesses and healing processes occur in relationship—relationships of an individual with self and with others—and that in deepening these interpersonal relations (specifically the relationships between clinicians and patients), we can improve health outcomes. The inequities in birth outcomes experienced by Black individuals are driven by historical and structural injustice that can only be remedied through relationships that shift power, that is, through the application of a critical race lens to relationship-centered care. At the intersection of relationship-centered care and critical race theory may be an antidote to structural racism's insidious influence on maternal and infant health outcomes.

1.1 | Relationship-centered care principle 1: relationships in health care ought to include dimensions of personhood and roles

In the clinical encounter, relationship-centered care makes explicit that both the patient and the clinician are unique individuals with their own sets of experiences, values, and perspectives.[12] This notion of "doctor-as-person" requires authenticity.[17] For example, clinicians should not simply act as if they have respect for someone; they must also aim to believe (internally) the respect they display (externally).[12] Many standard cultural competency and implicit bias trainings aim to achieve this principle.[18-20] However, a focus on becoming aware of one's implicit (automatic) biases or receiving a checklist as to how to be "competent" in another person's culture is not enough to achieve an authentic relationship between (mostly White) clinicians and their Black pregnant patients. Clinicians must disabuse themselves of the notion that "competence" or unbiased care is easily achieved and must look past defined end points or achievements and commit to an ongoing practice of self-critique.[20] Cultural humility on the other hand requires a lifelong commitment to self-evaluation and critique, which includes addressing power relations and working in respectful partnership with diverse individuals.[20]

Applying a critical race lens to this principle requires two things: critical consciousness (digging beneath the surface of information to develop deeper understandings of concepts, relationships, and personal biases) and race consciousness (explicit acknowledgment of the workings of race and racism in social contexts or in one's personal life).[16] For example, in relationship-centered care between a White clinician and a Black pregnant patient, critical consciousness could appear as a clinician understanding how the historical vestiges of racism dictate where their patient lives, the resources that they have access to, and how this history influences the clinician-patient relationship.[21] In this same example, race consciousness could include the clinician reflecting individually, with colleagues, or in personal or professional support settings to analyze if and how their implicit bias influences how they classify patient behavior (as aggressive or combative) and the nonverbal cues and behavior (not acknowledging a patient's family when they attend prenatal appointments) that reinforce their racial position. Clinicians may have very low levels of explicit bias while harboring high implicit bias—this implicit bias then results in stereotypical or biased clinical conclusions and nonverbal behavior that alienates or stigmatizes Black patients.[3]

1.2 | Relationship-centered care principle 2: affect and emotion are important components of relationships in health care

Emotional support is provided through the emotional presence of the clinician; this notion challenges the practice of detached concern often modeled formally and informally in medical education.[12,22] Emotional support has particular salience for perinatal care because birthing people are experiencing a transformative life experience. Rather than remaining detached or neutral, clinicians ought to be encouraged to empathize with patients, which in turn helps patients express their emotions.[23,24] Data show the opposite is more common—empathy declines during training.[25,26] When a racial lens is applied, empathy declines further, White clinicians are found to have less empathy for Black patients.[27] The problem is not just that people disregard the pain of Black people; several researchers posit that the issue is that the pain is not even felt. Indeed, studies show that people do not respond to the pain of others equally. For example, researchers found that when White study participants saw White people receiving a painful stimulus, they responded more dramatically than they did for Black people.[28,29] Furthermore, when the racial empathy gap intersects with the White racial frame, the result is a devaluation of Black lives, which may show up during the clinical encounter.[30] In perinatal settings, this devaluation and lack of empathy may fuel the "mother blame" narrative, which suggests that among Black birthing people, individual characteristics, behaviors such as smoking and late entry to prenatal care, or other "bad" decisions during pregnancy are exclusively responsible for poor birth outcomes.[31] This blame often occurs with little attention to the structural factors that contribute to an individual's decision-making process. Thus, relationship-centered care, emotional support, and empathy from a clinician may not be enough for a Black pregnant person if there is a failure to understand how racism shapes empathy and the everyday lives of Black people.

Merging this principle of relationship-centered care with a critical race lens requires clinicians to enter the relationship with their Black patients fully understanding and conveying the ordinariness of experiences of racism—that racism is embedded in the social fabric of society.[16] Typically, clinicians may make a statement, such as "Black people who become pregnant are at higher risk of preterm birth," which attributes risks to race rather than to racism. A combined relationship-centered care and critical race approach would center the notion of racism as embedded in the social fabric of society (including health care delivery systems) and operationalize it as a routine exposure for Black pregnant individuals. For example, a clinician could instead say, "the lived experience of being Black in America puts those individuals and their newborns at greater risk of preterm birth"—a conclusion that acknowledges the empirically documented impact that racial discrimination has on cortisol levels and biological weathering.[32,33] Another example would be for a clinician to acknowledge and allow space during a 20-week anatomy scan to discuss why media coverage of a police killing of an unarmed Black man might cause apprehension and sadness for someone who is pregnant with a Black male fetus.[34,35]

1.3 | Relationship-centered care principle 3: all health care relationships occur in the context of reciprocal influence

Principle 3 explains that although traditionally, the hierarchical nature of medicine suggests that clinicians play the role of the "expert,"[12,36] in relationship-centered care, participants are encouraged to develop a "friendship" based on virtue, wherein the two parties develop each other's character.[12] This principle acknowledges the patient's "expertise" about their own body and experience and honors the fact that that the clinician derives benefits in serving the patient. In order for a clinician to recognize and incorporate this principle into their practice, there must be a flattening of hierarchy and a sharing of power. It requires an understanding that the patient has just as much (or more) to offer than the clinician and that the clinician has much to gain from embarking on an authentic relationship with their patient.

Applying a critical race lens to principle 3 requires the clinician to consider disciplinary self-critique (the systematic examination by members of a discipline of its conventions and impacts on broader society).[37] A clinician would form authentic relationships with patients that are both clinical and supportive while also being a vocal advocate for the adoption of shared decision-making approaches professionally. Advocating for shared decision-making requires clinicians to be critical of the harms that have been done under the guise of clinician expertise including eugenics and forced sterilizations of marginalized individuals. For example, inpatient insertion of long-acting reversible contraceptives (LARCs) (intrauterine devices and implants) is increasingly offered to birthing people immediately after childbirth. Enthusiasm for this approach stems from robust safety, efficacy, and cost-effectiveness data, and responsiveness to patient needs and preferences. Although clinical evidence for immediate postpartum LARC is well established, the ethical implications of both the timing of when to offer contraceptive counseling and the enhanced access to this care have not been fully considered.[38] For Black birthing people, this type of clinical practice could be considered a form of reproductive coercion. A clinician who has not considered or is not prepared to articulate and discuss eugenics and the history of experimentation and reproductive exploitation that Black communities have experienced until as recently as the 1980s is unprepared to adequately care for Black birthing people.[39]

Adopting reciprocal influence in the context of racial equity must also include consistent efforts at "centering in the margins"—shifting one's viewpoint from a majority group's perspective to that of the marginalized group or groups.[16] Centering at the margins in clinical care and research necessitates redefining "normal." For clinicians, this means critically analyzing how and why their understanding of a diagnosis or clinical encounter may differ from the experiences or understanding of a Black patient, and doing so by taking that patient's perspective.[40]

1.4 | Relationship-centered care principle 4: health care has a moral foundation

Clinicians are trained to keep a professional relationship, with substantial emotional distance from patients, but principle 4 suggests that an enhanced commitment to personal relationships is morally desirable, allowing for a more genuine interaction between patients and clinicians.[12] Genuine relationships are morally desirable because it is through these relationships that clinicians generate the authentic investment that one must possess in order to serve others, and to be renewed from that serving. A complicating factor is that personal relationships are easiest to forge between individuals with a shared sense of identity.[41] Racial identity is one of the earliest identities we form; at three months, infants can identify their own race and distinguish from those of another race.[42]

Without a critical race lens, principle 4 is difficult to carry out in a system where 70% of OBGYNs are White and 48% of babies born are from non-White racial and ethnic backgrounds.[43-45] Developing positive clinician-patient relationships across race may be challenging. Black patients report greater satisfaction and deeper connection with clinicians of their own race.[46-48] Receiving perinatal care from someone who shares your identity and lived experiences can be transformative, but if the clinician does not share their patients' identity, they have a moral and

clinical obligation to develop empathy for the racialized experiences of their patients, check their implicit and explicit biases, and become actively antiracist. Applying a critical race lens emphasizes that a moral foundation for a relationship cannot exist without acknowledging racism and making a commitment to dismantling systems of racism and oppression. Thus, critical race theory demands critical analysis of the moral foundations that guide relationship-centered care and suggest that this morality must stem from a commitment to racial and social justice. Furthermore, medical education's reliance on implicit racial bias training as the solution to counteract adverse outcomes experienced by Black birthing people represents an abdication of moral responsibility and accountability to systems of racism because it fails to explicitly name and examine how racism influences adverse outcomes. Indeed, a focus on the individual unconscious attitudes of a clinician without recognizing how implicit biases fit into the larger system of structural racism is morally irresponsible.[3,49] A failure to incorporate racial justice at the core of relationship-centered perinatal care provides lip service to vulnerable Black individuals while refusing to supply the social and institutional reform required to facilitate birth equity.

2 | CONCLUSIONS

Critical race theory provides a structural lens to explore and understand relationship-centered care and its power to improve clinical experiences and birth outcomes for pregnant Black people. Although relationship-centered care itself as put forth by Beach and colleagues offers a transformative approach to care that centers the patient, inclusion of a critical race framework is required to make progress toward birth equity. New and innovative models of care delivery that center the lived experience of Black people and specifically highlight how racism influences health are urgently needed. These models offer a pathway through which we can begin to chip away at the persistent inequities experienced by Black birthing people.

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