Black Lives Matter: Claiming a Space for Evidence-Based Outrage in Obstetrics and Gynecology

While the phrase "Black Lives Matter" began inauspiciously—a hashtag on Twitter following the 2013 acquittal of George Zimmerman in the shooting death of Trayvon Martin[1]—it has been widely embraced by those describing the larger context of persistent inequities for Black Americans. The phrase is provocative by design, and its use conveys both urgency and frustration with the status quo.

What is notably absent, with the exception of three isolated commentaries,[2–4] is the use of the phrase in medical literature. We are trained as clinician and researchers to operate within the world of testable hypotheses and restrained conclusions. Where, then, is the space for evidence-based outrage in medicine? What *P* value would be necessary to conclude that persistent health disparities are unacceptable?

As subspecialist obstetricians–gynecologists, we use data from our field to demonstrate the significant disparities Black women face across their reproductive lives, and conclude that these outcomes are not only statistically significant, but morally significant and fundamentally unjust. (All reported comparisons and measures of association in this article are for Black women compared to a cohort of White women, unless otherwise indicated. We have chosen to use "Black" and "White" in this piece because we believe these terms best reflect the sociocultural identification of the women about whom we speak.)

FAMILY PLANNING

The history of family planning for Black women is one of the most abhorrent in medicine, with eugenics campaigns and forced sterilization disproportionately targeting Black women. Currently, Black women experience over 50% more unintended pregnancies compared with White women (64% vs 38% in 2011; data references are provided in the Appendix, available as a supplement to the online version of this article at http://www.ajph.org). Black women at risk for unintended pregnancy are more likely not to be using any contraception (adjusted odds ratio [AOR] = 0.65; 95% confidence interval [CI] = 0.51, 0.83) and less likely to be using the most effective contraceptive methods (AOR = 0.63; 95% CI = 0.46, 0.84). Black women have nearly four times the rate of abortions (40.2 vs 11.5), and a higher proportion of abortions are performed in the second trimester (10.6% vs 7.9%), a procedure associated with greater morbidity.

MATERNAL FETAL MEDICINE

Black women in the United States from 2006 to 2010 were more than three times as likely to die a pregnancy-related death than White and Hispanic women, accounting for 14.6% of live births but 35.5% of pregnancy-related deaths (see Appendix). Black infants die at more than two times the rates of White infants, with infant mortality ratios of 5.2 deaths per 1000 live births for White infants and 11.4 per 1000 live births for Black infants in 2011.

In every state where data on Black births are reported, Black women have a higher preterm birth rate. In 2014, the prevalence of preterm birth for White women was 9.1%, compared with 13.4% in Black women. Black women are significantly less likely to express understanding that genetic testing is optional (AOR = 0.44; 95% CI = 0.22, 0.91), and are less likely to receive recommended influenza vaccinations during pregnancy (adjusted prevalence ratio = 0.80; 95% CI = 0.74, 0.86 for seasonal influenza; 0.75; 95% CI = 0.68, 0.82 for pH1N1).

Finally, at the time of birth, Black women are at least twice as likely to experience severe maternal morbidities. They have a significantly higher primary cesarean delivery rate (relative risk [RR] = 1.23; 95% CI = 1.17, 1.29), and are more likely to experience postpartum hemorrhage and peripartum infection (3.0% vs 1.6% and 4.9% vs 4.1%, respectively; $P < .001$ for both), differences which are not explained by either site of delivery or patient-level risk factors.

REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY

In a population-based sample of women aged 33 to 44 years, Black women had twofold odds

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of infertility after adjustment for socioeconomic position, correlates of pregnancy intent, and risk factors for infertility (see Appendix). In an analysis of the Society of Assisted Reproductive Technology national database, Black women underwent only 3666 (4.6%) cycles of in vitro fertilization (IVF) compared with 68 607 (85.4%) IVF cycles in White women. Even when Black women attain equal access to IVF, disparities in odds of achieving pregnancy persist, and women who have a live birth are disproportionately White. Black women had lower live birth rates (18.7% vs 26.3%; RR = 1.41; $P < .001$) and higher miscarriage rates (20.4% vs 13.2%, RR = 1.5; $P < .001$) relative to White women.

One proposed mechanism for IVF outcome disparities in Black women is poor access to quality clinics. However, among a cohort of women with access to a single large-volume IVF program, the AOR for intrauterine pregnancies was 0.63 in Black women (95% CI = 0.44, 0.88). Despite state law–mandated insurance coverage for IVF in Illinois, Black women in Chicago, a city with 32% Black population, made up only 5.3% of the treated women. Beyond the reproductive years, Black women have a 1.6-fold risk of experiencing vasomotor symptoms during the menopausal transition, and even so, are less likely to be offered effective hormone replacement therapy.

GYNECOLOGIC ONCOLOGY

Black women with endometrial cancer, the most common gynecologic cancer, have a 55% higher death rate than White women (see Appendix). Within high-risk histology types, the mortality gap is even greater: Black women have a 1.5- to 2.9-fold mortality rate. Black women have lower odds of receiving surgery (AOR = 0.44; 95% CI = 0.34, 0.56), even within early stage disease (AOR = 0.28; 95% CI = 0.19, 0.41). Among those for whom it is indicated, Black women are 20% less likely to receive chemotherapy (adjusted hazard ratio = 0.8; 95% CI = 0.6, 0.9).

Although cervical cancer incidence rates between Black and White women are converging, Black women still have a significantly lower five-year survival rate (58% vs 69%). Despite similar screening rates, Black women undergo lower quality screening and poorer follow-up of abnormal results. When afforded access to the same quality of care as White women, unsurprisingly, long-term survival rates are the same.

Overall survival for ovarian cancer has two percent every year from 2002 to 2011, but not for Black women: 31% of Black women survive five years after diagnosis, compared with 44% of White women. Black women have lower odds of any surgery (AOR = 0.53; 95% CI = 0.42, 0.66), of comprehensive surgery (AOR = 0.66; 95% CI = 0.52, 0.83), and of treatment by high-volume surgeons (AOR = 0.55; 95% CI = 0.44, 0.69). They are less likely to receive critical chemotherapy (adjusted rate ratio = 0.87; 95% CI = 0.83, 0.92) and less likely to have hospice services (47% vs 38%; $P < .001$). When Black women with ovarian cancer receive equal care, they have the same survival rate.

CONCLUSIONS

Enough is enough. Race is a social construct and the overwhelming statistics we present are attributable to a broken racist system, not a broken group of women. Evidence-based outrage is the objective, logical conclusion. We, as the caretakers of women's health, must realize that real action requires enough courage to embrace a fundamental shift in our perspective. We challenge obstetricians–gynecologists to consider how accepting that Black women do worse in your research study, worse in your quality improvement project, or are absent from your clinical trial as the status quo directly reinforces the lesser value our society has assigned to Black women's lives. Instead of sitting back on the reflexive defense that racial disparities are too complex for us to do anything about, what if we decided to try anyway? What if every obstetrics and gynecology department made racial equity in known areas of disparity the priority of all quality improvement projects? For researchers, how would your study designs change if the primary metric was whether they helped Black women? How would your interventions be modified if you could not claim success without racially equitable outcomes? Let's start with these challenges and learn what works, together. We can prioritize racial equity in women's health, but we must actively choose to do so. How can we look at the evidence and do anything else? AJPH

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