In the United States, the incidence of maternal deaths and near misses far exceeds that of other industrialized countries. African American mothers are hit especially hard.
LABORS AND LOSSES: WHY ARE NEW MOTHERS DYING AT AN ALARMING RATE IN THIS COUNTRY?

In 2016, journalist Adriana Gallardo and her colleagues at ProPublica and NPR were tasked with reporting on a worrying trend: Between 2000 and 2015, the number of maternal deaths and near-deaths in the United States rose by 25 percent. And African American mothers are four times more likely to die or nearly die as a result of pregnancy than white mothers.

But who, they wondered, are these women? And why haven't we heard about them?

One reason, they later found, has to do with data collection. It turns out there is no standard means of reporting pregnancy-related deaths. Approaches vary from state to state, leaving researchers and the public alike ignorant of national or even regional trends in the data that could point to a solution. And despite attempts by states to better identify pregnancy-related deaths, for a number of reasons, the data collection is frequently prone to error.

Although the data pose more questions than answers, it's clear that the United States has far more maternal deaths and near-deaths than any other country in the developed world. In every other developed country, these numbers continue to drop. In the United States, an estimated 700 to 900 women die of complications related to childbirth each year, and at least 60,000 women nearly die of pregnancy-related complications. Probably 70 percent of these deaths and near-deaths are preventable.

While the data offered little in terms of reasons for this rise, it was the lack of discourse about these mothers that Gallardo found unsettling. The journalist team scoured the Internet and asked for families to reach out with their stories. More than 4,700 people responded. From their research, the team created the award-winning Lost Mothers series, for which Gallardo and her colleagues dissected the data and engaged with communities around the country to illuminate the names, faces, and stories behind the trends.

Momentum is building here to find answers. Gallardo visited the University of Pittsburgh’s Oakland campus in May for a maternal mortality forum hosted in part by the nonprofit Healthy Start. Likewise, the Magee-Womens Research Institute and the Jewish Healthcare Foundation (JHF) of Pittsburgh held related symposia in October. JHF just announced it’s partnering with Magee and RAND to develop a center to combat cardiovascular disease in pregnancy, a leading cause of maternal death. And the Commonwealth has established a Maternal Mortality Review Committee.

We sat down with the CEO of Healthy Start, which is charged with improving maternal and child health in Allegheny County, and three Pitt professors who’ve been appointed to Pennsylvania’s Maternal Mortality Review Committee. We wanted their perspectives on why new mothers are dying at an alarming rate and what can be done to spare families from these tragedies.

“Long gone are the days when I could go to bed and the man would get up to lose his life,” said Susan Wiedel, CEO of Healthy Start, which is charged with improving maternal and child health in Allegheny County, and three Pitt professors who’ve been appointed to Pennsylvania’s Maternal Mortality Review Committee. We wanted their perspectives on why new mothers are dying at an alarming rate and what can be done to spare families from these tragedies. —Susan Wiedel

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To paraphrase ProPublica and NPR’s Lost Mothers series: American women are three times more likely as Canadian women to die in the maternal period. They are six times as likely to die as Scandinavians. In every other developed country, and many less affluent ones, maternal mortality rates have been falling. The Lancet noted that in Great Britain the rate has declined so dramatically that “a man is more likely to die while his partner is pregnant than she is.”

And, though the data are difficult to get a handle on—the United States doesn’t even release an official maternal mortality figure anymore—the situation appears to be getting worse.

What are the data, with all the current limitations, telling us so far?

Dara Mendez (public health researcher): We’ve seen on the national scale the rates have been actually increasing quite a bit, although there are no formal national rubber-stamped estimates.

We have seen variations by state. Some states have seen tremendous decreases in maternal mortality—California being one example. There are a few [reasons] they point to: They instituted their maternal mortality review committee in, I want to say, 2006. That state also has what would be equivalent to a perinatal collaborative, which is a group that not only takes the recommendations but applies them. Some of the core elements they’ve instituted in California [have addressed] postpartum hemorrhage. There are no . . . national protocols . . . for hemorrhage.
In addition to hemorrhage, what other conditions are behind these deaths?

DM: Pregnancy-related hypertension or hypertensive disorders, preeclampsia, these are some of the leading causes of maternal death.

If we’re thinking about morbidity in general, we also see a tremendous disparity, racial difference, there.

Betty Braxter (nurse midwife): I think we have to look at factors that we know impact healthy pregnancies, and [sedentary lifestyle] is one. And the substance abuse issue, which is not something new. We’re just seeing more press now because a different population is being shown as substance abusers who end up dying. [And] we’re now beginning to think of preconception counseling. How do we get people more healthy before they even think about becoming pregnant?

I’m just assuming there’s more obesity in the United States than in, say, Western Europe. Is that correct?

DM: I believe that is correct.

Yet, I’m reading mostly about conditions that arise during pregnancy, not preexisting conditions, related to these deaths.

Sonya Borrero (internist): Well, they’re related. Prior to entering pregnancy, obesity, existing diabetes, and existing dysregulation around metabolism can all contribute to worsening outcomes during pregnancy. Pregnancy is an incredible stress on the body. These preexisting conditions are exacerbated during pregnancy. So, a lot of attention also needs to be placed on the pre-pregnancy period, although that is incredibly tricky. There is a lot of pushback around the overmedicalization of women’s reproduction. How do we talk about this? We don’t want to elevate the importance of women’s health only because of their reproductive capacity, right? We care deeply about women and women’s health for themselves.

A couple of years ago, I did a qualitative study with low-income women in Pittsburgh. We asked them, “What does it mean to you to plan a pregnancy?” Most of them, if not all of them, talked about the need to have your finances in order, to be married. None of them talked about optimizing health. They also recognized that sort of the social norms that they felt that they needed to achieve were really elusive in their life.

What they conveyed to us is that is socially more acceptable to have an unintended pregnancy than to explicitly state that they were trying to get pregnant, or open to pregnancy, in these sorts of nonnormative circumstances. This just blew me away. Women also talked about the fact that life had taught them that they did not have much agency around their reproduction. So they just chose to let it happen. All of [this flies] in the face of our biomedical paradigm, which is: You should plan all pregnancies.

We have been recognizing the limitations of this very strict planning paradigm, and that it doesn’t actually meet women’s needs or match their lived experiences or realities. So one of the first things I did was I removed “planning” language from my counseling. I’ve been using “preparing” language: Would you like to talk about this? There are ways to prepare for pregnancy, especially if you are taking some medications or have chronic medical conditions. Do you feel like that’s relevant to you right now? Sometimes providers might seem to be imposing our own normative ideas on who should and should not be reproducing and when they should be. That can really erode the relationship.

What are some contributing factors in the racial disparities in maternal mortality?

SB: We [providers] use heuristic processes, especially in the time constraints of clinical encounters. This is a natural human cognitive process to stereotype and use shortcuts. We are all guilty of it. And the first step is to recognize situations in which that is happening. We’re doing some implicit bias training in the medical school. And we’re [having] a meeting of the minds to figure out how to continue doing this throughout training.

DM: There’s been quite a bit of work that we’ve been doing at the health department. There’s a local infant mortality collaborative that has included Healthy Start, University of Pittsburgh scholars, folks within the maternal- and child-health space. We’ve been looking at things beyond just pregnancy and birth, but throughout the continuum. And some of our most recent actions have been around institutional equity. One way that we’ve done that has been work around undoing racism. And really (continued on page 33)
“D” Way to Teach

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how anything works normally. So when it came to getting a PhD, I was 100 percent focused on normal function. Over the years, I’ve taught in 12 different first- and second-year courses. Almost every single organ system. And my focus was always: How does it work normally? If you understand the foundations of normal, then the diseases start to make a lot more sense.

SD: I was a drama major in college. I guess I went into medicine because I decided there was no way I was ever going to make a living as an actress. Medicine is the only other thing I ever knew. I’m the fifth generation of my family to go into medicine, and my son and daughter are the sixth generation. My father was a surgeon, so I thought I wanted to be a surgeon. But then I read about emergency medicine and thought it sounded cool. It was a brand new residency when I was in med school, so I tried it out, and it’s been an absolutely perfect fit for me. I’ve had so much fun. It fit my attention deficit disorder perfectly.

Do you have a funny story about being colleagues?

SD: The worst thing she ever asked me to do was make gluten-free muffins for her class.

GD: I knew this story was going to come up. So one year in the GI course, every Tuesday morning at 8 a.m. we would do something totally different. One time, we had a hypnotherapist come in and talk about her study treating IBS patients with hypnosis. Another time, we had a yoga instructor come in. And then one Tuesday was healthy breakfast day. We had probiotic yogurt drinks, green tea, and I had asked Sue to make gluten-free muffins.

SD: And I can bake, but I had never baked gluten-free before.

GD: She called me and said, “Do you know how awful this is?” She said, “My only option is rice flour, and it’s like sand.” But she did it. She came through. Sue, you remember what happened the next week then, don’t you?

SD: Oh yes, yes, yes, yes, yes, I do.

GD: I had a real problem getting to sleep one night, and at 4 in the morning, I went to the ER with what ended up being a gallbladder attack.

After a half hour with one doc, shift change occurred, and, lo and behold, Sue Dunmire was my new ER doc. At one point, just Sue and I were sitting in a dimmed room, and she leaned over to me, and she said, “You know what they’re going to find when they open you up?” She said, “Your gallbladder is going to be filled with this gritty sand because you made me bake gluten-free muffins.” It hurt so bad to laugh; and you just kept going on, Sue, and making me laugh and laugh.

SD: Yep, that’s me.

GD: That gallbladder was taken out by a second-year resident who was our former student.

When you look back and think of the students you taught, what sticks out?

GD: They’re very altruistic.

SD: Exactly. They are doing this because they want to learn to take care of patients. And I love that. I love the enthusiasm. I think they are a complete joy to teach.

GD: I still keep in contact with some of them. Last Christmas, I got a card from a graduate of the second year that I taught. He had failed the last course of his first year and had to remediate it over the summer. I chewed him out, told him there was no excuse; he got lazy. And he wrote, “You have no idea how many times I thought about that and realized that that was exactly it.” It feels good to have had an impact. It felt good to have students stop by my office. We must have gone to a dozen weddings of our students over the years.

GD: I went to a conference with my husband. I happened to see five to 10 people who I’d trained. And just to have them come up to you and say, “Hey, tell me what’s going on in your life.” It’s very gratifying because a couple of them said, “I still remember what you taught me about this.” That made me feel good. And I’m happy I became friends with so many of the students. They knew that they could call me. Or I could pick their brains. And we could get through this together. It was a very gratifying career.

—Interview by Gavin Jenkins

Read more of the conversation at www.pittmed.health.pitt.edu/story/d_way_teach

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naming racism as a core element that would be contributing to the racial disparity that we see in maternal health and infant health, as well as in death. We’ve been working closely with [others] to think about: As practitioners, as researchers, as community organizers that are coming together around these issues, how do we move forward together in a collective impact sort of way?

What is contributing to this disparity at the policy level?

SB: A lot of women, low-income women in particular, become eligible for insurance coverage, Medicaid coverage, during the time of pregnancy—[coverage] which then they often lose 60 days postpartum.

JS: One of the unintended consequences of these policies that we see in community-based programs is moms come to us repeatedly with subsequent pregnancies that are back to back. So if she loses her health coverage and isn’t able to continue to manage whatever chronic health condition that she may potentially have, then in that subsequent pregnancy, that condition presents itself again.

[There’s a mindset of a mom’s value] being centered around her capacity to continue to have children. It’s kind of like a backdoor access to things that should be provided anyway. It puts a lot of strain on community-based programs that aren’t necessarily meant to cover basic needs.

What can be done at the level of the provider, of the community, of the family, to help mothers and babies?

BB: Sometimes [women] just don’t know they have the power to tell the provider, I’m having these dizzinesses, I’m having these headaches, and to not necessarily accept it if the provider dismisses them.

JS: The mental health aspect is really important. I think that, as a community, we’re doing a better job of making sure that we’re paying attention to mom’s mental health, and the fact that, at this perinatal period, there is a lot going on. And it’s normal to get help. It’s normal to recognize that this is a huge change and shift. And that we’re not superwomen. Well, we are superwomen, but we still need help.

—Interview by Erica Lloyd

This conversation has been edited. To hear more, tune in to our Pitt Medcast: www.pittmed.health.pitt.edu/pitt-medcast