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Unequal Medicine: The Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

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Unequal Medicine: The Impact of Patient Mistrust on the Racial
Differences in Reproductive Health Outcomes

by

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Table of Contents

Abstract	Page 2
Introduction	Page 2
Methodology	Page 5
Overview of Literature	Page 6
Defining the racial gap in birth outcomes	Page 6
Medical Explanation	Page 8
Genetic differences	Page 9
Prenatal care utilization	Page 9
Behavioral differences	Page 10
Racism and Social Explanation	Page 11
Segregation	Page 11
Psychosocial stress and racism	Page 13
Patient Mistrust Explanation	Page 13
Interventions	Page 17
Discussion	Page 20
Implications for the healthcare field	Page 21
Future research	Page 22
References	Page 23

Abstract

Despite impressive medical advancements the gap in health and the quality of health care between blacks and whites has remained consistent, or even increased in the past several decades in America, and reproductive health outcomes reveal similar trends. Black infants have a mortality rate that is 2.4 times higher than whites in the first year, and black mothers are 3 times more likely to die when giving birth when compared to white women (MacDorman et al. 2011 & Paxton and Wardlaw, 2011). Some attribute the current and historically poor birth outcomes for black women and infants compared to whites to a medical explanation, such as inadequate prenatal care, genetic differences, or higher engagement in at-risk activities. Others claim this quality gap is present between blacks and whites because of racism, stress, and segregation for blacks in the United States. While these factors are influential they cannot account for the entire gap in birth outcomes, and further there is little explanation as to why these behavioral factors are present. Patient mistrust in the health care system is a unique form of racism influenced by a history of inequality and mistreatment in medical practices for black patients, which affects the discrepancy in birth outcomes by creating reluctance to receive medical treatment.

Introduction

Tremendous achievements have been made in health care since the 20th century, due to the technical advancements in the ability to detect and treat medical conditions in their early stages. However, despite these interventions that have improved the overall health of the majority of Americans, blacks have benefited less from these advancements. Black Americans in the United States experience worse health outcomes than white Americans. In 2002, blacks suffered 40.5 percent more deaths (83,570 deaths) than would be expected if they

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

had experienced the same mortality rate as whites (Satcher et al. 2005). The life expectancy gap between black and white females was a 4.5 year difference in 2005, with white women living an average of 80 years and black women 75.5 years (Harper et al. 2007). Males had a racial difference in life expectancy of 6.5 years, with white men living to 74 years and black men living to 67.5 years on average (Harper et al. 2007). Blacks in the United States have a higher prevalence and death rate for many common illnesses when compared to whites, blacks have an 11 percent higher rate of hypertension than whites, and greater odds of stroke (Thom et al. 2006). Compared with whites, blacks have lower rates of survival when cancer is diagnosed. Trends in 5 year cancer survival rates from 1996 to 2003 show whites have a 67 percent chance of survival, while only 57 percent for blacks (Jemal et al. 2008). Also, blacks age 20 and over have a diabetes rate of 18.7 percent, compared to whites at 10.2 percent (Center for Disease Control and Prevention, 2011).

When examining reproductive health outcomes for blacks and whites this disparity is apparent and has been increasing over the past decade (Frisbie et al. 2004). In this thesis reproductive outcomes are described by maternal and infant mortality rates. Despite an overall decrease in the rate of infant and maternal mortality, the gap between races has increased. In 1980, the black-white ratio for infant mortality was 1.9 and by the year 2000 it rose to 2.3 (Frisbie et al. 2004). The black infant mortality rate is currently 2.4 times higher than that of whites, and blacks have higher rates for the four main causes of these deaths: preterm related causes, congenital malformations, sudden infant death syndrome (SIDS), and unintentional injuries (MacDorman and Matthews, 2009). In addition black women are 3 times more likely than white women to die from pregnancy complications, and have a higher rate for every cause of these complications: hemorrhage, pregnancy-induced hypertension, and pulmonary embolism

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

(Paxton and Wardlaw, 2011 & Anachebe and Sutton, 2003). There are many possible explanations for why this large health discrepancy is present for black mothers and infants, however the largest agreed upon contributing factor is higher rates of preterm delivery and delivery of low birth weight infants for blacks, due to the greater risks for mother's as well as infants.

Gestational age-specific mortality rates vary widely among white and black racial groups. In 2007 nearly one in five infants of black women (18.3 percent) were born preterm; less than 37 weeks of gestation (MacDorman and Matthews, 2011). This is higher than any other racial group in the United States, and 60 percent higher than the percentage for white women which was 11.5 percent (MacDorman and Matthews, 2011). For black women the percentage of those who give birth to very preterm infants, less than 32 weeks gestation, was 4.1 percent, more than double the rate for whites at 1.6 percent (MacDorman and Matthews, 2011). The increased rate of preterm births for blacks is a devastating problem and large contributor to the inequality present in birth outcomes. It is estimated in some literature that preterm births account for more than half of the difference in infant mortality rates between blacks and whites due to the many complications that arise as a result. (MacDorman and Matthews, 2011).

The inequality in infant and maternal mortality rates between blacks and whites in the United States has been studied extensively in the last several decades, many with opposing views on the causes for this large and growing discrepancy. A few known contributors to this gap have been determined and quantified in the literature; preterm related causes accounted for 55 percent, SIDS accounted for 6 percent, congenital malformations 5 percent, and unintentional injuries 4 percent of the difference (MacDorman and Matthews, 2011). These four causes can be attributed to 71 percent of the difference in birth outcomes between blacks and whites (MacDorman and

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

Matthews, 2011). Still despite much attention and dedicated studies, 29 percent of the difference is unaccounted for. Even though some of these causes are now known, why they are present is still a topic of debate. A medical explanation is one current idea used by some, which attributes factors such as inadequate prenatal care, genetic differences, and higher engagement in at-risk activities. While others believe this gap in birth outcomes is present between blacks and whites because of racism, segregation, and unique stress for blacks in the United States. The effect of patient mistrust as an extension of the racism category has not been fully described in the body of current literature, however how patients react to the health care system and their health care providers impacts the quality of their care. A long history of racism and mistreatment for blacks in America, especially malpractice in the medical field, continues to affect how blacks will utilize the health care services and suggestions that are provided to them. This thesis emphasizes the importance of all the factors presented and each contribute to the reproductive differences between blacks and whites in the United States, however patient mistrust is one important factor that is unique to blacks in current society and needs to be recognized and expanded in the literature.

Methodology

This thesis uses articles from the year 2000 and onward, on differences in birth outcomes between blacks and whites in the United States. Studies were chosen based on the useful primary statistics they provided on this phenomenon, on their ideas on what they believe is the cause behind this health discrepancy, or the solutions they propose to address the inequality in birth outcomes between blacks and whites. Two distinct categories were chosen to group the articles in that argue the cause of the racial gap in birth outcomes. The first category is the medical explanation which states physical factors such as genetic and behavioral differences

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

affect the racial gap in birth outcomes. The second category is racism and social differences which attributes differences to segregation, poverty, and the negative effects of racism experiences. Patient mistrust is an additional and key aspect to the racism category, however it is not as commonly studied in the research on this phenomena. This explanation states that patient mistrust effects the gap present in black-white birth outcomes due to decreased utilization of care and reluctance to follow physician instructions. Patient mistrust is a unique element because it is a result of racism but as a result of it factors for the medical explanation are affected, such as underutilization of prenatal care. Patient mistrust creates reluctance and is stalling black women from getting the preventative and prenatal care they may need to have a successful pregnancy. Studies demonstrating policy interventions for this inequality and their outcomes are also included, to examine what is currently working and what still has not been adequately addressed.

Overview of Literature

Defining the Racial Gap in Birth Outcomes

The United States infant mortality rate declined by 93 percent during the 1900's, from approximately 100 infant deaths per 1,000 live births in 1900 to 6.89 per 1,000 live births in 2000 (Roth and Henley, 2012). However, as the new millennium continued this trend has halted, in 2005 the infant mortality rate was 6.86 per 1,000 live births which is not statistically different from the prior years (Roth and Henley, 2012). Despite spending more money on healthcare than any other country, the United States has higher maternal mortality than many other developed countries, ranking fiftieth among 59 developed countries in 2010 (Roth and Henley, 2012).

A reason why the infant mortality rate is 2.4 times higher for blacks than whites is that despite innovations in new healthcare medicine and technology these treatments may benefit whites greater than blacks (Frisbie et al. 2004). The case of respiratory distress syndrome

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

(RDS), which results from a deficiency of naturally occurring surfactant in the lungs of the fetus that aid in gas exchange, is largely a problem in very preterm infants where there is little to no natural secretion of surfactant (Frisbie et al. 2004). From 1980 to 1998, RDS ranked as the fourth leading cause in infant death, however during this period the RDS mortality rate was reduced almost fivefold due to the introduction of surfactant replacement (Frisbie et al. 2004). In 1989, prior to surfactant replacement therapy the RDS mortality rate per 100,000 live births was 172.2 for blacks and 74.7 for whites, a rate ratio of 2.3 (Frisbie et al. 2004). However by 1999, after the introduction of surfactant replacement the ratio was greater than 2.7, the infant mortality rates from RDS was 61.9 for blacks and 22.5 for whites per 1,000 live births (Frisbie et al. 2004). The decrease in infant deaths from this syndrome has contributed significantly to the overall decline in infant mortality in the past few decades, but it has also led to the widening black-white difference in birth outcomes for blacks have benefited less from this medical advancement (Frisbie et al. 2004). This could be due to a higher rate of uninsured blacks, blacks resistant to treatment, or unequal treatment from healthcare providers.

Another medical treatment affecting this gap in birth outcomes between blacks and whites is the use, and overuse, of cesarean sections in the United States. Cesarean sections are now the most common surgical procedure in America, the rates have skyrocketed from 4.5 percent of births in 1965 to 31.8 percent in 2007 (Roth and Henley, 2012). Dramatic rises in cesarean sections have coincided with increasing maternal mortality, as there are risks of infections, blood loss, blood clots, injury to other organs, venous thromboembolism, anesthesia-related complications, and potential complications in subsequent pregnancies due to permanent scarring of the uterus (Roth and Henley, 2012). Three of the leading causes of maternal mortality are associated with cesareans: hemorrhage, complications of anesthesia, and infection

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

(Roth and Henley, 2012). As the risks for this procedure is high, like any other surgery, the World Health Organization (WHO) recommends a cesarean rate of 10 to 15 percent, less than half of what the United States is currently performing (Roth and Henley, 2012). A reason why this is contributing to the inequality in birth outcomes between whites and blacks is due to the fact that blacks are more likely to have medically necessary and unnecessary cesarean sections, both contributing to their 3 times higher maternal mortality rate than whites (Roth and Henley, 2012). Among mothers of similar age, education, marital status, and parity, black mothers have 1.29 times higher odds of having a primary cesarean section than white mothers (Roth and Henley, 2012). Once a primary cesarean section was utilized, 92 percent of mothers had needed a repeat cesarean delivery for their next children (Roth and Henley, 2012). The overuse of cesarean sections in the United States impacts the much higher maternal mortality rate for blacks, as it is much more common in populations with lower education levels and fewer resources.

Medical Explanation

One explanation for the gap in birth outcomes between blacks and whites is a medical explanation, which attributes the health discrepancies of blacks to physical factors such as lack of adequate prenatal care, genetic differences, and engagement in high risk activities such as drinking or smoking during pregnancy. These factors are included in this explanation because they each demonstrate physical health differences between blacks and whites that can be regularly examined in a medical setting at an individual level. This explanation does not look at social differences between whites and blacks and does not look to find the motives behind engagement of high risk behaviors, rather just the effects.

Genetic Differences

Black singleton babies in the United States are twice as likely to be born low birth weight and die during the first year of life as whites (Conley and Strully, 2012). In full-term pregnancies, underlying genetic variation appeared to generate larger birth weight-mortality associations for mature fraternal twins, relative to mature identical twins (Conley and Strully, 2012). When twins had ample time in which to grow, but were still born severely growth retarded, underlying genetic vulnerabilities may be more likely to drive mortality risk (Conley and Strully, 2012). These authors suggest that select empirical patterns point to inherent tendencies toward racial differences in optimal sizes at birth, and black singleton babies tend to be born smaller than white babies, regardless of gestational age (Conley and Strully, 2012).

They also argue that while low birth weight and infant mortality are more common among black babies than white babies, a black baby born with a low birth weight is more likely to survive than a white baby born at a similar weight due to the fact that they are more capable to deal with this because of their genetics (Conley and Strully, 2012). Although it seems unlikely that this lower birth weight for blacks is optimal, but rather a necessary adaptation to their circumstances. Also blacks not born in the United States do not have this lower optimal birth size as described (David and Collins, 1997).

Prenatal Care Utilization

Women who received no prenatal care or delayed prenatal care, which is described as entry after the first 12 weeks of gestation, do not receive education from their physician or early medical interventions if complications arise. This leaves these women at higher risk for having undetected complications of pregnancy that can result in severe maternal and fetal morbidity and sometimes death (Anachebe and Sutton, 2003). Women with inadequate prenatal care are three

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

times more more likely to have a low birth weight infant, under 5.5 pounds, when compared with women who do receive early and comprehensive prenatal care (Anachebe and Sutton, 2003).

Even though there has been a decline in the infant mortality rate in the past few decades, this decline is a result of improved survival rates among low birth weight infants not the reduction in the incidence of them (Anachebe and Sutton, 2003). Many attribute the difference in birth outcomes between blacks and whites to delayed entry or complete absence of prenatal care, as well as higher rates of unintended pregnancies and teen pregnancies among blacks, for those groups of women are the least likely to receive timely prenatal care (Anachebe and Sutton, 2003).

Behavioral Differences

Another factor included in the medical explanation is behavioral differences, and it is argued that this causes some of the racial discrepancy in birth outcomes. It is suggested that infant mortality is contributed to by five domains, either individually or in conjunction with one another. The domains include behavioral patterns, which are estimated to account for 40 percent of early deaths, genetic predispositions 30 percent, social circumstances 15 percent, shortfalls in medical care 10 percent, and the last 5 percent due to environmental exposures (Bryant et al. 2010). These authors attribute 85 percent of the gap in birth outcomes are attributed to the medical model, and that risky behaviors during pregnancy is the highest contributing factor. The authors define behavioral factors in pregnancy as adequacy of prenatal care, pregnancy weight gain, use of prenatal vitamins, smoking, and alcohol use (Bryant et al. 2010). However the authors do state that black women are less likely to smoke during pregnancy than white women (Bryant et al. 2010). In this article the effects of social circumstances are minimized compared

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

to many other pieces literature examined, attributing maternal stress, racism, segregation, and socioeconomic differences to just 15 percent (Bryant et al. 2015).

Racism and Social Explanation

Another explanation for the difference in birth outcomes between whites and blacks in the United States is the dramatic inequalities in the socioeconomic status for blacks and the effects that segregation and racism have on black's health.

Segregation

Those attributing the black-white difference in birth outcomes to racism and social differences argue that the social structure in the United States promotes inequality for black mothers and babies. Place-based exposures that have been associated with pregnancy outcomes include neighborhood crime, access to retail food outlets, city-level segregation, city-level air pollution, state-level income inequality, and national politics and welfare state status (Kramer and Hogue, 2008). Residential segregation has been associated with increased black but not white infant mortality and very preterm birth, less than 32 weeks gestation. Segregation is a process of sorting individuals into residential environments on the basis of race or income, and has been declared a fundamental cause of racial health disparities (Kramer and Hogue, 2008).

Residential segregation affects blacks negatively and not whites because black neighborhoods that are isolated have increased odds of being poverty stricken and lacking resources (Kramer and Hogue, 2008). These neighborhoods influence school quality, educational attainment, economic opportunity, exposure to crime, high crowding, and quality of housing (Kramer and Hogue, 2008). Areas with greater segregation have higher odds of very preterm birth rates for blacks; in cities with less segregation black women had very preterm birth infants at a rate of 30.8 per 1,000 live births, compared to cities with high segregation with a rate of 37.1 per 1,000

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

live births (Kramer and Hogue, 2008). Whites were not affected by segregation to a significant degree and remained close to average for very preterm birth weight rate of 12.3 per 1,000 live births (Kramer and Hogue, 2008).

Another study examines the impact of residential segregation and two dimensions of this phenomenon, isolation and clustering. Residential isolation is a measure of the extent to which minority members are exposed to only each other and the limited possibility for interaction between minority and majority group members (Walton, 2009). Clustering is the extent to which minorities reside in contiguous census tracts within the metropolitan area (Walton, 2009). A high degree of clustering indicates the presence of large, expansive ethnic neighborhood as opposed to smaller, scattered ethnic neighborhoods throughout the city (Walton, 2009). These two forms of segregation could yield different birth outcomes for black women, living in a large neighborhood with few health care facilities, limited options for nutritious food, and poor quality recreational facilities can ultimately affect maternal and infant health status because residents have to travel further to access these health related resources. However, if ethnic neighborhoods are able to concentrate this health-related infrastructure, than living in a large ethnic neighborhood could mean that recreational opportunities, healthy food operations, and health care resources are more abundant and easily accessible to residents. This study found that as the proportion of blacks relative to the total population increases, black individuals experience higher odds of low birth weight (Walton, 2009). Though black poverty itself was found not related to birth weight in this study, its inclusion in the model makes the negative effects of both isolation and clustering on birth weight significant. The metropolitan area control variables also operate in a similar fashion, with low birth weight incidence increasing as the proportion of blacks in the metropolitan area increases, and incidence decreasing as the household income rises

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

(Walton, 2009). Black segregation is an issue for birth outcomes because a higher rate of this racial minority lives in poverty, and isolation and clustering leaves them in areas with limited health resources.

Psychosocial Stress and Racism

Psychosocial stress can negatively impact the outcome of a pregnancy, and some argue that blacks are especially susceptible to stress during pregnancy due to the racism they have experienced. When surveyed, pregnant black women reported experiencing a greater number of negative and impactful life events and are more distressed by them than other racial groups (Dominguez et al. 2008). It is also suggest that stress may be more detrimental to black pregnancies when compared to whites. Psychosocial stress can be operationalized as stressful life events, daily hassles, daily anxiety, and pregnancy-related anxiety; and this type of stress is negatively associated with birth weight (Dominguez et al. 2008). Racism should be included in this operational definition for minorities, for it poses a particularly noxious threat to well-being because it is an undeniably negative, demeaning, and threatening reaction to an immutable personal characteristic (Dominguez et al. 2008). A psychosocial study in North Carolina found that black women who reported experiencing higher levels of racial discrimination versus those reported lower levels, there was an increased risk for preterm birth (Dole et al. 2004). A larger national study found that each unit increase in lifetime perceived racism stress was associated with a 39.59 gram decrease in birth weight (Dominguez et al. 2008).

Patient Mistrust Addition

Mistrust of black patients in the healthcare field can be described as reluctance to go see a physician or get preventative care, and hesitance to follow through with treatment options.

Although blacks know this behavior can yield negative health consequences, the fear and anger

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

they feel towards this once abusive system is still strong (Coffman et al. 2001). When the disparity in the quality of care for minorities is studied the results reveal members of minority groups who do gain access to care are likely to receive lower-quality care than whites. When insurance status and income are controlled for, blacks are less likely to receive bypass surgery when medically indicated, are less likely to receive adequate pain management, and are less likely to be treated with medications for HIV infection compared to whites (Coffman et al. 2001). A survey on the quality of care different racial groups are receiving revealed black racial minorities were less likely to have a regular physician, less likely to understand everything their physician says, less likely to be involved in decisions, more likely to feel judged by physician, and have a lesser rate of overall satisfaction in their health care compared to white respondents (Cohen et al. 2002). These feelings of judgment and lack of understanding continue to contribute to patient mistrust and leave blacks hesitant to receive medical care (Cohen et al. 2002). Another survey which analyzed the varying trust level in the healthcare system and race reported that 80 percent of white patients trust their physician, while only 43 percent of black patients do (Grumbach and Mendoza, 2008). A study of doctor-patient race concordance and greater satisfaction with care stated that black patients who were race concordant with their physician reported a higher level of satisfaction (Gardner, 2005). Blacks trust their physician at a rate that is almost half than what whites do, however having a black physician significantly narrows this gap (Gardner, 2005). This potentially demonstrates that patient mistrust does stem from racism and abuse of the medical system done by whites towards black patients.

Patient mistrust is experienced by blacks through many different areas of the healthcare field, not just reproduction. In the mental health field professionals describe this phenomenon of patient mistrust experienced by blacks as cultural mistrust or paranoia. It is often viewed as a

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

mental disorder, defined as the notion that blacks have developed paranoid-like behaviors due to historical and contemporary experiences with racism and oppression (Whaley, 2001). Some mental health professionals argue that the term cultural paranoia is an inappropriate term for an adaptive behavior for blacks, and that the root of the problem needs to be addressed. However many others insist it needs to be defined and the behaviors treated (Whaley, 2001). In 2001, paranoid schizophrenia was the most common diagnosis given to blacks and many believe that this is due to the fact that psychologists working with black patients could not comprehend the mistrust they were feeling (Whaley, 2001).

HIV-AIDS affects blacks significantly more than whites, and it has a large impact on the feelings of mistrust that blacks experience. Medical mistrust, including mistrust of HIV treatments, health care providers, and the medical system, is prevalent among blacks and may influence health care behaviors. Blacks have reported lower satisfaction with health care; are skeptical about the efficacy of medications; and perceive that the U.S. healthcare system is racist or discriminatory (Bogart et al. 2010). Such feelings of mistrust are believed to stem from current and historical segregation, racism, and unjust treatment in the healthcare system and society in general. One form of medical mistrust as a potential barrier to treatment adherence are conspiracy beliefs about HIV, such as the idea that HIV is a manmade virus (Bogart et al. 2010). Research indicates that conspiracy beliefs are prevalent among blacks, for example, substantial proportions of blacks in a national random sample endorsed conspiracy beliefs about the origin and treatment of HIV: 48% believed that HIV is a manmade virus; 53% agreed that a cure for AIDS is being withheld from the poor; and 44% thought that people who take antiretroviral medications are human guinea pigs for the government (Bogart et al. 2010). Research suggests that belief in conspiracies is higher among blacks versus whites, people of lower socioeconomic

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

status, and men (Bogart et al. 2010). Blacks in poverty have the worst health outcomes of groups in the United States, and they are also the most likely to believe in the medical system's conspiracies demonstrating patient mistrust.

During the past several decades, epidemiologists have researched many important associations between the sociodemographic characteristics of mothers and the birth weight of infants to identify why the racial gap in birth outcomes persists. For example, the extremes of childbearing age, cigarette smoking, inadequate prenatal care, urban poverty, and black race are well-documented risk factors for low birth weight, although these factors cannot fully be attributed to the gap in birth weight between whites and blacks. Some investigators believe that genetic factors associated with race influence birth weight because both races are improving in this issue due to medical advancements, but at different rates. However, when looking at the incidence of low birth weight among U.S.-born white women, U.S.-born black women and African-born black women, surprising statistics emerge; African-born black women have a much lower incidence of low birth weight infants and are at a similar rate to U.S.-born white women (David and Collins, 1997). This discredits the genetic theory, and it means that black women born in the United States are dealing with a unique set of circumstances, even a different experience than black women who live in the United States but who were not born here. This suggests the effects of a different interaction with the health care system in the United States, due to patient mistrust (Giscombe and Lobel, 2005).

Black American communities have experienced a long history of abuse by the medical system and researchers in the United States, creating patient mistrust. Feelings resulting from patient mistrust are anger and anxiety towards science generally, and more specifically towards physicians and other healthcare providers, which create reluctance to make use of the health care

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

system, and suspicion about recommended treatments (Giscombe and Lobel, 2005). Although not all blacks may know about the details of specific historic abuses, suspicion and mistrust of the medical system is common, and could be passed along intergenerationally. In the United States blacks continue to receive substandard medical care, including numerous examples involving women (Rosenthal and Lobel, 2011). Black women have been denied treatment during pregnancy and refused hospital admission for delivery because they lacked health insurance (Rosenthal and Lobel, 2011). Attention has also been turned to the apprehension black women feel towards birth control and abortion due to the history of violent control by the medical system over black women's reproduction (Rosenthal and Lobel, 2011). Power also plays an important role in relationships and interactions between patients and healthcare providers, with women often reported feeling dissatisfied and powerless when interacting with physicians, particularly gynecologists and obstetricians (Rosenthal and Lobel, 2011). It is likely that pregnant black women experience a heightened power asymmetry with obstetricians, particularly when the physician is not of their same gender and/or race, as is common. Data from the American Medical Association indicate that among gynecologists and obstetricians in office-based practice, 93 percent are white and only 7 percent are black (Rosenthal and Lobel, 2011). Generally, blacks feel that they participate less in their interactions and decision-making with physicians than whites feel, but not when their physician is of the same racial/ethnic background (Gardner, 2005). Additionally, female patients communicate more effectively with female than male physicians (Gardner, 2005).

Interventions

Disparities in birth outcomes can be attributed to both differential exposures during pregnancy and differential developmental trajectories across the lifespan. Prenatal care cannot

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

be expected in less than nine months to reverse the lifelong, cumulative impact of social inequality on the health of black mothers (Lu et al. 2010). Closing the racial gap in birth outcomes requires a life course approach, addressing both early life disadvantages and cumulative allostatic load (Lu et al. 2010). One strategy suggested is to provide interconception care for women with prior adverse pregnancy outcomes. Interconception care allows for continuity of health care from one pregnancy to the next, this is important because women with a poor pregnancy outcome are at substantial risk for having another poor pregnancy outcome (Lu et al. 2010). This is particularly a problem for many black women, especially low-income women whose pregnancy related Medicaid coverage generally terminates at 60 days postpartum (Lu et al. 2010). An interconception care program in Denver was shown to reduce the risk of recurrent low birth weight births by one-third, which is a huge contributing factor to infant mortality (Lu et al. 2010). Expansion to preconception care, prenatal care, interconception care and healthcare access over the life course for black women are all necessary strategies to promote equality in care for the birthing process to mothers as well as their infants.

Genesee County Michigan has implemented policies to reduce infant mortality that is grounded in community-based public health. Genesee County has a population of approximately 436,000 residents, of whom 20 percent are black. The city of Flint, Michigan is in the geographic center of Genesee County and more than half of the residents are black (Pestronk and Franks, 2003). Genesee County has had Michigan's highest rates of infant mortality and the highest black-white discrepancy in the state (Pestronk and Franks, 2003). The current plan to reduce infant mortality in Genesee County is based on three themes: reducing racism on the part of health care workers, administrators of healthcare organizations, educators who train healthcare workers, and community members; retooling the perinatal care system; and fostering community

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

mobilization (Pestronk and Franks, 2003). To reduce racism throughout the community and its health care system many “undoing racism” seminars to educate white citizens on racism and its structure in society have been held. Although the long-term effects of these seminars have yet to be determined, the instantaneous changes reported were significant; sixty-two percent of respondents felt their attitudes about racism had been changed, sixty-nine percent admitted a change in their knowledge about racism, and fifty-seven percent expressed a belief that they would change the way they would act in the workplace (Pestronk and Franks, 2003). Genesee County’s efforts to retool the perinatal system involves the use of paraprofessionals, known as Advocates, who are women indigenous to the high-risk community, with life experience similar to the women they work with. Advocates are trained to provide social support to pregnant and parenting women and to connect families with resources to address basic needs such as housing, food, and medical care (Pestronk and Franks, 2003). Efforts to foster community mobilization have been implemented through a media campaign designed to educate and elicit a response over the large racial disparity in infant mortality. A “one-stop shop” was created with job development and training, counseling, WIC services, healthy food demonstrations, banking, and education on child safety and health issues. An African culture, education, and development center was opened for people to learn about and reflect on black history. Additionally, a community organization received grant funding for a fitness program to reduce overweight and obesity among black women of childbearing age. Although long-term effects of these changes have yet to be determined, acknowledging and addressing this issue is the first step to establish racial equality in birth outcomes.

Discussion

There are many factors that influence the difference in birth outcomes between blacks and whites in the United States. This thesis is intended to describe the importance of the role of patient mistrust on this epidemic, not to discredit any other proposed cause but rather add to the integral body of research. This problem is dynamic and is likely a mixture of many factors, some which might be unique to individual black woman. The issue presented in this thesis goes beyond birth outcomes, and even health outcomes. It describes a problem of racial inequality that is reflected throughout our society. Differences in poverty rates, unemployment, incarceration, as well as overall health and disease prevalence all demonstrate black-white inequalities.

The medical explanation suggests that the differences in birth outcomes between blacks and whites can be attributed to genetic differences, prenatal care utilization and higher engagement in at-risk activities. However, black women who were born in Africa have similar birth outcomes to white women born in the United States, and black women born in the United States are uniquely suffering from this disadvantage (David and Collins, 1997). Inadequate prenatal care utilization does have a large impact on this inequality in health outcomes between blacks and whites, black women who have delayed or absent care are three times as likely to give birth to a low birth weight infant as women who receive timely prenatal care (Anachebe and Sutton, 2003). The medical explanation does not provide any insight as to why more black women do not go and get prenatal care, even with insurance or Medicaid coverage. Patient mistrust results from racism that black women may have experienced personally or have learned about in our nation's history, and it affects the way they interact with the health care system. Blacks underutilize preventive care and prenatal care because many only will go see a physician

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

when they deem it absolutely necessary, and if blacks do go to the doctor they may react with skepticism and reluctance to following the prescribed orders due to this mistrust. When pregnant black women do not receive timely prenatal care they are also missing out on the vital education that this service provides, which may affect some of their behaviors during pregnancy.

Racism and segregation leave expectant black mothers feeling isolated and defeated, and as a result they do not trust the social or health care system in the United States. Black women in poverty-stricken, segregated urban areas are at the higher risk to delivering preterm and experiencing fetal or maternal mortality. They have the greatest need for assistance but also the greatest reluctance to go get the prenatal care and education needed for a successful pregnancy. Racism itself carries detrimental health outcomes, with each additional recalled racist event counting as a negative life event and causing slightly worse health (Dominguez et al. 2008). However, racism can cause much further and worse health outcomes for blacks if they suffer patient mistrust. This mistrust of the health care system in America is a vital piece in the continuing cycle of subpar health and health care for black minorities.

Implications for the Healthcare Field

This brings serious implications for the healthcare field, where every person is supposed to get equal care, regardless of gender, race, or socioeconomic status. However, this is an ideal that has not yet been achieved in the United States. The United States' healthcare system has shifted towards diagnosing and medicating, and to adequately address the needs for every patient a more integrative approach is necessary. Preventative care is crucial to increase health outcomes in all fields and lower health costs. Programs helping minorities get connected with timely preventative care, education on behavioral impacts during pregnancy, dealing with racism stressors, providing accessible health resources in segregated poverty-stricken neighborhoods, as

Impact of Patient Mistrust on the Racial Differences in Reproductive Health Outcomes

well as dealing with patient mistrust by ensuring patient engagement and comfort with their physician need to be expanded and implemented. Providing a quality gynecologist-obstetrician match with black women presents the need for minority physicians, as black women reported higher feelings of satisfaction towards physicians that are also black (Gardner, 2005). Blacks overall are extremely underrepresented in medicine, which can be attributed to why black patients view the health care system with anger, reluctance, and mistrust.

Future Research

Many future studies will need to be done for patient mistrust to be a serious contender as a major contributing factor to the racial discrepancy in birth outcomes. The impact of the recent healthcare reform in the United States will provide valuable knowledge on the impact that increased health insurance might have on prenatal care utilization for black women who may not have had any coverage prior. Also many cities have created individual reforms to address this issue, by starting to provide interventions for the racial gap in birth outcomes. Studying these long term effects will be crucial to identifying successful strategies to combat this inequality and expand efforts throughout the healthcare field.

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