FROM THE EDITOR'S DESK

Obstetric Research That Addresses Health Care Disparities

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Editor in Chief

We are excited to feature several important articles in this issue of *JLGH.* From our nursing colleagues comes a report of a project conducted at the Ann B. Barshinger Cancer Institute, demonstrating that trauma-informed care education can positively impact the attitudes of clinicians. Our colleagues in the Penn Medicine Lancaster General Health Research Institute describe the new collaborative relationship being built with the University of Pennsylvania Office of Clinical Research, under the umbrella of One Penn Medicine.

Further, one of our Philadelphia colleagues, who gave the Larry Carroll memorial lecture earlier this year at LG Health, offers thoughts on the adverse outcomes of accountable care in our hospitals and society. Health care policies presumably designed to level the playing field in fact may be eliminating care opportunities. Dr. Rachel Werner's eloquent analysis reinforces the need on our part to be always mindful, to reexamine our system and practices. Even the best of intentions may have negative impact.

Regarding thoughtful reexamination of practices that have broad implications, three provocative studies are soon to be launched at Women & Babies Hospital, led by both local and national research teams.

In the first, "Optimizing Outcomes for Patients with Pre-Viable PROM," Drs. Sarita Sonalkar and Rachel McKean will conduct a qualitative analysis of patient care in cases of premature rupture of membranes. Rupture in the second trimester can be devastating, forcing parents to make challenging decisions about termination and the birthing person's own health. The management of these circumstances can vary greatly depending on local protocols and resources, as well as provider and patient needs. These researchers aim to determine best practices and barriers to care; their long-term hope is to establish a standardized and evidence-based protocol that can be implemented broadly.

The second study, "Disrupting Obstetric Racism — Evaluating Interventions That Mitigate Harm to Black Birthing People," aims to decrease the impact of systemic racism as a source of our national Black maternity care crisis. Dr. Crista Johnson-Agbakwu, of UMass Memorial Health, leads a team that includes Dr. Cherise Hamblin. This team notes that non-Hispanic Black birthing patients suffer the worst mortality among any racial group in the United States, with 69 deaths per 100,000 live births.[1] They propose a change in culture and practice and are preparing to launch a study with two variables: implementing anti-racism training at the systemic level, as well as employing doula care to help support Black birthing persons at the individual level.

Anti-racism training is designed not to blind us to color differences, but to help us see the root causes of inequity and look for solutions to a system that may subtly reinforce substandard care for one group of patients. This can and should happen at many levels, including the individual, interpersonal, systemic, community, and organizational levels.[2] Doula support during pregnancy and labor has already been shown to result in fewer cesarean deliveries and higher birth weights, increase rates of breast feeding, and improve the health of the mother.[3]

This study will have a qualitative component to characterize usual care received by Black patients, as well as a comparative effectiveness component to determine morbidity outcomes achieved by the above interventions. With plans to study implementation at four sites in Massachusetts as well as here in Lancaster at Women & Babies Hospital, the researchers will recruit 600 patients; the total sample will be 3,000 birthing mothers, and Dr. Robert Faizon will be the local principal investigator.

Finally, a third study aims to decrease morbidity and cesarean deliveries associated with prolonged and failed labor induction. Penn Medicine's Dr. Rebecca Hamm will head a quality improvement team that has developed a cesarean risk calculator for patients undergoing labor induction.

While we already know that across medicine increasing objectivity and standardizing decision-making

limit the effects of bias, the team hopes that use of their calculator will decrease disparities specifically associated with labors that are actively initiated. Nationally, more than 20% of birthing patients undergo labor induction; at Women & Babies Hospital, during both fiscal years 2023 and 2024, the rate was 33%. What's more, as many as a third of these inductions end in cesarean delivery nationally; at our institution it's 20%. These surgical deliveries can result in an increased risk of morbidities such as hemorrhage and surgical site infection.

The cesarean risk calculator requires data on height, body mass index, parity, gestational age, and cervical exam at the start of induction. Development of this risk predictor has already yielded encouraging outcomes: in a single-site prospective cohort study of 1,600 patients, use of the calculator was associated with a 6% absolute risk reduction in maternal morbidity and an 8% absolute risk reduction in cesarean delivery.[4] Further, it has been shown to reduce disparities in dissatisfaction with induction that otherwise correlate with race.[5]

In a stepped-wedge randomized roll-out trial to determine obstetric outcomes overall and specifically among patients who are Black, indigenous, and other people of color, the study team will oversee implementation at 14 labor and delivery sites, with the goal of developing and studying tailored implementation plans. The long-term hope is to implement at a national scale, consistent with a goal of the National Institute of Child Health and Human Development's "Implementing a Maternal health and PRegnancy Outcomes Vision for Everyone (IMPROVE)" initiative.[6]

We wish these researchers success in conducting their trials and look forward to reporting on what societal changes may be born of these groundbreaking endeavors.

REFERENCES

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Letter to the Editor

To the Editor:

I am a retired family doctor in Harrisburg, and I have been reading *JLGH* for six to eight years. Even though I'm retired for four years, the journal maintains my interest because the articles are so practical.

I think it should be required reading for all the residents at UPMC and CGOH hospitals.

Regarding the lead article on clinical inertia [vol. 19, no. 1], I've witnessed this problem in colleagues. I think the solution is regular peer review and feedback, as suggested in the article. Keep up the good work!

– Robert Little, MD

Response from the editor in chief:

I was pleased to receive Dr. Little's letter and kind words. CGOH is now named UPMC Community Osteopathic. We have reached out to UPMC Lititz and UPMC Central PA with complimentary copies of JLGH *for their internal medicine and family medicine residency programs.*

Thank you, Dr. Little, for your suggestion to better spread the word about the good work being done here in Lancaster.

– Corey Fogleman, MD

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