AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime®

# POSITION STATEMENT

## Racism and Racial Bias

The American College of Nurse-Midwives (ACNM) is committed to eliminating racism and racial bias in the midwifery profession and race-based disparities in reproductive health care.

ACNM's position is that midwives must

- Understand the history and current manifestations of racism and white supremacy in medicine, midwifery, and reproductive health care.
- Recognize and address the structural forces that perpetuate racism and race-based disparities in health care.
- Engage in lifelong introspection and self-development to identify and address their own implicit bias, internalized racism, and potential to perpetuate racism.
- Provide nonjudgmental, culturally sensitive care to all people and work simultaneously to identify and implement ways to reduce the effect of racism on the health outcomes for their patients of color.

ACNM is committed to

- Increasing the racial and ethnic diversity within the profession with the aim that ACNM members will reflect the racial diversity of the populations they serve.
- Identifying and supporting midwives of color to develop and achieve leadership positions at all levels throughout ACNM.
- Including strategies to address racism and race-based disparities in subsequent revisions of the Core Competencies for Basic Midwifery Practice.[1]
- Including robust content on racism and race-based disparities at all events and in documents and communications.
- Working with the Accreditation Commission for Midwifery Education to incorporate and regularly update content on racism and race-based disparities into midwifery education programs.
- Working with the American Midwifery Certification Board to develop continuing competency assessment modules to ensure that midwives do not reinforce negative biases and racial stereotypes that harm patients.

- Providing continuing education on racism, its relationship to health disparities, and strategies for midwives and midwifery services to address racism in themselves and in their communities.
- Evaluating the challenges and successes related to these commitments and reporting on these biannually at the ACNM Annual Meeting.

**BACKGROUND**

A health disparity is defined as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health."[2] The persistent and pervasive race-based disparities that currently exist in maternal child health are unconscionable and unacceptable. Often cited examples include disparities in rates of maternal and infant mortality. African American women are more than 3 times[3] and American Indian/Alaskan Native women are more than 1.5 times as likely to die in childbirth as white women in the United States.[4] The African American infant mortality rate is 2 times that of white infants,[4] and the American Indian/Alaskan Native infant mortality is 1.5 times that of white infants.[5]

Racism is the root cause of the social, economic, and environmental disadvantages that result in race-based health disparities.[6] Race is a social construct that does not describe genetic or biological differences in human beings.[6,7] Therefore, race-based disparities are not the result of intrinsic differences between people from different racial categories. Racism is the system of interlocking factors perpetrated intentionally and unconsciously by individuals and institutions that maintain the power and privilege of white people to the detriment of people of color.

To understand racism and race in relation to health disparities, one must understand American history. The establishment of British and French colonies in the early United States was based on a system of violence, oppression, and subjugation.[6] The concept of a superior white race was used to justify the genocide and displacement of indigenous peoples and the capture and enslavement of African peoples.[6] In the 19$^{th}$ century, legal categories to define different races were developed and pseudosciences, such as phrenology, were used to support the idea that there were inherent biological and hierarchical differences between the races.[6,8] Indeed, many of the stereotypes that were prevalent during that period, which portrayed people of color as lazy, stupid, lacking in direction, and responsible for their plight, persist in society today.

Native and African Americans have been victims of racism the longest, but Latinx and Asian Americans also faced discrimination as the United States expanded west. African Americans gained citizenship under the 14$^{th}$ Amendment in 1868, however Native Americans were excluded from citizenship until 1924. Displacement, Jim Crow laws, Black Codes, and legalized housing and job discrimination policies and laws were subsequently instituted against African Americans. Internment of Native Americans on reservations and immigration acts to exclude and restrict the

ability of Asian Americans to own businesses and become citizens contributed to the establishment of societal norms that continue to this day to segregate, subjugate, and impoverish people of color.[9]

While legalized racial discrimination has been outlawed, structural, institutional, and individual racial bias persists and limits the health, welfare, and opportunity for people of color in the United States. Structural racism refers to "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources."[6] Structural racism can be seen in residential racial segregation, which persist well after the end of the legalized segregation. Residential segregation limits access to the resources necessary for overall well-being: quality education (including access to higher education), employment, housing, health care, and the ability to acquire wealth. Thus, the zip code in which one lives is an analog for race, ethnicity, poverty, and health disparities.[10,11] While significant gains have been made by people of color, the effects of structural, institutional, and interpersonal racism continue to significantly restrict their health and well-being.[6] Without deliberate and intentional correction of the systems in place, people of color are more likely to live in poverty and in communities with inadequate resources and services, including health care.

Midwives can contribute to the dismantling of structural racism by recognizing and addressing racism in themselves and in their institutions. Research indicates that provider bias is implicated in disparities in health care[12-14] and that providers treat patients of color differently than white patients.[15-18] Evidence also shows that greater racial diversity in the health care workforce improves access to care and the quality of care people of color receive and is an important intervention to reduce racial health disparities.[19] However, for the past 4 decades, membership of ACNM has remained racially homogenous at more than 94% white.[20,21] Midwifery research shows that racism is common in midwifery education, clinical practice, and professional organizations and that racism acts as a barrier to people of color completing midwifery education programs and fully participating in midwifery professional organizations.[22] It is our duty as midwives to address racism in ourselves and our organization by following the steps above so that we can better address health disparities.

**REFERENCES**


1. American College of Nurse-Midwives. Core competencies of basic midwifery practice. http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000050/Core%20Comptencies%20Dec%202012.pdf. Approved December 2012. Accessed April 6, 2018.

2. U.S. Department of Health and Human Services. Disparities. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities. Updated April 5, 2018. Accessed April 5, 2018.
3. Centers for Disease Control and Prevention. Pregnancy Mortality Surveillance System. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html. Updated November 9, 2017. Accessed April 6, 2018.
4. MacDorman MF. Race and ethnic disparities in fetal mortality, preterm birth, and infant mortality in the United States: an overview. *Semin Perinatol*. 2011;35(4):200-208. doi:10.1053/j.semperi.2011.02.017.
5. March of Dimes. Fact sheet: racial and ethnic disparities in birth outcomes. https://www.marchofdimes.org/March-of-Dimes-Racial-and-Ethnic-Disparities_feb-27-2015.pdf. Accessed April 6, 2018.
6. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *Lancet.* 2017;389(10077):1453-1463. doi: 10.1016/S0140-6736(17)30569-X
7. Mukhopadhyay CC, Henze R, Moses YT. *How Real is Race? A Sourcebook on Race, Culture, and Biology.* 2nd ed. Lanham, MD: Rowman & Littlefield; 2013.
8. Lyons SL. *Species, Serpents, Spirits, and Skulls: Science at the Margins in the Victorian Age.* Albany, NY: State University of New York Press; 2009.
9. Haney López I. *White by Law: The Legal Construction of Race.* Albany, NY: New York University Press; 2006.
10. Summer LH, Balls E. Report of the Commission on Inclusive Prosperity. https://www.americanprogress.org/issues/economy/reports/2015/01/15/104266/report-of-the-commission-on-inclusive-prosperity/. Published January 15, 2015. Accessed April 6, 2018.
11. Iton A. Tackling health inequities through public health practice: a handbook for action. http://msue.anr.msu.edu/uploads/files/Health%20and%20Nutrition/naccho_handbook_hyperlinks_000.pdf#page=115. Published 2006. Accessed April 6, 2018.
12. Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. *Am J Public Health.* 2015;105(12):e60-e76. doi: 10.2105/AJPH.2015.302903.
13. Loftman PO. Racial And Ethnic Disparities In Birth Outcomes: The Challenge To Midwifery. Best Practices In Midwifery.2nd Ed. New York, NY. Springer Publishing Company; 2017.
14. Maina IW, Belton TD, Ginzberg S, Singh A, Johnson T J. A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. *Soc Sci Med.* 2018;199:219-229. doi: 10.1016/j.socscimed.2017.05.009.
15. Thorburn S, Bogart LM. African American women and family planning services: perceptions of discrimination. *Women Health.* 2005;42(1):23-39.

16. Gomez AM, Wapman M. Under (implicit) pressure: young Black and Latina women's perceptions of contraceptive care. *Contraception.* 2017;96(4):221-226. doi: 10.1016/j.contraception.2017.07.007.
17. Calabrese SK, Earnshaw VA, Underhill K, Hansen NB, Dovidio JF.The impact of patient race on clinical decisions related to prescribing HIV pre-exposure prophylaxis (PrEP): assumptions about sexual risk compensation and implications for access. *AIDS Behav.* 201418(2):226-240. doi: 10.1007/s10461-013-0675-x.
18. Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med.* 1999;340(8):618-626.
19. U. S. Department of Health and Human Services. The rationale for diversity in the health professions: a review of the evidence. http://bhpr.hrsa.gov/healthworkforce/reports/diversity reviewevidence.pdf . Published October 2006. Accessed April 6, 2018.
20. Schuiling KD, Sipe TA, Fullerton J. Findings from the analysis of the American College of Nurse-Midwives' membership surveys: 2009 to 2011. *J Midwifery Womens Health.* 2013;58(4):404-415. doi:10.1111/jmwh.12064.
21. Fullerton J, Sipe TA, Hastings-Tolsma M, et al. The midwifery work- force: ACNM 2012 and AMCB 2013 core data. *J Midwifery Womens Health*. 2015;60(6):751-761. doi:10.1111/jmwh.12405.
22. Wren Serbin J, Donnelly E. The impact of racism and midwifery's lack of racial diversity: a literature review. *J Midwifery Womens Health.* 201661(6):694-706. doi: 10.1111/jmwh.12572.

Source: Midwives of Color Committee and Clinical Standards and Documents
Approved: Board of Directors, May 2018.