Between Scylla and Charybdis; Pathologising normality and normalising pathology for Black and brown women in maternity care. And how relational midwifery might be the way through.

1) Pathologisation

Most research on midwife-led care and birthplace choice takes as a starting point those women already classified as 'low risk'. Despite the well-documented benefits of midwife-led care [1–5] increasing numbers of women are classified as high risk, with the consequent obstetric-led care pathway, especially in labour and birth. However, the mechanisms of this classification into low and high risk merit some scrutiny, as data suggests this disproportionally effects Black and brown women and leads to higher rates of intervention in that population [6–9]. I contest the mechanisms for this include; The white body as the 'norm' leading to both under- and over- diagnosis, social determinates of health, mis-use of race-based risk algorithms and falsely locating the cause of poorer outcomes in physiology rather than in social determinates.

The question of risk, pathology and ethnicity must be careful to neither pathologise normality, nor to normalise pathology. The arbitrator of the line between the normal and the pathological is itself a political issue and varies over time, by country and even by maternity care provider. Discussing the US context, Niles *et al.* (2021) emphasise the problem of the authority of the medico-legal regulatory environment to define low and high risk and therefore to place midwifery care within certain boundaries and terms; reifying itself as arbitrator. The risk discourse then clashes with the midwifery drive to humanise and individualise care as evidenced in the UK in research into the tension between hospital guidelines and women's choice [11–13].

Defining the 'norm'

The Caucasian (male) body as the norm has long been noted by black feminists [14–17] and even the human genome project is replicating this global bias [18]. Firstly, this can lead to underdiagnosis such as not recognising jaundice in black neonates [19] or false readings on pulse oximeters [20]. Recent strides have been made to rectify this such as the 'Mind the Gap' project [21]. Significantly in maternity care is the tragic litany of underdiagnosis due to racialised women not being listened to or taken seriously [22].

Secondly, the 'norm' as the standard of low risk may also inadvertently discriminate against the 'other'. For example, normal, or common, BMI levels for childbearing women vary by ethnicity [23]. If the norm for Caucasian males is the standard for defining 'low risk', there will be black women who fall outside this category. This may categorise Black or brown women as 'high risk' or 'outside of normal range' at a disproportionate rate. Orthodox Jewish women in the UK have on average over six children, meaning the guidelines used by most care providers around parity classify many of their births as 'high risk'. This may unfairly discriminate against them, if in fact their outcomes are not

significantly worse for their fourth and subsequent pregnancies [24]. Where more detailed research has been done into ethnicity as a risk factor for type 2 diabetes, ethnic specific calculations and different cut-off points were recommended, challenging the idea of one standard measure [25].

However, what is usual is not necessarily non-pathological. For example, regarding BMI, it may be the case that a dipropionate rate of women from any specified ethnic group maybe be over or under weight as defined by what is health for them. There are normal but unhealthy high BMIs in children in the US [26], or low haemoglobin levels amongst some women who suffer long term poverty exacerbated by gender inequality [27] , or in fact the caesarean section rates of over 40% in some areas which are increasingly common but not necessarily desirable or healthy. In the US the use of a race-based algorithm for diagnosis of kidney disease may have led to late diagnosis in members of the Black population, leading to subsequent worse long-term outcomes or even higher morbidity rates [28,29].

Social determinates of health

The long-term impact of the social and economic inequalities that disproportionately effect Black and brown communities undoubtably cause higher rates of medical, social and obstetric risk factors [30,31]. Add to this the well documented racism and racial bias of care givers, and higher rates of pathophysiology follow [32–35]. Given generational structural racism there is often difficulty separating the causes of any observed medical differences; whether they are caused by innate physiological difference, or by the social determinates both in daily life, and in medical care. The Black woman screened for gestational diabetes based on ethnicity, found positive, offered and accepted an induction of labour, resulting in an emergency caesarean and subsequent breastfeeding difficulties and a UTI, may have many complex factors of an interplay of social and physiological determinates as well as care-giver bias. The work done by March of Dimes on pre-term birth and racial disparity the US [36] is an impressive attempt to map and analyse upstream and downstream factors of social determinants of health and racism.

Confusing poor outcomes with pathology of the black body

Where outcomes are demarcated by ethnicity, is usually the social determinates not the physiology that makes the difference. Medical anthropologists Gravlee and Sweet (2008) claim that using race and ethnicity in biomedicine lacks a rationale, obfuscate the social determinants and "*reinforces the insidious assumption that racial inequalities stem from innate, immutable differences between racially defined groups." (p40).* The point is to emphasise not race, but rather racism, with it's long and short term effects. Kane et al [38], in their examination of the choice for vaginal birth after caesarean without race-based algorithm risk assessments, advocate for full discussions of values and preferences, including the "*context of the effects of structural racism on their bodies, environments, and hospital care*".

Extrapolating beyond evidenced physiological differences risks seeing ethnicity or race as a risk factor in itself. We can attribute genetics to melatonin levels in skin, or possibly the genetic propensity for South Asian women to develop gestational diabetes [39]. But beyond any direct

physiological causality, we must not confuse poor outcomes with inherent risk and fall into the trap of pathologising Black- or brown-ness itself. The example of NICE suggesting that all black women be offered induction of labour at 38 weeks due to being Black being seen as a risk factor was a stark example of this [40]. Viewing it this way risks looking at race and poor outcomes from the wrong end of the telescope and seeing blackness as the cause, rather than racism as the cause; via social determinates such as poverty, weathering or care-giver racism and bias.

Erroneous use of race risk algorithms

Trying to use ethnicity to calculate 'risk' depends on whether there are significant biological differences or specific physical attributes that are common in some ethnic groups, and vary more from group to group than within the group. Despite discussions around for example differences in pelvic shape [41], propensity for perennial trauma [42] or effectiveness of different blood pressure medication [43] there is no conclusive evidence of race or ethnicity as a significant factor. Tong and Artiga (2021) state "*The use of race to inform clinical diagnoses and decision making may reinforce disproven notions of race as a biological construct and contribute to ongoing racial disparities in health and health care*."

Kane et al [38] make a strong case that routine use of race in a risk calculator for vaginal birth after caesarean in the US actually leads to iatrogenic harm and undermines both the woman, and the woman's relationship with her health care providers. The result of the race score raising the risk factor was more Black women having a caesarean birth, with its associated higher rates of maternal morbidity. They conclude that regardless of whether the race-as-a-risk-factor is claim about physiology or an acknowledgement of the social determinants of health, the resultant higher scores for 'risk', i.e. the pathologisation, leads to high intervention and iatrogenic harm.

2) Midwifery practice; reducing pathologisation and promoting relationality

I suggest that moving away from pathologisation (avoiding too much, too soon) and also ensuring we don't do 'too little too late'[45] we might achieve more egalitarian, women-centred care by; acknowledging the benefits of midwifery-led care for women with intermediate risk factors, confronting racism and the social determinants of health, and promoting community-based women-centred midwifery practice.

Intermediate risk factors

For Black and brown women with physiology outside of the 'norm', access to midwife led care can still be facilitated and likely beneficial, regardless of the exact cause or origin of the condition (social or physiological). Reducing the emphasis on automatically promoting an obstetric pathway for all women with intermediate risk factor may lead to improved outcomes. Secondary analysis from the Birthplace Study showed that women with intermediate risk factors had better maternal outcomes if they had home births, compared to an obstetric unit. They showed comparative neonatal outcomes and (albeit worse than women with no risk factors with the same other variables). [46,47]. There was

insufficient data to analyse outcomes of women with intermediate risk factors using midwife led units. A freestanding midwifery unit with a robust but accessible process for women with intermediate risk factors using the service showed excellent results. Women with a BMI over 35, women having a vaginal birth after caesarean, women with twins or diabetes, all showed excellent outcomes and high maternal satisfaction [48]. This midwifery unit served an area with a large south Asian population. Many of the women had haemoglobin levels below the set minimum level of 105, although it is unclear as to whether this is related to normal physiology for that ethnicity, or to the documented levels of poverty and sex inequality within those communities leading to the women being malnourished. However, a one-year trial lowed the minimum haemoglobin level to access the unit from 105 to 90. There was no increase in women needing post-natal blood transfusions, leading to a permanent threshold of 90 [49].

Acknowledging racism, not race.

Looking at midwifery care for Black and brown women, acknowledgement of the structural factors must not be a demoralising, but rather a galvanising force for change. MacLellan *et al.* (2022) point out that when commissioners and care providers feel the cognitive dissidence of knowing they are offing a rushed and substandard service, 'othering' can help them cope with that. "*This 'othering' creates and sustains inequalities, such that unequal health outcomes are understood simply as a reflection of wider structural conditions, in the context of resource constraints, and easily accepted as the norm."* (page 2186). However, what we are challenged to do is to work on a multi-agency level, in an overtly anti-racist way, engaging with government, non-governmental and community organisations to address issue of inequality and social justice.

Relationality in the midwifery model of care

Where Kane *et al.* (2022) and Hernandez-Boussard *et al.* (2023) recognise that individualised care would be an improvement to race-based risk algorithms, within the midwifery model of care a deeper level of relationality is possible. Community-based midwifery practice with an emphasis on relationality may offer a counterbalance to pathologisation. This allows for midwifery to be a restorative force; engaging with pluralistic, heuristic knowledge, community power, and webs of social care and support. "*Being "with woman," … cannot be a prescription and obtains meaning only when organically arising from a reciprocally meaningful relationship*" state Rocca-Ihenacho, Yuill and McCourt (2021, page 110).

The UK's Nation Health Service (NHS) offers high quality care, free at the point of use which is undoubtably a crucial element of equal care for all. However, as part of the medico-industrial model it is also influenced by its historical place in patriarchal medicine, colonial and imperialist history, and on-going structural inequalities and structural racism [32–35]. The very idea of racial categorisation stems from a racist colonial ideology [52]. This plays a role in the negative experience of many Black and brown women being cared for in obstetric-dominated mainstream settings [22,53,54]. Despite midwifery's claim to be a woman-centred profession, Black and brown women's experiences reveal there being at times only lip-service to a genuine women-centred midwifery model of care. The Black pregnant or birthing woman is the canary in the coalmine that reveals the flaws in the system;

a genuine women-centred model would meet each woman where she is at, not only those with enough social capital to navigate system.

Acknowledging the inherently social and cultural nature of birth, there is a disconnect in basing them within large hospitals with their medico-industrial culture, and racial historical and ideological specificities, rather than in the grassroots community health provision of their origin [10,55,56]. Midwifery care rooted in communities both geographically and culturally, may increase access to midwifery care across the board, bridge the gap between the NHS behemoth and the women it is trying to serve. This would allow a chance for a genuine women-centred midwifery model of care, so elusive when trying to achieve this within the confines of the dominant medical model. To recentre midwifery in the communities of women; a midwifery service arising out of, and an interregnal part of, the communities' birth culture and social meaning of birth [55] could be a powerful force. At best it would have the potential of redressing the history of intersectional oppression of sex, race and class still impacting NHS midwifery.

Developing an NHS freestanding midwifery unit in an area with a high rate of south Asian women, the team carried out weekly outreach visits for six months before inviting those women to the trust premises to outline and discuss plans for the new FMU [49]. In developing the space they emphasised the importance of a joint area for families and staff and the importance of 'breaking bread' together [57,58], something also mentioned by Rocca-Ihenacho, Yuill and McCourt (2021) reviewing a freestanding midwifery unit. It takes a village to raise a child, and so it takes a village to integrate a women-centred relational midwifery service. And it is in those midwifery relationships within and as part of communities of Black and brown women that we could begin to steer a path between Scylla and Charybdis.