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Healthcare professionals: a significant variable?

COMMENTARY

PATJI ALNÆS-KATJAVIVI

palnaesk@hotmail.com
Patji Alnæs-Katjavivi, senior consultant in the Department of Obstetrics and Gynaecology, Oslo University Hospital, Ullevål.
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The study by Ottesen et al. demonstrates significant differences in the risk of Caesarean section in Norway for mothers born in a low- and middle-income country, particularly those born in Sub-Saharan Africa. The risk of emergency Caesarean section is higher than for mothers born in Norway, and the risk of planned Caesarean section is lower compared to mothers born in Norway. The risk of planned Caesarean section, but not of emergency Caesarean section, becomes comparable for those mothers from low- and middle-income countries who have completed higher education (1). It might have been interesting to know if differences in the observed Caesarean section rates were associated with possible differences in induction rates according to maternal birthplace (Norway vs. low- and middle-income countries). However, categorising the mothers into Robson groups might have reduced the statistical power of the study's calculations.

It would have been interesting to have information about the specific indication for the Caesarean section set by the gynaecologist, where objectivity is called for. Either the objective criteria for planned Caesarean sections are met less often in women born in low- and middle-income countries, and twice as often for emergency Caesarean sections, or some form of discriminatory treatment is occurring in encounters between healthcare professionals and these mothers. The authors conclude that the differences 'cannot solely be explained by medical factors'. The study lacks information on various non-medical factors, though patient-centred factors are suggested.

In addition to the risk of Caesarean section, recent Norwegian registry studies have pointed to a clear association between immigrant status and worse neonatal outcomes (2), increased odds of anal sphincter injury and lower odds

of the use of epidural analgesia during labour (3).

One common element in these studies, which has not been focussed on enough, is how our mistakes or shortcomings as healthcare professionals – in interactions with mothers from low- and middle-income countries – may contribute to disparities in the medical outcomes currently reported.

Although we intend that our patients should receive the best treatment we can offer, we know that, just like everyone else, we are affected by implicit bias in our interpersonal interactions. Does our bias influence the patient treatment we provide? Probably all the time, in a way that is not necessarily clinically significant or easy to measure. Healthcare professionals do not have more or less implicit bias than the general population (4).

A study in the UK has documented clear and sustained differences in maternal death (there is no harder endpoint) based on patient ethnicity, which highlights differences in patient treatment based on ethnicity (5).

A recently published study comparing maternal mortality between eight European countries found that maternal mortality was 50 % higher among mothers with minoritised or migrant ethnic background, except in Norway (6).

Although Norway is 'top of the class', we should examine whether implicit bias is contributing to the differences found in Norwegian registry studies. Interactions between patients and healthcare professionals are the key to good health. Awareness of our own blind spots will enhance the quality of our encounters with patients.

REFERENCES

1. Ottesen HS, Sørbye IK, Lindskog BV et al. Keisersnitt blant utenlandsfødte kvinner med ulike utdanningsnivåer. Tidsskr Nor Legeforen 2022; 142. doi: 10.4045/tidsskr.22.0256. [CrossRef]

2. Vik ES, Nilsen RM, Aasheim V et al. Country of first birth and neonatal outcomes in migrant and Norwegian-born parous women in Norway: a population-based study. BMC Health Serv Res 2020; 20: 540. [PubMed] [CrossRef]

3. Waldum ÅH, Jacobsen AF, Lukasse M et al. The provision of epidural analgesia during labor according to maternal birthplace: a Norwegian register study. BMC Pregnancy Childbirth 2020; 20: 321. [PubMed][CrossRef]

4. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics 2017; 18: 19. [PubMed][CrossRef]

5. Knight M, Bunch K, Vousden N et al. A national cohort study and confidential enquiry to investigate ethnic disparities in maternal mortality. EClinicalMedicine 2021; 43: 101237. [PubMed][CrossRef]

6. Diguisto C, Saucedo M, Kallianidis A et al. Maternal mortality in eight European countries with enhanced surveillance systems: descriptive population based study. BMJ 2022; 379: e070621. [PubMed][CrossRef]

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