Welcome To Aim For SaferBirth. I'm Christy Allen.

And I'm Veronica Gillespie-Bell. On This Podcast, We Dive Deeper Into The Rising Severe Maternal Morbidity And Maternal Mortality Rates In The United States Through A data-driven Quality Improvement Lens.

And In This Episode, We're Talking About Sort Of The Integration Of Equity With Quality. Why Are We Talking About These Things Together? We've Touched On That In Other Episodes. But I Think This Is An Opportunity For Us To Talk About The Evolution Of That Work, Both In Our Own Experiences And Programatically. I'll Start By Talking About The AEM Program's Evolution. So The AEM Program Came About, For Those That Don't Know, In 2014. It Is A Cooperative Agreement. It's Funded By The Federal Government, HRSA, The Health Resources And Services Administration, And Their Maternal Child Health Bureau. ACOG, The American College Of OBIGNs, Is Funded To Do This Work. And Early On In AEM, I Was Not Involved, But Major Credit To The Founders. They Recognized A Need To Really Address Racial And Ethnic Disparities In Particular. I Am So Impressed By This Innovation Because At The Time It Was Around 2015. We Weren't Talking About This In The Way We Are Now, Not As A Culture, Not In Health Care. And I Don't Know That We Had The Recognition Of The Maternal Mortality And Maternal Morbidity Disparities That Are Resulting From Inequities. So In That Frame And Time Work, Experts Were Brought Together And Made An AEM Bundle That Is Called The Racial And Ethnic Disparities Bundle. That Is A Wonderful First Step. And I Think That As The Program Has Grown And Evolved, We've Moved From 13 States To 49 In The District Of Columbia. We Have Over 1900 Engaged Facilities, Hospitals, Health Systems And Birthing Centers. We've Recognized The Need As Culture Has Shifted And As We've Recognized More And More Deeply The Disparities That Impact The Patients We Work With, The Need To Integrate Quality. So That Bundle, While Innovative For Its Time, Has Really Evolved Into A Resource That Is Well Integrated Into All Of Our Inpatient Safety Bundles. As I Think You're Aware, We Went Ahead And Revised Those Bundles Both For Clinical Accuracy And With Additions Over The Last About Year Or Two. It's A Slow Process. We Want To Do It Right, Not Fast. The Bundles, The Inpatient Safety Bundles, Were Built Around That For Our Framework. So Readiness, Recognition, Response, Reporting And Systems Learning. And We Recognize That We're Missing An R, That Respectful Care Was Not A Thing That Was Integrated. So Respectful, Equitable And Supportive Care Was Added To The Bundles. But I Think That The Kicker That I Feel Like Is Most Important To Recognize Is Quality And Equity. Equity Is Not An add-on. It Has To Be Woven Into All Of The Work That We Do. And I Think That As We Move Forward In The Space, It Isn't Just That We Added A Fifth R, Which Is The Fast And Easy Way To Say This. Each Of The Rs Has Concepts Of Equity Really Integrated Into Those Steps. So It Might Be That Patient Education Is To The Appropriate Literacy Level In The Language That That Patient Prefers To Receive Education In, That It Is Trauma Informed. We Move To Using More Gender Inclusive Language. We Recognize That Not Everyone That Gives Birth Identifies As A Woman, Uses She/Her Pronouns, And Has Their Own Identities That We Can't Always Even Be Aware Of. So We Wanted To Make It Language That Actually Met The Needs Of All Of The Patients That We Were Working On. So That Was A Lot Of Talking. But That's Sort Of The Journey That I've Been Able To Witness. And I Know It Happens Differently On The Ground. And I Know It Also Happens Differently At The State Or Regional Level, Like With An AIM Team And A PQC, A Perinatal Quality Collaborative. What's Your Experience, Ben?

So We Similarly Have Had An Evolution. We Have Evolved Ourselves As Individuals In Understanding Equity And How It Works Into Quality Improvement As A Part Of Quality Improvement, But Just How We Take This Journey With Our Teams As Well. When We Started, As I Mentioned, The Decision Was Made To Include Equity Into Our Aims, Into Our Goals. And At That Time I Was Faculty For The PQC, I Was Not The Medical Director, So I Cannot Take Credit For Making That Final Decision Because That Decision Was Met With A Lot Of Resistance. And Even Though We Made The Decision To Include Equity Into Our Quality Improvement, I Don't Know That We Really, Really Integrated It In, Definitely Not The Way We're Integrating It In Now. We Started With Awareness Of Implicit Bias And Having Our Team Members Take The Implicit Association Tests And Then Talk About Again, What Bias Is And Some Of The Things That We Know That Are Effective In Changing Bias, But We Didn't Have That Practical Part To Then Once You Learn That And You Start Thinking About Skills To Undo Your Biases, How You Put That Into Practice. And So That Has Been An Evolution For Us. And I Would Say That's Been Over Probably A Year, Two Year Timeframe Of, Okay, Now We Realize We Have Biases, What Do We Do About Them? And So It's Been First Very
Internal Work In The Hospitals And Doing Things Like Having An Equity Pause During Debriefs And Thinking About How You Make The Culture So That It's More Inclusive, Which Is I Think Is Very, Very Important For Sustaining Diversity As Well. And So We've Now Evolved From More Of What Do We Do Internally To How Do We Partner With Our External Partners? And Really, I Shouldn't Say External Partners, Really How We Partner With Our Patients And They're Really Not External Partners. They're Really, This Is Who We're Doing This For, This Is Who We Need To Do This With. And So We Focused On Having Patient Partners As Part Of Our Quality Improvement Team To Make Sure That When We Are Doing Our Improvement And We're Doing The Implementation Of Our Practices, That We're Doing It In An Equitable Way. You Can't Know What You Need To Do For Patients If You Don't Have Patients At The Table. We Know What We Need To Do From A Quality Improvement Standpoint As Far As The evidence-based Practices, How We Go About Doing Those Things. We Need To Have Our Patients At The Table. I Mean, It's Been Really, Really Interesting And Really Great To See Our Hospital Teams On The Ground. And Also For Us As A PQC, Having Patient Partners As Part Of Each Of Our Initiatives, Which Was Not Something That We Really Did Before. We Had Different community-based Organizations, But It's Still Very Different Than Having A Patient Partner That Has Lived Expertise. I Am Changing My Language From Lived Experience To Lived Expertise, Because I Got A Lesson Yesterday, But Having That Patient With Lived Expertise To Help Guide The Work. I Really Feel Like That's Taken Our Equity Journey Even Further, But It's Been An Evolution. I See In My Head Right Now, The Multiple, As We Referred To In Another Episode, I See The Multiple PDSAs For Even Our Journey Towards Equity And That Ramp Up. And It's Been Just Very Interesting To See.

Christie - 00:07:09:

I Hear A Couple Of Points In There. I'd Love To Kind Of Circle Back On And Touch On. I Wanna Start With Kind Of What You Were Saying Towards The End About Patient Partners And About Lived Expertise. That's A Mental Shift For A Lot Of Us In Healthcare. The Patient Comes To Us, We Provide Them With Care, Right? So When We Talk About Expertise, What Is That Expertise You're Describing? Because They Don't Know About Hemorrhage, They Don't Know About Hypertension, They Might Not Know About Sepsis. What Is Their Expertise As You Describe It?

Veronica - 00:07:38:

Yeah, The Patient May Not Know The evidence-based Practices Around The Medical Complications Or Around The Medical Conditions, But They Know How They Would Like To Receive Care. They Know When They're Not Listened To, They Know How They Want To Be Engaged In decision-making. And So That's The Expertise That The Patients Bring. Again, You Cannot Design Something For Patients Without Having Patients At The Table. It's Just So Important To Have That Voice And Again, When We Talked About In The Previous Episode Around Diversity, It Doesn't Just Mean Diversity Around Race, Around Ethnicity, But When We're Talking About Quality Improvement, It's Also Diversity Around Skill And Around Different Education Levels Because That Diverse Opinion Or That Diverse Expertise Is Going To Give You A Perspective That You Had Not Considered. You Know, For Me, My Lens Is OB-GYN That's Been In Practice For 15 Years. I May Not Be Able To Deliver A Message Or I May Think I Am Delivering A Message To My Patient In A Way That They... Understand That They're Going To Be. Adherent To Care, Even Though I Don't Like That Term, But What The Output Is For Me Is Very Different Sometimes From The Input That's Coming From The Patient. And I Only Know That If I Include My Patient In That Quality Improvement.

Christie - 00:09:00:

That Makes A Lot Of Sense. It's The Expertise On Their Own Experience And Their Own Body, Right? I Certainly Wanna Be Treated That Way In Care. And I Think That Providing Care That Way Is Incredibly Important. I've Heard Patients Say, Well, You're The Expert. I Think Sometimes It's Reminding Us Both That We Have Shared Expertise. Also, You know, The Expertise Piece Is Complicated And Experiences Come Fast In OB. We Have Talked About Together In The Past About High Risk, Low Risk In Pregnancy. We Don't Wanna Treat Everyone Like They're, And I'm Making Air Quotes Because We Don't Have Real Definitions Of What Is Low Risk, High Risk. We Have Some That We Try, But Again, You Can't Apply That Lens To Every Patient And Things Change. You Can Have A Low Risk Patient That Suddenly Is High Risk. You Can Have A Higher Risk Patient That Is More Stable And Becomes Lower Risk. But I Think It's Helping The Patient Understand Where They Are Maybe On That Spectrum Without Maybe Using Those Concerning Terms. And Also The Concept Of Shared decision-making. We Talk About Shared decision-making A Lot And I Have Heard It For Over 20 Years. And I Always Understood It As, You know, The Doctor Gives You All Your Options And Then You Guys Move Forward. And Yes, But Also I Actually Had A Colleague Say To Me, Well, I Don't Want Shared decision-making In My Reproductive Health. And I Was Like, Come Again, Please Explain What You Mean. And She Said, I Don't Want Them Making Any Part Of That Decision. I Want Them To Inform My Decision. And Ultimately That Is An Uncomfortable Place To Be. I Can't Speak On Behalf Of OB-GYNs, But You
Train For Many, Many Years. You Devote A Big Part Of Your Life To Becoming Experts. It's Sometimes Hard To Share That Expertise, I Think.

Veronica - 00:10:48:

It's Very Hard. We Have All Been Trained In A Very Paternalistic Way Of I Have The Answers, I Will Give You Information, But Ultimately I Have All The Expertise, So I'm Gonna Make The Decision. It Really Is How We Have Been Trained. And So It Is A Shift In Our Thinking And A Shift In Our Culture In The Healthcare System To Somewhat Give The Patients The Power. And For Me, I Think... For Whatever Reason, Maybe Part Of My Reasons For Choosing To Go Into OB-GYN, I Think I Kind Of Always Practice That Way. I Commonly, As I Treat Patients With Fibroids. Commonly Have Patients Say, Well, What's The Best Choice? What's The Best Answer? And I Tell Them There Is A Best Answer, But There's A Best Answer For You And Only You Can Tell Me That. And So It Really Is A Process Of Us Understanding As Providers And Listening To, No Matter What Medical Condition We're Talking About, What Are Your Issues? What Are Your Concerns? What Is Your Goal For Therapy? What Is Your Goal For Treatment? And Then, And Also Understanding Too, What Are Your Goals From Even A Social Standpoint? If You're Someone That Needs To Get Back To Work In A Couple Of Weeks, If You're Someone That Needs To Be Able To Make Arrangements With Your Family, Understanding Those Factors As Well, Because That's Part Of The Healing Process As Well. And Then For Me To Guide Patients Towards A Decision By Just Giving Them The Information And Then Letting Them Choose. And I Tell Them When They Tell Me Just To Make A Decision, Like I Can't Do That, Do That. And I Say, You Know, When We Make This Decision Together, We Both Have To Live With This Decision. You Have To Physically Live With The Decision. I Have To Emotionally Live With A Decision And Whatever The Outcome Of That Decision Is. And That's Why We Are Sharing In This Process And In This Decision Together.

Christie - 00:12:42:

I Think Of Two Things As You're Talking About This. One Is The Clinician Or Even The Public Health Professional Or Even The Lay Person Who Might Be Listening To This Who Says, But We're Talking About Emergencies. We're Talking About When People Are Gonna Die And You've Got To Move Fast. And Yes, We Are. But There Are Aspects Of Care That I Have Slowly Learned And I'm By No Means An Expert, But Just As An Example, I Worked In ICU In The Recovery Room, We Call It PACU Now, When I Was A Relatively New Nurse And I Was Not Cognizant Of Body Language. My Patients Are Somewhat Sedated Or Going Into Surgery Or Whatever, Whatever That Might Be. And I Was Young And Moving Fast And It's A fast-paced Environment. And I Actually Ended Up Having A Clinical Procedure. And I Remember Being On The Stretcher And These Were With People I Knew That I Had Established Trust With Or I Wouldn't Have Been Undergoing The Procedure In The First Place. And, Them Leaning Over Me. Felt Weird. It Felt Like I Was A Patient And I Felt Like I Had To Be Quieter. Maybe I Had To Shrink Myself To Their Expertise So I Would Feel Safer And Liked. There Are Very Real Aspects Of Care That Have Led To Me Squatting By People's Beds And Chairs While I Talk To Them. Because When You Are Even That Small Action Of Squatting Down, Being Where They Can See You, You're Not Hovering, You're Not Leaning. It Shifts Power To Your Point About Power. So That Was The One Takeaway I Have. And Yes, Emergencies Happen. And Yes, Sometimes We Do Have To Move Fast To Save People's Lives. But There Are Ways Within Your Care To Establish Trust Even Then. I Know What It's Like To Roll Down On The Stretcher With The Patient To The Operating Room. And I Used To, Over Time, Learned To Say Things That I Hoped Were Helpful. You're Safe, We're Taking Good Care Of You. This Is To Keep You Both Safe. Really Going Back To The, What Are We Doing? This Feels Really Scary, But We're Here, We're Not Scared, And You're Safe. There Are Small Things We Can Do, Even In Those Hardest Times, Even When It's The Outcome Nobody Wants. To Add Resiliency For The Patient, To Give Power Where We Can, And To Support Them. That Feels Incredibly Important To Me.

Veronica - 00:14:49:

It's Absolutely Important. And I'm Thinking Of Several Situations Where I Have Walked Into A Delivery Experience And It's An Emergency And I Happen To Like Just Walk In And I'm The Doctor Of The Day Or Whatever The Situation Is Where It's Not My Patient, Where Now I Have To Quickly Establish Trust Because They Don't Know Me From Jane For Anybody. I Have Gotten Really Good Feedback From Patients That They Didn't Know Me, But They Felt Safe. And It Doesn't Take Much Time. All, And It's Not A Lot Of Skill. It's Just Coming In, Introducing Myself, Holding Their Hand. Like You Said, Letting Them Know, I Am Here For You. I Am Here To Keep You Safe. I Know It's Scary. Everything Is Okay. We Are Moving Fast And That Looks Fast To You, But It's Not Because We're Scared. We're Moving Fast So That We Can Make Sure Things Happen In A Very, Quick And Organized Way, And I Use Different Language, But Just Giving Them That Reassurance That I Am Here For You, I Am Here For Your Baby, It's Going To Be Okay, And Giving Them That Reassurance.
Christie - 00:15:58:

Incredibly Important. Again, It's Language Matters. It's The Thing People Remember. It's The Way We Can Reframe Things. And It's Our Duty To Patients To Do That. We've Had Some Themes As We've Been Talking Over The Course Of This Podcast. Joy Is One. Safety Sounds Like Another One. All Of Those Are Woven Into Quality As Well As Equity Concepts. The Second Thought I Had As You Were Talking About Your Experience With Patients And Especially Folks Maybe Experiencing Fibroids Who Say, Well, You Tell Me What To Do. A Little Bit Of My Personal Lived Experience. I Don't Know That I Call It Expertise But It Was Definitely An Experience. I Was Diagnosed With Breast Cancer When I Was 32. No Family History, No Genetic Risk. Just A Thing That Happened. I Was Incredibly Fortunate. I Had Good Diagnosis. I Found It Myself. I Had Good Resources. I Was Able To Seek Care. But The Part That Terrified Me The Most Was Choosing The Wrong Thing. And Ending Up Responsible For Maybe No Longer Being With My Children, For Not Being In Their Lives, For Dying If I Chose The Wrong Thing. And I Think The Oncology Teams Have A Lot Of Expertise In This Where They Know This Stuff. I Can't Even Remember All The Names Of The Drugs I Received In Chemotherapy, But I Knew That They Explained The Courses Of Treatment And They Did Leave Things Up To Me. I Hated It. I Had To Choose If I Was Gonna Have A Mastectomy With Both Breasts, If I Was Gonna Have One, If I Had To. And Those Are Hard Decisions. You Don't Wanna Choose Poorly. And So Me Being Me, I Pulled Up All The Data, But Ultimately It Was My Decision, But I Felt As Well Informed As I Could Be Because The Doctor Who Talked To Me About It Drew Pictures On The Back Of A Piece Of Paper To Explain Invasive Ductal Carcinoma To My Husband Who Is Not Medical. They Sent A Child Life Specialist In After To Talk About How To Talk To My Children About This. I'll Never Forget The Surgeon, Dr. Soudin, Who Worked With Me. She Sat On A Chair Below The Table I Was Sitting On And Talked To Me Like A Real Person And Talked About Her Kids, Joked A Little Bit About Halloween Costumes The Morning Of My Surgery. I Went To Sleep Holding Her Hand. It Was One Of The Most Terrifying Experiences In My Life. It Was 11 Years Ago. I Still Remember What It Felt Like To Go To Sleep. I Had Never Had Major Surgery And Here I Was Having A Mastectomy. I Didn't Know Exactly What I Was Gonna Wake Up With. I Can't Apply That To My Experiences Of Birth, But I Can To Being Human. And I Think The Ability Of That Clinician To Meet Me Where I Was, To Use The Big Words Because I Was Smart And Capable And Worth Using The Big Words With Is How I Felt, But Also To Stop And To Draw A Picture, Not A Really Good Picture, But A Very Educational Picture For My Husband So He Understood Why The Treatment Was Needed Was Incredible. And The Ability To Modulate Your Care To The Person In Front Of You, Even At Their Most Vulnerable, Because Vulnerability Is Part Of This On Both Sides Was life-changing For Me. It Changed How I Saw My Role With Patients And It's Permanently Changed How I See That. I Wouldn't Say Cancer Is A Gift. It's Not At All. Jewelry Is A Gift, But Cancer Was An Experience That Shaped Who I Am. And I Think About How Birth Shapes Some Of The People That Give Birth And Our Identities As Parents And Where We See Our Role In The Healthcare System And Everything Else. And I Think It Is A Worthwhile, If Not Imperative Investment Of Our Time.

Veronica - 00:19:17:

Absolutely, And That Partnership That You Talk About, That Partnering With Patients. I Do Not Want To Have Any Healthcare Provider Ever Have The Words Come Out Of Their Mouth That A Patient Is Noncompliant. A Lot Of The Times When We Say, Quote Unquote, The Patient's Noncompliant, It's Because We Didn't Partner With Them. We Didn't Create A Relationship Where They Are Invested In Whatever Decision Has Been Made For Them To Comply To That Decision. And So When We Find That Patients Are Not Adherent To Care, We Need To Ask Why. Why Is It? Sometimes There Are Barriers That They Can't Access The Care That We've Not Assessed For. But Sometimes We Have Not Engaged Them In The Decision Process For What That Care Is Supposed To Be. And So We Have Not Created Any Ownership On The Patient's Part For Whatever The Decision Is Going To Be. And So That Partnership Is So Important. And We Also Need To Get Out Of Our Heads As Providers That, You Know, We Went To School For All These Years And There's No Way That Someone Sitting In Front Of Us That Doesn't Have Our Medical Expertise Is Going To Understand All These Things. At Some Point, You Didn't Understand These Things. I Certainly Didn't Come Into Medicine Knowing What I Know Now. Somebody Had To Figure Out How To Break It Down To Me. And So That So The Process Can Happen. And So We Need To Do That And Take That Time To Break It Down So That Our Patients Do Understand And Then Use Techniques To Make Sure They Understand Doing Some Teach Back. I've Explained These Options To You. You Tell Me What Does That Mean To Do That Check In To Make Sure That They Understand. But Again, Just Making Sure That We're Partnering With Our Patients On That Decision Making Process.

Christie - 00:20:59:
I remember in nursing school, we talked a lot in the pediatric portion about communication, and there were stages of development which we dive deep into, and there were stages where you needed to use really concrete language when you would talk to younger children. And I think it's actually a good lesson for all ages. When you are under stress, you don't interpret things in the way that you normally would. When I saw oncology, I was not a nurse with 15 years of experience or 10 years of experience. I was just a terrified person who didn't want to die, and I wanted to see my kids graduate from high school. You know, and they were small, so it was a lofty goal, and I'm incredibly fortunate that it's been realized. But I think that the examples they would give in school, you know, 'were things like, you don't want to tell a toddler, quick poke! That's not a stick; that's not sharp, it's not work. It's just gonna be a quick stick. Then they have this in maybe a tree branch or a stick, and I think that we have to be sure that even when somebody is understanding the concepts that we haven't used inadvertently, language that is othered from their experience and understanding, and that's not always medical words. It's perceptions that we hold and carry or are inculturated into our speech. And so I do think that it's teach back, but it's repeat back. Like, what did you take away from that so that I'm sure you understand? Like, what are the key concepts kind of without asking that? I think that's a huge step in the right direction. And it takes intentional approaches. And it's tiring.

Veronica - 00:22:29:

It is, but it's the right thing to do. And as we are trying to achieve equity, you have to. You have to remember that equity or you know this, so I'm not saying this to you in particular, but we have to remember that equity is making sure that everybody has the same quality of care. And part of that is making sure that they understand and that they are partnering in that care. And so you have to do that. You have to take the time.

Christie - 00:22:56:

When understanding can mean different things, right? As an example, I think you can present something perfectly with the language someone fully understands and your recommendation does not align with their priorities or their values. But you can also sometimes miss the mark. An example that I'll give that I'm gonna stay intentionally vague on. When I was working at bedside, we had a patient situation where there was a non-reassuring fetal assessment. The monitor didn't look good to the point where this patient was being recommended for a cesarean. They were not from the United States and did not speak English as a first language. And even with interpretation, repeat back, all of it was refusing a C-section. And this was incredibly terrifying to the staff who desperately wanted to do the right thing. I think both parties had the exact same goal, right? They wanted everyone to be healthy and safe. And it was only after some repeated conversations that they were able to suss out at the bedside that the patient believed a cesarean was gonna result in no longer being able to get pregnant or give birth. And that was a huge value and something that was really deeply important to her. And she thought we were going to take that away. And her mental trade-off was one baby for future babies because her life experience had already included losing multiple children. As a white woman in the United States with a very limited scope and experience would never have occurred to me to think about that trade-off, right? And I think for the clinicians at the bedside who were trying so desperately with pain themselves and trauma around this and desperately wanting to do the right thing, there was still a disconnect. And so I think that repeating back, but also taking the time to say, I'm gonna pause, this is a lot. Like, what are you feeling? What are you hearing? What about this is scary to you? Instead of them being like, no, be like, is this making you nervous? Because it's not compliance. We're moving away from that word more and more, and then the patients don't do what we recommend. Doesn't always mean that it's lack of compliance. It is autonomous decision-making, but we wanna be really sure that we've met their needs in an equitable way so that they can really make autonomous decisions.

Veronica - 00:25:11:

And you bring out so many points. It's one about seeing individuals as individuals. It's about meeting patients where they are, and then just asking why. I think we get so caught up in our roles. We forget we're all just people. Nobody, for the most part, I would say, I have not in, I'll include residency, almost 20 years had a patient, go against quote unquote medical advice without a why. Nobody wakes up and says, I'm just not doing what that doctor says. There's always a why. And I don't know why we are hesitant to ask the question. It's just ask, just ask why. Just ask why, and then we're able to then meet the needs. Sometimes the why is religious reasons. Okay, then let's talk about what we can do that is within what you accept and still be able
To Deliver You Care So That We Can Get The Best Outcome. Sometimes, Most Of The Time, It's Just What You
Said. It's A Lack Of Understanding About What We Are Gonna Do. I See This Quite Commonly With Patients That
Want A Hysterectomy, Need A Hysterectomy, But They Tell Me, But I Don't Wanna Have Hot Flashes, I Don't Wanna
Grow Hair, I Don't Wanna Lose My Sex Drive. And It's Because They Don't Understand That When We Do A
Hysterectomy, That Doesn't Mean Removing Ovaries. Depending On The Situation. And So It's Just, Again, We
Have To Ask The Why. And Then, And Again, That Is That Patient Partnership And Partnering With Our Patients.

Christie - 00:26:45:

Yeah, I Mean, So Many Things Influence How We Seek Care, Even Ourselves, Right? And I, Well, My Mother Had A
Bad Experience With This Or My Aunt Did Or My Cousin Did. That Is Lived Expertise For That Person. And
Sometimes It's Acknowledging That Things Happen. Sometimes It's Helping Correct Misunderstandings Because
That Other Person Was Not Explained Their Options Or Things Weren't Explained Clearly, Right? Or They Were, But
They Had An Unfortunate Outcome Because It Does Happen In The Reality Of Healthcare And In Human Bodies.
They Don't Always Do What We Hope They're Going To Do. But I Do Think That It's Critically Important, The Why.

Veronica - 00:27:21:

It Is, I Was, As You Were Talking, I Was Remembering One Experience, What I Had When I Was Early In Practice.
So I'm Originally From Mississippi, But I Practice In New Orleans Where We Have Mardi Gras. And I Had A Patient
Come In And We're Doing Like Her Visit, It's During Mardi Gras Season. And She Tells Me, She's Like, I'm Worried
Because I Went To The Mardi Gras Parade And I Raised My Arms. And So I'm Trying To Understand. So I Was Like,
Did You Get Hit In The Face? Did You Fall When You Were Raising Your Arms? And She's Like, No, You Know, My
Grandmother Told Me That When You Raise Your Arms, Then The Umbilical Cord Gets Wrapped Around The Baby's
Neck. And So I'm Worried If My Baby Is Okay. And So I Was Like, Okay. And Again, Because I Asked The
Why. And So We Were Able To Work Through That. I, It, First Of All, Did Not Make Her Feel Like That Was An
Unrealistic Expectation. And I Validated Her Feelings. I Validated Her Concerns. We Went Through What That
Means To Have The Cord Wrapped Around That The Arms Or Your Arms Are Not Actually Linked. Cause A Lot Of
Patients Think That They Think That Their Arms And Their Belly Button Is Linked To The Baby's Belly Button And
Linked To, You Know, Just An Understanding Of The Anatomy Part. And So I Again Validated Her Concerns, But
Also Explained. And After That. And Of Course Reassured Her And Showed Her The Baby, Got Her Heart Tones
And That The Baby Was Okay. But I Just Think About What Would Have Happened If I Had Laughed At Her
Response. What Would Have Happened If I Said, Well, That's Just Ridiculous And Didn't Acknowledge Her. That
Would Have Destroyed Our Relationship. That Would Have Stopped The Trust That We Had Delivered. So That
When She Had Something Else That Really Could Be A Concern For The Baby's Wellbeing, She Would Not Have
Said That To Me Because The First Time She Came, If That's How I Responded The First Time When She Came
Forward, She Wouldn't Do It Again. And So We Have To Think About That Why And Then How We Respond To The
Why.

Christie - 00:29:29:

So What's So Interesting Is As You're Saying That, I'm Like, Yep, Old Wives Tales, We Hear Lots Of Those, And
Especially In Obstetric Care, I Think, Because That's How Things Have Been Handed Down To Families. But I Hear
The Love Of Her Wanting To Protect That Baby. That Was Not Ridiculous. That Was Her Wanting To Protect Her
Child Who Wasn't Born Because She Loves Her Baby, Like I Love Mine. Like To Me, It's Such A Human Connection
That, I Mean, We Giggle Sometimes In Healthcare, Not At People, But Sometimes I've Said Things That Were Quite
Embarassing At The Bedside, Which We're Not Going To Get Into For This Podcast Episode. But, You Know, We're
All People And Meeting People Again, Where They're At, Creating Safety And Building That Trust, It's Incremental.
Whether It Has To Be Pressure Cooked Because It's An Emergency Or Whether It's A Question Like That In The
Office, It's Just Incredibly Important To Allow People To Feel Heard. Thank You For Tuning In To AIM For SaferBirth.
If You Like The Show, Be Sure To Follow Wherever You Get Your Podcasts So You Don't Miss An Episode.

Veronica - 00:30:36:

And To Learn More About The Alliance For Innovation On Maternal Health, Visit saferbirth.org. I'm Veronica
Gillespie-Bell.
And I'm Kristi Allen. And We'll Talk With You Next Time On AiM For SaferBirth.

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