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REVIEW ARTICLE

From assumptions to outcomes: How unconscious bias shapes obstetric care

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Abstract

Unconscious bias influences clinical judgment and communication across healthcare, but its effects in obstetric practice are particularly consequential due to time-sensitive decision making, high emotional vulnerability, and longstanding maternal health inequities. When bias-driven interactions escalate into coercion, non-consented procedures, or normalized mistreatment, they constitute forms of gender-based violence embedded within routine clinical care. This review synthesizes evidence on how unconscious bias shapes provider–patient communication, shared decision making, autonomy, and obstetric outcomes. A systematic review with narrative synthesis was conducted using PubMed Central and Google Scholar from inception to August 2025. English-language studies examining unconscious or implicit bias in obstetric communication or decision making were eligible. Dual screening, structured data extraction, and thematic synthesis were performed. A total of 89 studies met inclusion criteria, including qualitative, quantitative, mixed-methods, and conceptual designs. Across settings, unconscious bias manifested through: (1) Dismissal of symptoms and credibility discounting; (2) selective or incomplete information exchange; (3) stereotyping and moral judgment; (4) differential clinical discretion, surveillance, and escalation; and (5) normalized mistreatment and non-consented care. These mechanisms systematically undermined communication quality, restricted shared decision making, and reduced autonomy, particularly for Black, Indigenous, migrant, low-income, uninsured, adolescent, and disabled patients. Quantitative and vignette studies demonstrated measurable effects on clinical decisions, including biased cesarean recommendations,

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disparities in pain management, and delays in recognizing deterioration. These processes contributed to documented inequities in severe maternal morbidity, intervention rates, and maternal near-miss events. Notably, coercive consent practices, non-consented procedures, and normalized disrespect emerged as manifestations of gender-based violence within obstetric settings. Unconscious bias shapes obstetric interactions through interconnected communication and decision making pathways that constrain autonomy, reduce quality of care, and reinforce structural inequities. At its most severe, bias-driven care constitutes a form of gender-based violence that disproportionately affects racialised and socially marginalized women. Effective mitigation requires multi-level strategies combining communication-focused interventions, standardized protocols, interpreter support, reflective practice, and institutional accountability frameworks.

KEYWORDS
autonomy, communication, gender-based violence, maternal health disparities, obstetric care, obstetric violence, shared decision making, unconscious bias

1 | INTRODUCTION

Unconscious bias, or implicit bias, refers to attitudes or stereotypes that function automatically and beyond conscious awareness, affecting perception, judgment, and behavior.[1] In the healthcare system, these biases arise from a complex interplay of cultural standards, medical education and personal experiences of the healthcare providers themselves.[2] Even though medical and healthcare staff including doctors, nurses and midwives typically believe in fairness and professionalism, their unconscious biases can still affect how they think, how they interact with others, and generally how they work and make decisions, especially when under stress, time pressure, or cognitive overload.[3] These biases contribute to longstanding disparities related to race, ethnicity, socioeconomic status, age, and bodyweight, affecting access, treatment quality, and ultimately clinical outcomes.[4,5]

By its nature, obstetric care constitutes a high-vulnerability healthcare environment. The repercussions of unconscious prejudice may be, in this clinical setting, especially significant. Moreover, pregnancy and childbirth carry critical and time-sensitive decisions that can have lasting effects on both the maternal and the newborn health. Due to this, clinical interactions in obstetric practice are frequently emotionally intense and take place during times of increased physical and/or psychological susceptibility for patients.[6] Timely shared decision making together with trust and clear communication are all very important for good care, especially in contexts marked by clinical ambiguity.[7]

In this scenario, healthcare personnel in the obstetric setting may inadvertently influence their clinical reasoning, affecting pain assessment, symptom interpretation, honest risk–benefit counseling, and the presentation of all the available options in the diagnostic and therapeutic pathway.[8] Biases associated with race, ethnicity, language proficiency, socioeconomic level, age, disability, body mass index (BMI, calculated as weight in kilograms divided by the square of height in meters), or perceived adherence, can influence whose concerns are acknowledged, whose suffering is validated, and whose preferences are emphasized in decision making.[9] Because obstetric care often involves negotiating consent for interventions under time pressure—such as induction of labor, operative vaginal delivery, or cesarean section—even subtle biased assumptions can have a disproportionate impact on the patient autonomy, on the perceived quality of care and indirectly on the clinical outcome.[10]

This review therefore asks how unconscious prejudice influences provider–patient communication and shared decision making in obstetric practice, and what the implications are for quality of care and patient autonomy. In particular, we examine how bias-driven interactions can escalate into coercive, non-consented, or disrespectful practices that constitute forms of gender-based violence within maternity care. We synthesize current evidence on how unconscious bias shapes communication dynamics, clinical decision making, and patient experience, examining prejudices related to race and ethnicity, socioeconomic class, language and migration history, age, and bodyweight, and their effects on maternal outcomes, satisfaction, and autonomy, with particular attention to the interactional mechanisms through which bias operates in obstetric decision making and the exercise of patient autonomy.

2 | METHODS

2.1 | Study design

We conducted a systematic review with narrative synthesis to synthesize qualitative and quantitative evidence on the impact of unconscious bias on provider–patient communication and shared

decision making in obstetric practice. A narrative synthesis approach was chosen because heterogeneity of study designs and outcomes precluded a meta-analysis. The review was reported in accordance with PRISMA guidelines and followed a structured process, including a comprehensive search strategy, dual independent screening, systematic data extraction, and quality appraisal of qualitative evidence.

2.2 | Search strategy

We performed a multi-database search using PubMed Central (PMC) and Google Scholar to capture both peer-reviewed medical literature and gray literature. We deliberately selected free-access databases to ensure collaboration equity among coauthors. Our search included records from inception until August 10, 2025, to incorporate the most recent evidence.

The search strategy was constructed around three core concepts:

- Unconscious bias: unconscious bias, implicit bias, implicit prejudice, implicit stereotypes, discrimination, bias, stereotypes, health equity, health disparity.
- Obstetric practice: obstetric care, maternity care, perinatal care, prenatal care, childbirth, pregnancy, labor and delivery, provider-patient relations.
- Communication and decision making: patient-provider communication, shared decision making, communication, informed consent, patient autonomy, decision making.

Search strings were developed iteratively by the review team. Artificial intelligence (AI) assistance (ChatGPT version 5.1) was used solely to help operationalize predefined concepts into structured Boolean syntax; no screening, inclusion, exclusion, or appraisal decisions were made by AI at any stage. All AI-generated syntax was reviewed, edited, and approved by the human review team before use. Disagreements among human reviewers during screening and data extraction were resolved through manual review and consensus discussion, with the lead author having the final decision. The final search strings constitute the reproducible record of the search and are provided in File S1.

2.3 | Eligibility criteria

Inclusion criteria:

- Published in English
- Explicitly examines unconscious bias in obstetric communication or decision making.
  - Population: Women receiving obstetric care
  - Exposure: Any type of unconscious/implicit bias from providers
  - Outcomes:
    - Quality of care (timeliness of interventions, respect for autonomy, communication clarity)
    - Patient experience (satisfaction, trust, perceived discrimination)
    - Obstetric outcomes (intervention rates, morbidity/mortality, disparities, among others)

Exclusion criteria:

- Editorials, opinion pieces, or non-peer-reviewed commentaries
- Studies not focusing on obstetric care
- Non-English publications (due to resource constraints in translation)

2.4 | Screening process

2.4.1 | Title/abstract screening

Two independent reviewers screened each title/abstract using a shared Google Sheet, marking articles as "include," "exclude," or "unsure." Conflicts or "unsure" designations were resolved by the lead investigator.

2.4.2 | Full-text review

Full-text articles were assessed for eligibility using predefined inclusion and exclusion criteria. Initial assessment was conducted by one reviewer for feasibility, with independent verification by the lead investigator for all included studies and a prespecified 30% sample of exclusions.

2.5 | Data extraction and synthesis

We used a standardized Google Sheets template to extract data. Data extraction was performed by the lead reviewer and discrepancies were solved by discussion. Study characteristics (authors, year, design) (Table S1).

- Type of unconscious bias examined
- Manifestations in provider-patient interactions
- Reported impacts on care quality and patient outcomes

We synthesized data thematically, aligning with our subquestions:

- Manifestations of bias
- Evidence on shared decision making

Methodological quality was assessed using the critical appraisal skills program (CASP) qualitative checklist for studies contributing primary qualitative data to the synthesis (File S2). CASP appraisal was used to inform interpretation of the qualitative

evidence rather than to determine study inclusion or exclusion. AI assistance (ChatGPT version 5.1) was used to draft preliminary appraisal summaries, which were then reviewed, amended, and approved by the human review team; no appraisal decisions were delegated to AI.

2.6 | Team composition

A multinational review team was assembled from the World Association of Trainees in Obstetrics and Gynecology (WATOG). Participants were obstetric/gynecology trainees within 10 years of starting their training and committed to completing the project. All qualified applicants were accepted to ensure diverse representation across different healthcare systems and cultural contexts.

We shared digital tools (Google Drive, Whatsapp) for real-time collaboration and adhered to strict deadlines to ensure timely progression. Methodological decisions were documented, and feedback was incorporated iteratively throughout the review process.

3 | RESULTS

A total of 1299 records were identified through database searching (689 from PubMed and 610 from Google Scholar). After removal of 49 duplicates, 1250 records were screened by title and abstract using a blinded process. During screening, 452 discrepancies were identified and resolved through adjudication by the lead investigator, with discrepancies arising from articles screened by the lead investigator adjudicated by a second reviewer. At this stage a total of 977 records were excluded, leaving 273 articles for full-text review. Following full-text assessment, 89 studies met the inclusion criteria and were included in the final synthesis (Figure 1).

3.1 | Overview of included studies

Detailed study characteristics and coding are provided in Table S1, with key characteristics summarized in Table 1. Of the 89 included

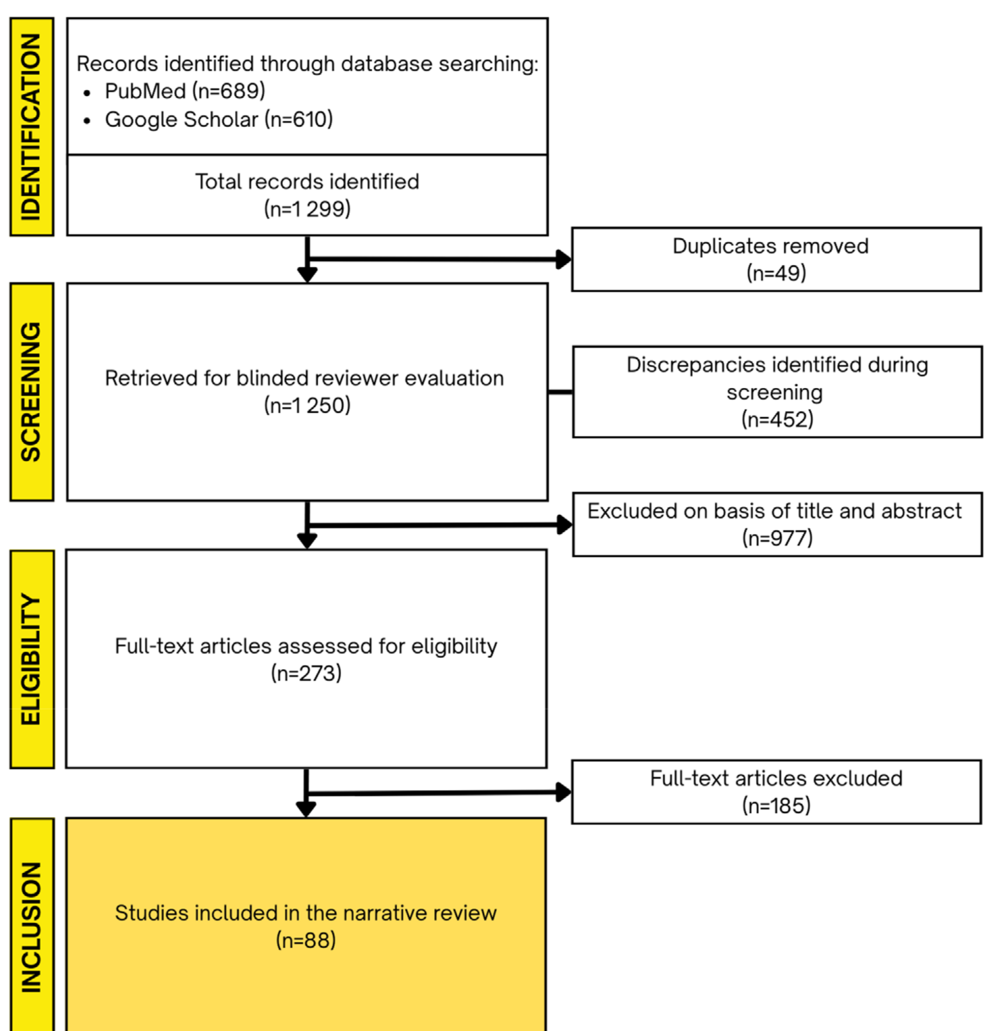

FIGURE 1 PRISMA flow diagram of study selection process.

studies, the evidence base was predominantly qualitative. A total of 62 studies used qualitative empirical designs, including in-depth interviews, focus groups, ethnographic approaches, and thematic analyses. A total of 14 studies employed mixed-methods designs, combining qualitative data with surveys, observational measures, or administrative datasets. A total of 12 studies used quantitative or experimental methodologies, including cross-sectional surveys, clinical vignette experiments, simulation-based studies, and implicit bias testing. One included paper was conceptual in nature and did not present original empirical data.

Studies were conducted across a wide range of geographical and clinical settings, with 63 conducted in high-income countries, 20 in middle-income countries, and five in low-income settings, alongside one conceptual paper drawing on examples across multiple income contexts. The majority of studies were based in high-income countries, particularly the US, with others conducted across Europe, sub-Saharan Africa, Latin America, South and Southeast Asia, and the Middle East, spanning antenatal, intrapartum, postpartum, and neonatal care settings, including hospital-based maternity units, community and safety-net services, rural and low-resource facilities, and specialized settings such as neonatal intensive care units.

TABLE 1 Overview of included studies and key characteristics ($n=89$).

Characteristic	n (%)
Study design	
Qualitative empirical	62 (69.7)
Mixed methods	14 (15.7)
Quantitative/experimental	12 (13.5)
Conceptual	1 (1.1)
Country income level	
High-income countries	63 (70.8)
Middle-income countries	20 (22.5)
Low-income countries	5 (5.6)
Multi-country/global conceptual	1 (1.1)
Primary clinical context[a]	
Antenatal care	Majority
Intrapartum care	Majority
Postpartum care	Common
Neonatal/NICU settings	Minority
Bias domains examined[b]	
Racial/ethnic bias	72 (80.9)
Structural/institutional bias	61 (68.5)
Socioeconomic bias	54 (60.7)
Language/immigration-related bias	33 (37.1)
Obstetric violence (coercion, non-consent, abuse)	23 (25.8)
Insurance/access-related bias	14 (15.7)
Age-based bias	12 (13.5)
Substance use-related stigma	6 (6.7)
Weight/BMI-related bias	4 (4.5)

Note: BMI, calculated as weight in kilograms divided by the square of height in meters.

Abbreviations: BMI, body mass index; NICU, neonatal intensive care unit.

[a]Studies frequently spanned more than one clinical context.

[b]Studies could be classified under more than one bias domain; percentages therefore exceed 100%.

Across the included studies, bias was examined across multiple domains. Most studies focused on racial and ethnic bias, alongside structural or institutional and socioeconomic forms of bias. Language- and immigration-related bias and obstetric violence, including coercion and non-consented care, were also commonly examined. Less frequently addressed domains included insurance or access-related bias, age-based bias, substance use–related stigma, and weight- or BMI-related bias. Several studies examined more than one bias domain.

CASP appraisal indicated that most qualitative studies had clear aims, appropriate methodologies, and coherent analytic approaches, with common limitations relating to reflexivity and recruitment transparency; these were considered in interpretation but did not alter the consistency of findings across studies.

4 | THEMATIC FINDINGS: MANIFESTATIONS OF UNCONSCIOUS BIAS IN OBSTETRIC INTERACTIONS

The synthesis identified five interrelated themes that describe how unconscious bias manifests in obstetric interactions through recurring patterns in communication, decision making, and care delivery, operating through distinct but connected mechanisms across clinical encounters.

1. Credibility and dismissal

Across studies, unconscious bias was most consistently expressed through differences in whose concerns were believed and whose were dismissed, particularly in relation to pain, symptoms, and perceived urgency. Women, especially Black women and other marginalized groups, described being interrupted, ignored, or having concerns reframed as anxiety, exaggeration, or non-compliance.[8,11–13] These interactional patterns were associated with delayed escalation of care, unmet postpartum needs, and lasting psychological distress, including in maternal near-miss contexts.[14,15]

2. Information control and autonomy

Bias frequently manifested through control over information exchange and limits placed on patient autonomy, shaping how options were presented and how decisions were negotiated. Studies described counseling that was filtered, incomplete, overly technical, or directive, particularly for women perceived as less educated, less compliant, or socially marginalized.[8,16,17] Language barriers and inconsistent interpreter use further restricted informed participation for migrant and minority-language speakers.[18,19] Consent was often

experienced as rushed or pressured, undermining shared decision making and meaningful choice.[20,21]

3. Stereotyping and judgment

A further manifestation of unconscious bias involved stereotyping and moral judgment, which shaped the emotional tone of encounters and the quality of patient–provider relationships. Women reported being labeled as difficult, irresponsible, or undeserving, influencing empathy, respect, and trust.[12,20,22] In contexts involving substance use or socioeconomic disadvantage, fear of judgment and punitive responses prompted strategic non-disclosure or disengagement from care.[23,24]

4. Clinical discretion and surveillance

Several studies demonstrated that unconscious bias influenced how closely patients were monitored and how clinical discretion was exercised, particularly under conditions of uncertainty. This included disproportionate toxicology testing, heightened suspicion, and differential thresholds for escalation or intervention affecting marginalized groups.[23,25] Experimental and vignette-based studies suggested that such biases were most evident when subjective judgment played a greater role in clinical decision making.[26,27]

5. Normalized mistreatment and obstetric violence

Across settings, unconscious bias was also embedded in the normalization of disrespectful and abusive practices, including verbal disrespect, neglect, lack of privacy, non-consented care, and physical abuse.[18,28,29] Conceptual and empirical studies framed these practices within broader understandings of obstetric violence and gender-based violence, highlighting how interactional harms are sustained by institutional cultures rather than isolated individual behavior.[30–32]

Together, these themes show a continuum of bias that begins with subtle shifts in credibility and information exchange and can escalate into overt surveillance or mistreatment. They illustrate how everyday interactions, institutional routines, and discretionary clinical choices combine to shape women's experiences, communication, and autonomy throughout maternity care. This progression also makes clear that unconscious bias is rarely a single act; it accumulates through small, often unnoticed behaviors that influence care long before major decisions or emergencies occur.

4.1 | Impact on provider–patient communication

Women frequently reported unanswered questions, conflicting advice, and reliance on written materials in place of dialogue, including comments such as "Here is all the information. Just go home and read."[19,33] Providers sometimes failed to explain procedures, and communication- and autonomy-related items scored lowest in routine assessments, indicating persistent gaps in basic explanation.[34] Even in complex clinical encounters, women described extended technical discussions with limited clarification and repeated questioning.[35]

Informational gaps were often compounded by dismissal and disbelief. Studies of maternal near-miss events and severe morbidity described providers minimizing symptoms, using jargon without explanation, and excluding women from discussions, leaving them feeling unheard or "left out."[14,15,36] In response, many women limited questions or relied on companions to facilitate communication.[8,37,38] Across settings, communication was commonly described as rushed, coercive, or dismissive, particularly for marginalized and socially disadvantaged groups.[8,12,13,14,16,17,33,36,39–44,45–50]

Studies documented Black women being ignored, rushed through encounters, or not taken seriously, with limited eye contact and brief visits signaling low prioritization of concerns. Observational evidence linked pro-White bias to shorter visits and fewer supportive behaviors.[11–13,21] Women also described providers failing to acknowledge questions or displaying impatience during labor or emergencies.[14] Similar interactional patterns were reported among publicly insured patients, including impersonal and fragmented care, sporadic interactions, and minimal continuity.[17,39,46]

Language and migration status also shaped communication by creating barriers to direct provider–patient interaction. Professional interpreters were often used inconsistently or replaced by family members, limiting direct engagement and increasing the risk of miscommunication. In one study, Micronesian women received directive counseling with minimal explanation and were characterized as "non-verbal" or "quiet," requiring providers to "pry things out."[51] Women with limited language proficiency reported mockery, verbal abuse, or exclusion through English-only conversations, experiences that caused distress and discouraged care-seeking.[16,18,43,52,53] Disabled women similarly described withheld interpreter support, being moved without consent, and not being asked whether they understood what was occurring.[47]

Women with a history of substance use reported communication shaped by mistrust and blame. Providers demonstrated dismissiveness, reduced listening, and interactional distancing, undermining disclosure and contributing to fear of punitive consequences, including increased toxicology testing.[23,24]

4.2 | Impact on shared decision making (SDM)

Across the reviewed literature, participation in shared decision making is unevenly distributed across maternity care encounters. Quantitative and qualitative studies consistently show that Black women, women of lower socioeconomic status, publicly insured patients, and other marginalized groups are less likely to be actively included in decisions regarding labor induction, mode of delivery, and intrapartum procedures.[54–56] These groups are more frequently positioned as recipients of decisions rather than contributors to deliberation, with reduced opportunities to engage in discussion or express preferences during key clinical moments.[34,57]

Exclusion from shared decision making is most pronounced in obstetric-led and high-intervention settings, where decision making is accelerated and structured around institutional routines. Women describe pressure to comply with recommended care, limited opportunities to ask questions, and constrained scope to negotiate care plans, particularly during labor and acute clinical situations.[14,58,59] Clinicians acknowledge these inequities but report that entrenched protocols, time pressures, medico-legal concerns, and hierarchical norms limit the feasibility of deliberative decision making in practice.[14,58,59] As a result, shared decision making functions less as a standardized process and more as a contingent practice, extended selectively to patients perceived as compliant, articulate, or able to engage on institutional terms.[54,57]

4.3 | Mechanisms through which bias undermines SDM

Consistent with the pathways summarized in Table 2, three interrelated mechanisms recur across the literature: paternalism and unilateral provider action, selective control and framing of information, and coercion operating through an illusion of choice. These mechanisms operate across the continuum of maternity care and constrain deliberation by shaping which options are presented, how risks are framed, and when decisions are considered negotiable.[10,54,55,60]

Paternalism represents a central mechanism through which SDM is undermined. Clinicians may assume authority over decisions, withhold viable alternatives, or override stated preferences, particularly during labor and delivery.[14,58] Consent is often presumed based on institutional routines or perceived urgency rather than actively negotiated through discussion of risks and options.[30,48] Although such actions are frequently framed as necessary for safety or efficiency, women, especially women of color, experience them as disempowering and distressing, contributing to mistrust and disengagement from care.[30] In high-intervention and hierarchical settings, providers may proceed with interventions despite refusals or present decisions as already settled, rendering resistance difficult or risky.[12,16,38,59,61]

Selective control and framing of information further undermine SDM. Clinicians are described as rushing explanations, omitting critical details, or selectively packaging information, leaving patients uncertain about available options and unable to participate meaningfully in decisions.[8,39,62] For racially marginalized, immigrants, and those with limited language proficiency, information is often oversimplified or filtered through provider assumptions, narrowing the perceived range of acceptable choices.[33,44,62] Truncated counseling has been documented in settings such as prenatal anomaly screening and HIV or PMTCT services, where limited explanation increases vulnerability to directive decision making.[44,62,63]

Coercion represents the most overt disruption of SDM and frequently operates through an illusion of choice. Women report being offered options under conditions of urgency, fear-based framing, or pressure that restricts deliberation, particularly in relation to induction, cesarean delivery, episiotomy, and invasive examinations.[16,20,50,64] Declining recommended care is associated with higher odds of perceived discrimination, especially among Black and Hispanic women.[10] These dynamics are reinforced by assumptions about compliance and risk among low-income and publicly insured patients and are frequently normalized through institutional routines and hierarchical authority.[10,30,31,48,56]

4.4 | Consequences for quality of care

4.4.1 | Consequences for care quality and patient agency

Evidence from qualitative and quantitative studies shows that biased communication and prejudice have direct and measurable consequences for the quality of obstetric care. Bias related to protected characteristics shapes clinical judgment, influences intervention thresholds, and affects patient outcomes across maternity settings. An online survey of 726 obstetric care providers found that younger obstetricians were more likely to recommend operative delivery for Black women with Category II fetal heart tracings in early labor, despite

TABLE 2 Pathways through which bias undermines shared decision making.

Mechanism of bias	Impact on decision making process	Consequence for patient	Primary target groups
Paternalism and unilateral action	Providers withhold options, override stated preferences, or assume consent rather than engaging in deliberation	Loss of bodily autonomy: non-consented procedures (e.g., episiotomies, membrane sweeps)	Racial/ethnic minorities, particularly Black and Indigenous women facing structural bias
Directive framing and coercive communication	Information is selectively "packaged," rushed, incomplete, or withheld; explanations are truncated, especially when communication is difficult	Inability to advocate: patients lack sufficient information to opt out, question recommendations, or choose alternatives	Linguistically diverse and immigrant women, for whom language barriers lead to more directive care pathways
Coercion and "illusion of choice"	Fear-based narratives (e.g., fetal harm), urgency, or pressure are used to secure compliance, replacing deliberation with apparent choice	Psychological disempowerment: feeling bullied or powerless; measurable reductions in decision making autonomy (e.g., MADM scores)	Low-SES and publicly insured patients, for whom assumptions about compliance constrain genuine offers of choice

Abbreviations: MADM, Mothers Autonomy in Decision Making scale; SES, socioeconomic status.

identical clinical scenarios.[26] Although based on self-reported decision making, these findings align with observed clinical patterns and highlight decision points where bias is more likely to influence care. Qualitative interviews with postpartum women further linked implicit bias and constrained participation in care decisions to pregnancy complications among racialised and socially marginalized women.[65]

Experiences of biased care also shape expectations and engagement with healthcare systems. Narratives from racialized women during and after pregnancy describe anticipatory mistrust, heightened health anxiety, and stress informed by prior encounters and observed treatment of others.[12,13] These experiences were associated with reduced trust in providers and reports of maternal or neonatal complications, suggesting that the effects of bias extend beyond individual encounters.

Intrapartum pain management is a particularly visible site where quality of care is compromised. Racialized and socially marginalized women, especially Black and Hispanic patients, describe the withholding of pain relief, limited explanation or consent, dehumanizing encounters, and the need for sustained emotional labor simply to be heard.[36,37] These interactional failures are mirrored in clinical outcomes. Racial and ethnic disparities in cesarean delivery rates and indications persist among marginalized groups even after adjustment for medical, socioeconomic, and obstetric risk factors, suggesting that non-clinical influences continue to shape operative decision making without clear maternal or neonatal benefit.[25,66,67]

Constraints on autonomy emerge within these quality failures through how information is conveyed and consent is obtained. Racialized and socially marginalized patients considering vaginal birth after cesarean often receive inequitable counseling, with recommendations varying by provider experience and institutional context. Providers with fewer than 10 years of practice were more likely to recommend cesarean delivery for Black patients, directly shaping mode-of-birth decisions.[26,55] Migrant women undergoing prenatal anomaly screening similarly report incomplete or unclear information, often reflecting assumptions about language proficiency or health literacy, which limits informed choice.[43] Across settings, Black and lower-income women experience restricted participation in decisions related to cesarean delivery and pain management, compounded by limited access to culturally competent counseling and midwifery care.[11,34,54,61,68]

Autonomy is further undermined by directive and coercive practices, particularly in time-pressured obstetric environments. Women from marginalized groups describe feeling pressured to accept recommended interventions, including cesarean delivery and postpartum procedures.[8] Rushed consultations, stereotyping, and dismissive communication limit opportunities for discussion and contribute to fear, emotional distress, and disengagement from care.[13,20] Less experienced providers appear more likely to engage in biased decision making, reinforcing disparities in intervention recommendations by race and socioeconomic status.[25,26]

In acute settings, biased assumptions often result in superficial consent processes. Providers' presumptions about literacy, language skills, or cultural background truncate discussions of risks, benefits, and alternatives, leaving patients with limited influence over critical decisions.[43,60] Patients undergoing repeat cesarean delivery report reduced involvement in surgical planning, while racialized women describe hurried communication and restricted participation in labor decisions.[12,37,55,60] Structural constraints such as staffing shortages, systemic racism, and inadequate language support further narrow opportunities for choice and consent.[62,68,69]

Bias affecting quality of care also extends beyond race and ethnicity. Women with a history of substance use experience altered clinical judgment and differential surveillance, including selective toxicology testing based on patient characteristics rather than objective risk. These practices expose women to legal and social consequences without corresponding improvements in outcomes.[23] Provider-reported stigma undermines communication and continuity of care, contributing to fragmented obstetric management.[24] Disabled women similarly report inappropriate interventions, unilateral recommendations for cesarean delivery, and denial of analgesia despite specialist assessment supporting its safety.[47] In some settings, discrimination and communication breakdowns contribute to avoidance of institutional delivery, resulting in unsupervised births and higher complication rates.[28,70]

Across regions and healthcare systems, mistreatment in maternity care, including denial of pain relief, unsafe practices, verbal or physical abuse, and harmful maneuvers, has been documented as a consequence of biased care.[18,59,70,71] Taken together, this evidence shows that unconscious bias compromises obstetric care through its effects on clinical decision making, communication, consent, and responsiveness. These processes shape both patient experience and clinical outcomes, with consequences that extend beyond individual encounters to maternal and neonatal health.

4.4.2 | Contribution to health disparities and obstetric outcomes

Across multiple qualitative and review-based studies, biased clinical interactions consistently emerged as a structural contributor to severe maternal morbidity. Black women frequently reported that dismissive communication, delayed evaluation, and disrespectful treatment directly preceded maternal near-miss events, illustrating how provider bias can impair timely recognition of clinical deterioration.[14,15,36,44] Review evidence further supports that implicit racial bias shapes diagnostic and treatment delays, contributing to persistent racial gaps in maternal morbidity and mortality, particularly among Black birthing people.[72,73] Additionally, high levels of pro-White implicit bias among nurses have been linked to poorer patient communication experiences, suggesting a mechanism through which inequitable care processes can reinforce adverse maternal outcomes.[74]

Evidence from both quantitative and qualitative studies indicates that bias influences obstetric intervention patterns. A vignette-based experiment showed that some less-experienced

providers were more likely to recommend cesarean delivery for Black patients early in labor, despite clinically identical scenarios, revealing bias-sensitive points in decision making.[26] Large cohort analyses demonstrated higher risk-adjusted NTSV cesarean rates among all non-White groups—most notably Black women—with disparities persisting even after adjustment for clinical and institutional factors.[25] Hospital-level analyses further showed substantial variation in Black–White cesarean differences across similar facilities, suggesting that institutional culture and subjective interpretation of indications may amplify bias-related inequities.[75] Qualitative studies documented that Black and other marginalized women reported reduced shared decision making, perceived stereotyping, and diminished autonomy during cesarean decision processes, reinforcing pathways from biased interactions to intervention disparities.[51,54,55,66]

The evidence highlights persistent racial and ethnic disparities in maternal and obstetric care, particularly affecting Black and other non-White patients. Black patients are significantly more likely to experience stereotyping, biased assumptions and poor communication from clinicians, including assumptions of substance abuse, sexual behavior and family stability.[20,23,51] These behaviors undermine patient-provider relationships, reduce prenatal care engagement and negatively impact maternal and neonatal outcomes.

Black women experience disproportionately high rates of severe maternal morbidity, maternal near misses and maternal mortality, often at two to three times the rate of other populations.[14,15] While traditional risk factors such as chronic disease, poverty, insurance status, and limited access to care contribute, they do not fully explain these disparities, pointing to the role of implicit bias, structural racism and differential treatment within health care systems.[15,73]

Communication challenges, negative stereotypes and perceived racism disrupt care, affect recommendations for delivery mode, and contribute to medical errors and near misses.[15,36,73] Importantly, evidence suggests that racial concordance between patients and providers (e.g., Black physicians caring for Black newborns) is associated with improved outcomes, including newborn mortality.[36,76] Overall, these findings underscore that racism–manifested through stereotyping, communication failures, microaggressions and inequitable care–plays a central role in driving maternal health disparities, beyond traditional medical risk factors, reinforcing the need for systemic and culturally responsive interventions to improve equity in maternal healthcare.

5 | DISCUSSION

This review demonstrates that unconscious bias consistently manifests in obstetric care through recurrent interactional patterns that shape communication, shared decision making, and the exercise of patient autonomy. Across diverse healthcare settings, these patterns operate through interconnected mechanisms that influence how credibility is assigned, how risks and options are framed, and how consent processes unfold, particularly in high-acuity and time-pressured contexts such as labor and delivery (Figure 2).[12,13,20,36,37,43,51,54,60]

The consequences of these interactional mechanisms are substantial. Rather than reflecting isolated communication failures, biased encounters function cumulatively to undermine quality of care, erode trust, and constrain meaningful participation in decision making. At the population level, these processes contribute to persistent inequities in obstetric experiences and outcomes, including disparities in maternal morbidity, mortality, and intervention rates among racially and socially marginalized groups.[25,72,73,75]

In terms of evidentiary strength, qualitative studies formed the backbone of the evidence base, providing consistent accounts of lived experiences and communication failures across populations

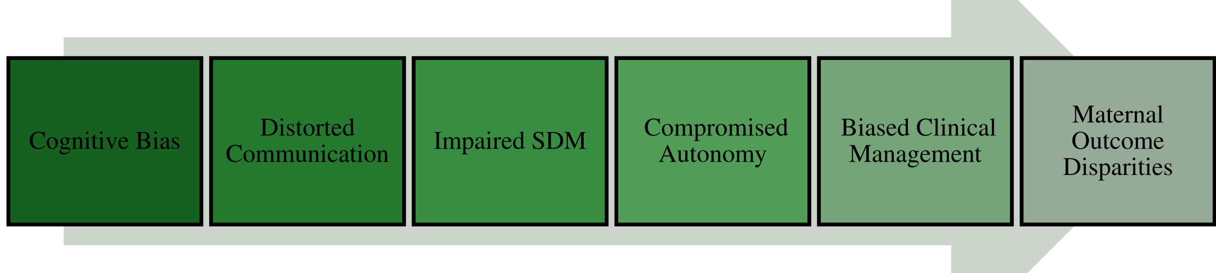

FIGURE 2 Unconscious bias shapes each step of obstetric care. It begins by influencing how providers perceive risk and interpret symptoms. These cognitive distortions then alter communication through selective information, minimizing concerns, and framing shaped by stereotypes, which weakens shared decision making. Patients are left with less autonomy, incomplete consent, and a reduced sense of control. These patterns affect clinical decisions, contributing to delays, inappropriate interventions, and missed chances for timely care. Together, they drive the disproportionate maternal morbidity and mortality seen among marginalized groups.

and settings.[12,13,36,37,51] These findings were reinforced by quantitative and experimental studies demonstrating differential recommendations, intervention rates, and outcomes even after adjustment for clinical and institutional risk factors.[25,26,75] The convergence of qualitative and quantitative evidence strengthens confidence in the pathways linking unconscious bias to inequities in obstetric care.

The patterns identified in obstetric care align closely with findings from other clinical domains, including emergency medicine, pain management, cardiology, and oncology,[77–81] where unconscious bias similarly shapes symptom interpretation, communication quality, and treatment decisions.[73,74] However, obstetric care represents a uniquely sensitive context. Urgent decision making, responsibility for both maternal and fetal outcomes, and heightened emotional vulnerability may amplify the effects of biased assumptions, particularly in relation to consent, autonomy, and long-term trust in healthcare systems. Critically, when these dynamics escalate into coercion, non-consented interventions, or normalized mistreatment, they constitute forms of gender-based violence perpetuated through clinical routines.[36,37]

The included literature describes a limited but growing range of strategies aimed at mitigating unconscious bias in obstetric care. At the individual provider level, interventions such as implicit bias awareness training, reflective practice, and communication-focused education may improve awareness but show limited evidence of sustained behavioral change or measurable improvements in clinical outcomes when implemented in isolation.[11,68,74,82,83]

More consistent evidence supports system-level and structural interventions. These include standardized clinical protocols, decision aids, structured consent pathways, improved access to professional interpretation services, and policies that promote continuity of care and midwifery-led models.[43,62,68,69,77] Reducing reliance on discretionary judgment at bias-sensitive decision points, such as labor management or cesarean indication, may attenuate disparities in intervention rates and patient experience.[25,54,75] Across studies, institutional culture and leadership commitment were critical to the successful implementation and sustainability of these interventions.[68]

5.1 | Current strategies and interventions

Broader healthcare initiatives increasingly acknowledge unconscious bias as a determinant of inequitable care. These efforts include mandated implicit bias training, frameworks grounded in cultural humility and trauma-informed care, patient-centered communication standards, and equity-oriented quality metrics.[11,68,74,82,83] While these initiatives were not the primary focus of most included studies, their presence provides important context: the evidence suggests that addressing unconscious bias in obstetric care requires multilevel approaches that integrate individual education with system redesign, accountability structures, and institutional commitment to equity.[68,69,73]

5.2 | Limitations

This review was limited to English-language publications retrieved from PubMed Central and Google Scholar. Free-access databases were selected deliberately to ensure equitable participation among the international co-author team. This approach may have introduced indexing bias and publication bias, it might have under-represented work published in other languages. The absence of a registered protocol (PROSPERO) is a further limitation, although an a priori protocol was developed and followed by the review team. Quality appraisal was restricted to qualitative studies using the CASP qualitative checklist; quantitative, mixed-methods, and vignette studies were not formally appraised with equivalent tools, which constrains comparative assessment of risk of bias across designs. Finally, most included studies originated in high-income countries, which limits the generalizability of findings to low- and middle-income country (LMIC) settings.

The study of unconscious bias is inherently methodologically challenging. Key limitations include the absence of universally accepted definitions, difficulties establishing the reliability and validity of measurement instruments, and the indirect nature of commonly used tools such as the Implicit Association Test.[1,84] Moreover, observed or perceived bias among healthcare workers may be confounded by institutional and structural factors, including staffing levels, workload, time pressure, and organizational culture, complicating causal attribution.[85]

5.3 | Implications for obstetric practice and policy

Despite increasing attention to unconscious bias in obstetric care, important evidence gaps remain. Most studies originate from high-income countries, particularly the US, limiting external validity. Evidence from low- and middle-income countries and diverse healthcare systems is needed to better understand how cultural norms, resource constraints, and health system structures shape biased communication and decision making in obstetrics.[32]

Because most included evidence comes from high-income settings, particularly the US, findings should be transferred to low- and middle-income country (LMIC) contexts with caution. In resource-constrained systems, unconscious bias and obstetric mistreatment are often shaped by different pressures such as workforce shortages, crowded facilities, out-of-pocket costs, or others. Bias-mitigating interventions developed in high-income settings may not transfer easily, and locally grounded research led by LMIC investigators is needed.

The literature has focused predominantly on racial and ethnic bias, with comparatively limited and inconsistent examination of other forms of unconscious bias, including socioeconomic status, language proficiency, disability, age, bodyweight, and gender identity. Intersectionality also remains underexplored, with few studies examining how multiple social identities interact to influence obstetric communication, clinical decision making, and patient experience.[86]

Robust evidence on the effectiveness of bias-mitigation interventions in obstetric settings is limited, with the strongest support observed for counter-stereotypic and intention-setting approaches.[87,88] Although training and awareness programs are widely promoted, few have been rigorously evaluated for sustained effects on clinician behavior, communication quality, or maternal outcomes. Additionally, institutional and structural drivers of unconscious bias such as clinical protocols, staffing patterns, and organizational culture remain insufficiently studied.[89]

At the provider level, standardized communication tools, including shared decision making frameworks and structured consent processes, may reduce reliance on subjective judgment. Reflective practices such as guided debriefings and case-based discussions can enhance clinician self-awareness and support behavior change.[87] Institutionally, longitudinal, skills-based unconscious bias training integrated into continuing professional development, alongside standardized clinical protocols for common obstetric decisions, may reduce unwarranted variation in care.[88,89]

Consistent with expert consensus, institutions should establish clear diversity, equity, inclusion, and accessibility goals supported by evaluative tools and evidence-based training strategies that emphasize practical skill-building and behavioral change.[90] At the policy level, regulatory bodies and training institutions should mandate formal education in unconscious bias, communication equity, and respectful maternity care across undergraduate, postgraduate, and continuing medical education. Policymakers should prioritize funding for rigorous evaluations of bias-mitigation interventions, focusing on patient-centered outcomes and scalability across diverse healthcare systems. Coordinated action at provider, institutional, and policy levels is essential to mitigate unconscious bias and promote equitable, patient-centered obstetric care.

6 | CONCLUSION

Unconscious bias is a fundamental driver of maternal health inequities. It rarely appears as overt discrimination; instead, it shapes clinical judgment and communication through subtle, everyday interactions. These biases accumulate throughout the obstetric journey, often eroding the autonomy of racialized, migrant, and low-income patients during critical moments of care. When such patterns escalate into coercion, non-consented procedures, or normalized mistreatment, they constitute forms of gender-based violence within clinical settings. Because these influences are systemic rather than just individual, simply raising awareness is not enough. Achieving truly equitable outcomes requires a shift toward standardized protocols and institutional accountability. By centering patient advocacy and evidence-based judgment, we can ensure that a patient's background no longer dictates the quality of their care. Future progress depends on translating these insights into evaluated, system-level interventions that reduce discretion at bias-sensitive decision points.

AUTHOR CONTRIBUTIONS

FR coordinated the overall study, including conceptualisation, study design, literature synthesis, and manuscript drafting. All authors contributed equally to study design, screening, data extraction, thematic analysis, interpretation of findings, and critical revision of the manuscript. ARN conducted the final review and approval of the version submitted for publication.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

All data is available in the Supplementary Files.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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