




## Christine Morton

Research Sociologist, Pediatrics - Neonatology

 NIH Biosketch available Online

 Curriculum Vitae available Online

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### Bio

#### BIO

Christine H. Morton, PhD is a medical sociologist with expertise in maternal mortality and morbidity, women's reproductive and maternal health experiences and maternal quality improvement. Since 2008, she has managed CMQCC's state funded project on California Pregnancy-Associated Maternal Review (CA-PAMR), overseeing data collection, committee matters and conducting qualitative analysis on improvement opportunities identified from case reviews. She served as co-chair of several CMQCC Task Forces, coordinating the development of Maternal Quality Toolkits on leading causes of maternal death in California (hypertensive disorders of pregnancy, cardiovascular disease, and embolism). She collaborates on projects that support CMQCC's goals and mission, including an qualitative study of women's experiences with severe maternal morbidity and works with Dr. Jochen Profit on research examining clinician and parent's views on racial/ethnic disparities in quality of care in the Neonatal Intensive Care Unit.

#### CURRENT ROLE AT STANFORD

Research Sociologist at California Maternal Quality Care Collaborative (CMQCC) & California Perinatal Quality Care Collaborative (CPQCC)

#### EDUCATION AND CERTIFICATIONS

- PhD, UCLA , Sociology (2002)

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### Professional

#### PROFESSIONAL INTERESTS

Maternal Mortality and Morbidity, Preeclampsia, Cardiovascular Disease, Quality Measurement, Quality Improvement, Childbirth and Pregnancy, Qualitative Methods

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### Publications

#### PUBLICATIONS

- **Disparity drivers, potential solutions, and the role of a health equity dashboard in the neonatal intensive care unit: a qualitative study.** *Journal of perinatology : official journal of the California Perinatal Association*  
Razdan, S., Hedli, L. C., Sigurdson, K., Profit, J., Morton, C. H.  
2023
- **National Partnership for Maternal Safety: Consensus Bundle on Support After a Severe Maternal Event** *JOGNN-JOURNAL OF OBSTETRIC GYNECOLOGIC AND NEONATAL NURSING*  
Morton, C. H., Hall, M., Shaefer, S. M., Karsnitz, D., Pratt, S. D., Klassen, M., Semenuk, K., Chazotte, C.  
2021; 50 (1): 88–101
- **Former NICU Families Describe Gaps in Family-Centered Care.** *Qualitative health research*  
Sigurdson, K., Profit, J., Dhurjati, R., Morton, C., Scala, M., Vernon, L., Randolph, A., Phan, J. T., Franck, L. S.

2020: 1049732320932897

- **Translating Maternal Mortality Review Into Quality Improvement Opportunities in Response to Pregnancy-Related Deaths in California** *JOGNN-JOURNAL OF OBSTETRIC GYNECOLOGIC AND NEONATAL NURSING*  
Morton, C. H., VanOtterloo, L. R., Seacrist, M. J., Main, E. K.  
2019; 48 (3): 252–62
- **Bearing witness: United States and Canadian maternity support workers' observations of disrespectful care in childbirth** *BIRTH-ISSUES IN PERINATAL CARE*  
Morton, C. H., Henley, M. M., Seacrist, M., Roth, L.  
2018; 45 (3): 263–74
- **The Problem of Increasing Maternal Morbidity: Integrating Normality and Risk in Maternity Care in the United States** *BIRTH-ISSUES IN PERINATAL CARE*  
Morton, C. H.  
2014; 41 (2): 119-121
- **Disparities and Equity Dashboards in the Neonatal Intensive Care Unit: A Qualitative Study of Expert Perspectives.** *Research square*  
Razdan, S., Hedli, L., Sigurdson, K., Profit, J., Morton, C.  
2023
- **Investigating Racial and Ethnic Disparities in Maternal Care at the System Level Using Patient Safety Incident Reports.** *Joint Commission journal on quality and patient safety*  
Alfred, M. C., Wilson, D., DeForest, E., Lawton, S., Gore, A., Howard, J. T., Morton, C., Hebbbar, L., Goodier, C.  
2023
- **Enhanced maternal mortality surveillance identifies higher mortality ratios and greater racial/ethnic disparity than death certificates**  
Krakowiak, P., Sun, D., McCain, C., Morton, C. H., Ramos, D. E., Reynen, D. J., Main, E. K., Mitchell, C.  
MOSBY-ELSEVIER.2021: S229–S230
- **Quality Improvement Opportunities Identified Through Case Review of Pregnancy-Related Deaths From Cardiovascular Disease**  
Van Otterloo, L., Main, E., Seacrist, M., Morton, C. H.  
ELSEVIER SCIENCE INC.2020: S13
- **Systolic Hypertension, Preeclampsia-Related Mortality, and Stroke in California.** *Obstetrics and gynecology*  
Judy, A. E., McCain, C. L., Lawton, E. S., Morton, C. H., Main, E. K., Druzin, M. L.  
2019; 133 (6): 1151–59
- **Quality Improvement Opportunities Identified Through Case Review of Pregnancy-Related Deaths From Cardiovascular Disease** *JOGNN-JOURNAL OF OBSTETRIC GYNECOLOGIC AND NEONATAL NURSING*  
VanOtterloo, L. R., Morton, C. H., Seacrist, M. J., Main, E. K.  
2019; 48 (3): 263–74
- **Quality Improvement Opportunities Identified Through Case Review of Pregnancy-Related Deaths From Preeclampsia/Eclampsia** *JOGNN-JOURNAL OF OBSTETRIC GYNECOLOGIC AND NEONATAL NURSING*  
Morton, C. H., Seacrist, M. J., VanOtterloo, L. R., Main, E. K.  
2019; 48 (3): 275–87
- **Quality Improvement Opportunities Identified Through Case Review of Pregnancy-Related Deaths From Sepsis** *JOGNN-JOURNAL OF OBSTETRIC GYNECOLOGIC AND NEONATAL NURSING*  
Seacrist, M. J., Morton, C. H., VanOtterloo, L. R., Main, E. K.  
2019; 48 (3): 311–20
- **Quality Improvement Opportunities Identified Through Case Review of Pregnancy-Related Deaths From Obstetric Hemorrhage** *JOGNN-JOURNAL OF OBSTETRIC GYNECOLOGIC AND NEONATAL NURSING*  
Seacrist, M. J., VanOtterloo, L. R., Morton, C. H., Main, E. K.  
2019; 48 (3): 288–99
- **Quality Improvement Opportunities Identified Through Case Review of Pregnancy-Related Deaths From Venous Thromboembolism** *JOGNN-JOURNAL OF OBSTETRIC GYNECOLOGIC AND NEONATAL NURSING*  
VanOtterloo, L. R., Seacrist, M. J., Morton, C. H., Main, E. K.

2019; 48 (3): 300–310

- **Racial/Ethnic Disparities in Neonatal Intensive Care: A Systematic Review.** *Pediatrics*  
Sigurdson, K. n., Mitchell, B. n., Liu, J. n., Morton, C. n., Gould, J. B., Lee, H. C., Capdarest-Arest, N. n., Profit, J. n.  
2019
- **In Reply.** *Obstetrics and gynecology*  
Judy, A. E., McCain, C. L., Lawton, E. S., Morton, C. H., Main, E. K., Druzin, M. L.  
2019; 134 (4): 880–81
- **Never judge a book by its cover: how NICU evaluators reach conclusions about quality of care.** *Journal of perinatology : official journal of the California Perinatal Association*  
Dhurjati, R., Wahid, N., Sigurdson, K., Morton, C. H., Kaplan, H. C., Gould, J. B., Profit, J.  
2018
- **Disparities in NICU quality of care: a qualitative study of family and clinician accounts.** *Journal of perinatology : official journal of the California Perinatal Association*  
Sigurdson, K. n., Morton, C. n., Mitchell, B. n., Profit, J. n.  
2018
- **National Partnership for Maternal Safety Consensus Bundle on Severe Hypertension During Pregnancy and the Postpartum Period** *OBSTETRICS AND GYNECOLOGY*  
Bernstein, P. S., Martin, J. N., Barton, J. R., Shields, L. E., Druzin, M. L., Scavone, B. M., Frost, J., Morton, C. H., Ruhl, C., Slager, J., Tsigas, E. Z., Jaffer, S., Menard, et al  
2017; 130 (2): 347–57
- **National Partnership for Maternal Safety: Consensus Bundle on Severe Hypertension During Pregnancy and the Postpartum Period** *ANESTHESIA AND ANALGESIA*  
Bernstein, P. S., Martin, J. N., Barton, J. R., Shields, L. E., Druzin, M. L., Scavone, B. M., Frost, J., Morton, C. H., Ruhl, C., Slager, J., Tsigas, E. Z., Jaffer, S., Menard, et al  
2017; 125 (2): 540–47
- **North American Nurses' and Doulas' Views of Each Other.** *Journal of obstetric, gynecologic, and neonatal nursing : JOGNN*  
Roth, L., Henley, M. M., Seacrist, M. J., Morton, C. H.  
2016
- **Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues.** *Obstetrics and gynecology*  
MacDorman, M. F., Declercq, E., Cabral, H., Morton, C.  
2016; 128 (3): 447–55
- **Women's Experiences Being Diagnosed With Peripartum Cardiomyopathy: A Qualitative Study.** *Journal of midwifery & women's health*  
Dekker, R. L., Morton, C. H., Singleton, P., Lyndon, A.  
2016; 61 (4): 467–473
- **Race, Insurance Status, and Nulliparous, Term, Singleton, Vertex Cesarean Indication: A Case Study of a New England Tertiary Hospital** *WOMENS HEALTH ISSUES*  
Morris, T., Meredith, O., Schulman, M., Morton, C. H.  
2016; 26 (3): 329–335
- **Pregnancy-Related Mortality in California Causes, Characteristics, and Improvement Opportunities** *OBSTETRICS AND GYNECOLOGY*  
Main, E. K., McCain, C. L., Morton, C. H., Holtby, S., Lawton, E. S.  
2015; 125 (4): 938–947
- **Pregnancy-related cardiovascular deaths in California: beyond peripartum cardiomyopathy.** *American journal of obstetrics and gynecology*  
2015
- **California Pregnancy-Associated Mortality Review: Mixed Methods Approach for Improved Case Identification, Cause of Death Analyses and Translation of Findings** *MATERNAL AND CHILD HEALTH JOURNAL*  
Mitchell, C., Lawton, E., Morton, C., McCain, C., Holtby, S., Main, E.  
2014; 18 (3): 518–526

- **California Pregnancy-Associated Mortality Review: Mixed methods approach for improved case identification, cause of death analyses and translation of findings** *Maternal Child Health Journal*  
Mitchell, C., Elizabeth Lawton MHS, Christine Morton PhD, Christy McCain MPH, Sue Holtby MPH, Elliott Main MD  
2013
- **Creating a Public Agenda for Maternity Safety and Quality in Cesarean Delivery** *OBSTETRICS AND GYNECOLOGY*  
Main, E. K., Morton, C. H., Melsop, K., Hopkins, D., Giuliani, G., Gould, J. B.  
2012; 120 (5): 1194-1198
- **Standardising or individualising?: A critical analysis of the 'discursive imaginaries' shaping maternity care reform** *International Journal of Childbirth*  
Reiger, K., Christine Morton  
2012; 2 (3): 173-186
- **Safety in childbirth and the three 'C's: community, context, and culture** *Midwifery*  
Sandall, J., Christine Morton, Debra Bick  
2010; 26: 481-482

## PRESENTATIONS

- Creating a Public Agenda for Maternity Safety and Quality in Cesarean Delivery - Perinatal Patient Safety and Education Quarterly Meeting/Regional Perinatal Programs of California, San Diego/Imperial Counties, and Hospital Association of San Diego and Imperial Counties, and Patient Safety First (2/26/2013)