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ORIGINAL RESEARCH: EMPIRICAL RESEARCH – QUALITATIVE

"I felt like it would've been perfect, if they hadn't been rushing": Black women's childbirth experiences with medical providers when accompanied by perinatal support professionals

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Abstract

Aims: This study examined the nature and characteristics of Black women's interactions with medical providers during childbirth when accompanied by a perinatal support professional (PSP; similar to a doula).

Design: The design was qualitative, and a phenomenological approach was employed to examine the meaning of women's experiences.

Methods: We conducted in-depth interviews with 25 Black women enrolled in a perinatal support program in Cleveland, Ohio, in late 2017 and early 2018, exploring their interactions with medical providers, the meaning of their experiences, and the roles their PSPs played.

Results: Clients broadly categorized experiences as positive or negative. When medical providers respected them, their birth plans and/or collaborated with PSPs, women reported more positive experiences. They associated negative experiences with providers having their own timelines and agendas, and women perceiving their needs were unheard and/or disrespected.

Conclusion: The findings emphasize the need for medical providers to be patient-centred, set aside assumptions, treat their patients as experts, value women's knowledge and voice, and treat patients and their supports as part of the team.

Impact: Findings support the importance of having a knowledgeable but non-medical support person present during birth. We discuss implications for how empowerment may be a tool to achieving better birth outcomes.

KEYWORDS

African American, childbirth, doulas, health disparities, nurses, nursing, phenomenology, qualitative

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1 | INTRODUCTION

In the United States, non-Hispanic Black infants have the highest rates of preterm birth and infant mortality (Matthews et al., 2018). In particular, Black infant and maternal mortality rates in the United States are more than twice as high as White infant and maternal mortality rates (Centers for Disease Control & Prevention, 2019). Over 100 years of surveillance data from 37 countries indicate the United States had the seventh highest infant mortality (IM) rate (falling between Russia and Cuba) and that there was a fivefold higher rate between the lowest IM rates of 2.3 per 1000 for Chinese infants and a high of 11.2 for Black infants (Singh & Yu, 2019). Prematurity, low birthweight and unintentional injury were the leading causes of death.

Environmental conditions play an important role in preterm birth and low birth weight. Research has found psychological distress is an important mediator in understanding the relationship between living in a high crime neighbourhood and preterm birth in U.S. mothers (Giurgescu et al., 2012). Although some researchers argue that race is a powerful predictor of poor birth outcomes, such approaches reify race, a social construct (Vyas et al., 2019). Davis (2019a), defining racism as 'institutionally and state sanctioned practices that make particularly designated groups of people vulnerable to harm and premature death' (p. 561), examines U.S. Black women's experiences with racism in healthcare, a system intimately involved with the pregnancy and childbirth experience. The most recent research indicates the importance of psychological distress, not race per se, to understanding pregnancy-related mortality. A large study conducted in the United States of over 10,000 women found that chronic worry over racial discrimination was positively related to preterm birth rates and that Black women were significantly more likely than White women in the United States to report such worry (37% as compared with 5.5%), and Black women with higher income and education levels had the highest levels of worry (Braveman et al., 2017). Much research concludes that systemic racism is associated with preterm birth, low birthweight and IM (Giscombé & Lobel, 2005). Less research has examined Black women's experiences with during the birth process.

1.1 | Background

1.1.1 | The medicalization of childbirth

The medicalization of the natural processes of childbirth is associated with worse IM outcomes. Black women in the United States are more likely to have C-sections (Vyas et al., 2019) and to be less likely to breastfeed (largely attributed to lack of support and bias; Robinson et al., 2019), two risk factors for IM (Chen & Rogan, 2004; Yang & Sun, 2017). Examining the medicalization of childbirth using intersectionality (Crenshaw, 1991), researchers have argued that medicalization of childbirth in the United States has roots in both gender inequalities and racism, particularly slavery. Conceived of as a form of violence against women, it is seen as a threat to women's human rights (Savage & Castro, 2017; Sen et al., 2018). A review of the literature found that mistreatment of women patients by healthcare providers (i.e., nurses and midwives) is common because of structural gender discrimination (Betron et al., 2018). Betron and colleagues also found that women patients who do not project 'traditional feminine stereotypes of chastity and serenity often experience mistreatment by providers' (para. 3), and there is a great need for women to receive respectful maternity care, which includes women in labour having information, voice and agency (Betron et al., 2018).

Other analyses of the medicalization of childbirth and the impact specifically on Black women in the United States focus on the history of how traditional home midwife births were made illegal and increased medicalization of birth disempowered and displaced traditional Black midwives (Davis, 2019a). In her Black feminist analysis, Davis (2019b) examines perceptions of patients more deeply in her examination of medical racism, focusing on the intersectionality of race and gender and explores how medical providers pass judgement on women and especially their partners. She argues that assumptions made about women and their partners are couched in coded terms including 'social determinants of health', low SES and 'urban.'

1.1.2 | Importance of medical professional/birthing woman relationship

Systematic reviews of randomized trials in which women are offered continuous labour support during birth found that continuous labour support is related to more positive outcomes. One review of 26 international randomized controlled trials (RCTs) and cluster-RCTs examining the relationship between continuous labour support and hospital childbirth outcomes in 17 countries found that continuous labour support was associated with shorter labours, less time between birth and breastfeeding initiation, lower likelihood of receiving pain medication or having a C-section, more likelihood of vaginal birth without technological intervention and better Apgar scores (Bohren et al., 2017). The study also found that continuous labour support was best when provided by a doula, but any support was preferable to none. Doula care in the United States is associated with lower financial cost due to employing fewer interventions (Kozhimannil et al., 2013). One qualitative studies on community-based doulas culturally matched with adolescent mothers found that a community-based doula intervention helped these mothers learn about childbearing, the importance of labor support, self-care and feeling attached to their newborns. The intervention also expanded support networks (Breedlove, 2005).

1.1.3 | Black women's experiences with medical providers in childbirth

What are U.S. Black women's experiences with medical providers in childbirth? Qualitative research is uniquely situated to answer the question and is ideal for lifting voices of those often not listened to or

stigmatized and helping to explain the mechanisms by which quantitative variables are related (Padgett, 2017). Listening to the voices of women's experiences at an important life moment is essential to making genuine change and affecting health disparities. Such research is needed, as having positive birth experiences is associated with positive birth outcomes (Gruber et al., 2013) and may have short- and long-term implications for women and infants' health and well-being.

There is a dearth of literature on African American women's experiences during labour and delivery. Although there is a rich literature on Black women's prenatal experiences, and some studies have examined women's birth experiences (see Lunda et al., 2018 for a review), to our knowledge, very few have specifically examined Black women's birth experiences qualitatively (Fries, 2010). This study contributes to the literature not only by highlighting U.S. Black women's birth experiences but also examining their experiences while accompanied by a perinatal support professional and thus adds to the literature on continuous labour support and doulas on which most of the literature has focused on White women.

1.1.4 | Aim

This research explores the childbirth experiences of Black women who were accompanied by a perinatal support professional (PSP) from a community-based agency. Our aim was to learn about women's interactions and experiences with medical providers during childbirth when accompanied by a PSP. Thus, we asked, among Black women participating in a perinatal support intervention, what is the nature of their childbirth experience interactions with medical providers, and what characteristics shape those experiences?

2 | THE STUDY

2.1 | Design

The design was qualitative, and a phenomenological approach was employed to examine the meaning of women's experiences. Each participant took part in one in-depth interview in late 2017 and early 2018. The approach to inquiry was descriptive Husserlian descriptive phenomenology (Christensen et al., 2017). In this approach, intentionality is important, consistent with our interest in exploring the meaning participants' experiences and interactions with medical professionals had for them during the phenomenon of childbirth. Assuming reality is subjectively and objectively experienced through interaction—both within the individual and as a shared experience—meant it was also appropriate for employing a symbolic interactionist frame.

2.2 | Site of the study

This research describes a study conducted with a perinatal service organization in the United States in Cleveland, Ohio. Despite Cleveland's being home to several world-class medical institutions, a Black infant born there is nearly six times as likely as a White infant to die by his or her first birthday (First Year Cleveland, 2020). A city classified as hypersegregated with high concentrated poverty rates (Massey & Tannen, 2015), Cleveland is ranked among the worst performing of 100 metro cities regarding racial inclusion (Berube et al., 2019). An innovative perinatal support programme in Cleveland, Birthing Beautiful Communities (BBC), focuses on addressing the structural violence of racism, social inequities and health disparities through community birth work. A place-based workforce development programme, BBC employs women from historically underserved, predominately Black Cleveland communities to provide social support and services for pregnant women and their families in their community before, during and after the baby's birth. All BBC clients are assigned an individual PSP who is, when possible, from the client's own community. At BBC, clients call their PSPs 'doulas,' but their service to clients is much wider than a traditional doula, working to support women from pregnancy through childbirth and 1-year postpartum. We thus refer to them, outside of direct client quotes, as PSPs. At BBC, clients participate in a range of individual and group support interventions, including but not limited to nutrition, breastfeeding, smoking cessation, yoga classes and support groups specifically created for and focused on Black women's issues (Neal-Barnett et al., 2011). Women are typically referred to the organization's services through community resources and organizations, word-of-mouth, social media and less often by medical providers.

2.3 | Sample/participants

PSPs assisted in participant recruitment. PSPs identified clients on their caseloads who might be eligible for the study. Eligibility included being at least 18 years old, having been consistently engaged with BBC's services throughout the pregnancy and having attended a series of Sister's Circle (SOS) classes. These eligibility requirements limited the sample to clients who were most knowledgeable about BBC. After PSPs developed a list of eligible clients, they requested clients' permission send the list to the research team, and we contacted clients using their mode of preference (e.g., text, phone call or email) to confirm interest in participating in the study, answer questions and schedule a time for the interview. We contacted 31 clients whom the PSPs identified and interviewed 25 (among the six who were not interviewed, one was under 18; one had moved out of state; four did not show up to the interview). Interviews proceeded as long as new information was being generated and ended when the team agreed the data were saturated.

2.4 | Data collection

We conducted early interviews using two interviewers, a narrative research expert and a student research assistant who was in

training. Research team members conferred regularly and resolved questions that came up during the interview process. Once trained, the student interviewer led the remaining interviews. We collected the data during a single interview, which lasted between 45 and 90 min at the organization's main office in a private room. We recorded the interviews using an MP3 player and field notes by hand. A professional transcriptionist transcribed the interviews. Each client received a $50 gift card.

The interview guide for the study focused on examining clients' answers to open-ended questions about their births that followed a longer set of questions asking about clients' experiences throughout their pregnancies with the PSP services. Four questions, developed by the qualitative research team, BBC's CEO, and reviewed by funders and staff, focused on the clients' birth experiences. The questions included: 'Tell me a little about how the nurses cared for you?' 'How did the doula care for you?' 'What worked well/best for you having the doula support you during delivery?' 'How did the doula interact with the hospital delivery team?' We asked two additional questions only of women who had experienced a previous birth. 'If you had a child before, how was this childbirth experience different with the doula supporting you in the process?' 'In what ways was the experience similar to the first?'.

2.5 | Ethical considerations

The full board of a university-based institutional review board approved all research protocols. Each client signed an informed consent document. During recruitment and at the beginning of the interview, potential participants were told the study focused on exploring their experiences with BBC, that participation was voluntary and would not affect the services they were receiving, that their names would not be used and that the organization and/or PSPs would not know who ultimately did or did not choose to participate.

2.6 | Data analysis

Team members started by reading through interview transcripts and marking sections that spoke to clients' experiences with medical providers during birth and discussing why they marked the sections/quotes and what they thought they meant, creating higher-level, but still grounded, codes. Thus, we developed the codebook iteratively as we analysed the transcripts. During the coding and analysis process, we met bimonthly to discuss coding issues, resolve questions and discrepancies and develop themes.

2.7 | Validity and reliability/rigour

We employed several techniques to increase the trustworthiness of our data and analysis process, including analyst, source and data triangulation (Patton, 2015), employing a member check and maintaining an audit trail through field notes. Analyst triangulation allowed us to guard against analyst bias. Three student research assistants and two PhD-level researchers experienced in qualitative methods conducted the data analysis. Data and source triangulation involved collecting and analysing quantitative administrative data and interviewing PSPs. To perform a member check, we developed summaries of a random sample of clients, emailed them asking for feedback, and none responded with corrections.

Consistent with phenomenology, we examined researchers' perspectives and experiences in relation to participants to guard against analyst bias. The researchers and participants had no prior relationships. The research team was a diverse, multidisciplinary team (public health, medicine, social work, nursing and organization development) and included an expert in narrative research. One investigator (who was White) had used a doula during her first childbirth experience in which she delivered prematurely, the baby was admitted to the neonatal intensive care unit, and had negative experiences with nurses. She delivered her second child at full term and had positive experiences with medical staff. She thus had experiences using a doula and both mixed experiences with medical providers. A second investigator was a mother and Black and reflected on experiences with medical providers in general and as mothers in particular. Investigators reflected upon and managed their biases and experiences during coding and analysis and actively checked one another's biases through discussion and bracketing.

3 | RESULTS

Twenty-five BBC clients participated in interviews in late 2017 and early 2018. All were Black. Participants' average age was 28 (*SD* 5.8), with a range of 18–41, and 68% were between 18 and 29 years old when they first enrolled with the programme; a little less than two-thirds (64%) had graduated from high school, gotten a GED or had less education; 20% had an associate's degree; and 12% had education beyond that. Most (84%) had one (40%) or two children, and 44% were married or living with a partner. Interviewed clients' babies were between 6.8 and 34.8 weeks old. As compared with the larger population of women receiving BBC services, study participants were slightly older (with an average age of 28 compared with 25), their marital status was similar, and they had a somewhat higher level of educational attainment (36% of interviewed clients had education past high school as compared with 24.7% of all clients).

Participants described experiences with a range of medical providers that included ambulance drivers who transported them to the hospital; nurses who monitored their labour, assisted with delivery and/or assisted postpartum; and with physicians or midwives who were primarily responsible for attending the birth and checking in postdelivery. Some women used physicians, and others used midwives as their primary provider.

Clients identified two major themes of positive and negative experiences with medical providers during labour (see Figure 1). Main subthemes and characteristics of positive experiences included

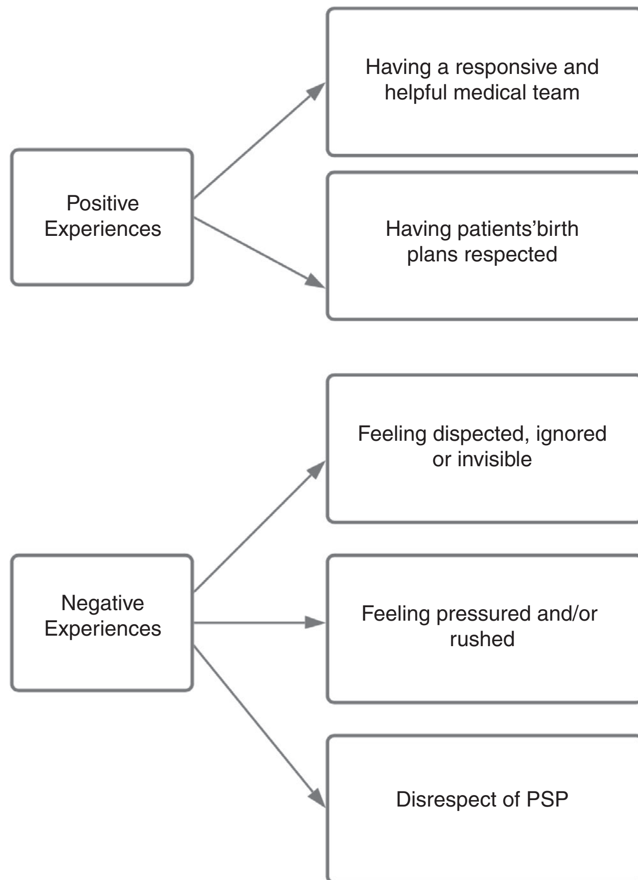

FIGURE 1 Themes associated with positive and negative birth experiences

having a responsive and helpful medical team and having their birth plans respected. In these cases, they described their labours and births as having gone smoothly. In other cases, clients described the labour and birth experience in more negative terms. Feeling disrespected, ignored and invisible, feeling pressured and rushed and having their PSP disrespected characterized negative experiences.

3.1 | Characteristics of positive experiences with medical providers

Most of the clients' positive feedback was reserved for nurses, rather than physicians or midwives. Among the clients who gave positive feedback, they said the interactions were 'smooth,' 'amazing,' 'awesome' and 'wonderful' that the staff were 'very helpful' and 'nice.' One client said her PSP introduced herself to the hospital staff, including the secretary and nurses and the interactions flowed smoothly. 'The whole time I was there, they was good.' [#4] Another client said that the hospital staff was really pleased with her PSP, and they told her, 'We need more doulas like you.' [#10] One client said her nurse and PSP 'already had a connection and relationship' and 'worked well together,' and another said her PSP 'interacted well with them. Some of the people were familiar with her and, if not, they were familiar with Birthing Beautiful.' [#18] Medical teams' responsiveness, helpfulness and respect for the client, her birth plan and her PSP were key themes of positive birth experiences.

3.2 | Medical team was responsive and helpful

One client said her medical team 'gave me everything … they were awesome.' [#11] Another client said she told one of her nurses, 'I would not have made it, if it was not for you.' [#23] Another client said her nurses 'were amazing,' and she never had to call them 'because they was just <finger snapping>on it.' [#15].

Comparing her experience with her BBC birth with her first birth, one client said, 'The nurses were … more helpful. They were in the room with me the whole time. They just helped me calm down.' [#21] Clients also noted that the nurses helped them 'to breathe and to relax' [#24] and appreciated being allowed access to food and drinks. Another client said her nurses 'were really good, actually. All the nurses were incredibly attentive and sweet. I did have a slight issue towards the end where I felt like they weren't hearing me,' but that issue was resolved. [#19] One client said of her positive birth experience,

> The birthing and everything afterwards, that was awesome … The delivery nurses were perfect. (They were) fine, really good … They paid close attention to my concerns … Anything I asked, they did without giving me a hard time. [#16]

These positive experiences were characterized by medical providers being attentive, responsive and having an attitude of calm and positivity.

3.3 | The medical team respected the birth plan

Participants' positive experiences were attributed to the medical team communicating early on their commitment to respect the participant's birth plans. Even when the birth plans could not be carried out as planned, one participant described her medical team as transparent, having open discussions that left the participants feeling empowered. One participant said her birth plan included not wanting to be checked on overly frequently, and she reported that had been respected. The nurses, she said, simply came in to check if she needed more juice and ice and to make sure she was okay. The participant said because her PSP was there, 'they understood and they was just like 'let you and your doula do your thing."' [#15] Another participant talked about her positive experience with her hospital staff expressing great understanding and acceptance of her birth plan. They said, 'We do everything within our power to make it as natural as possible. So everything that you have in your birth plan, we already do that. We're a teaching hospital.' [#24] The participant explained that they would limit interventions in the delivery. Another participant specifically talked about how once she and her PSP made it clear

the participant wanted a vaginal birth after caesarean (VBAC); her providers expressed their commitment to helping her achieve that goal. This helped the participant relax and increased her trust in her providers. The participant said:

> Everybody on the staff was on board and they reassured me that they understood my wishes and to the best of their abilities, they would follow through with them. And the doctor and the nurses actually came into my room with my birthing plan and went over them all with me … The nurses were awesome, every single one of them. They were very understanding,… very attentive. They kept reassuring me like 'We want you to have a successful VBAC as well,' and so it helped me to let my guards down…when I got into the hospital and I realized, 'They're not gonna rush me along.' [#13]

Another participant discussed her experience with her nurse, who, she said, paid close attention to her birth plan and asked 'a lot of questions' to make sure that what was happening in the delivery was aligning with the participant's desires and plan. The participant said, 'They did well caring for me,' making sure she had everything she needed. She elaborated:

> The nurse I had in my delivery was really good. She was really proactive. She knew I wanted to walk around, and she made sure she got the equipment…to enable me to be able to do what I wanted to do, and they took good care of me. [#18]

Another client said that although she was warned she would be pressured to have an epidural, that was not her experience.

> Everybody was just like 'Be careful. They force epidural on you.' They didn't do that. They gave me a choice and they just told me that, 'If you're in this much pain, and epidural would help, but if you also just wanna feel all this pain, it's up to you,' and so I didn't feel pressured. [#10]

One client who gave birth without any medical staff in the room said her nurse was kind afterward. She said she 'was very calm … taking her time. She was very gentle' [#17], actions that were appreciated as the client recovered from her birth experience.

3.4 | Characteristics of negative experiences with medical providers

Clients also described negative experiences with medical providers. These experiences were characterized by the main theme of disrespect, which included three subthemes of feeling personally disrespected and ignored, feeling pressured and/or rushed and their PSP being treated disrespectfully. Medical providers to whom clients' quotes referred included ambulance drivers, nurses and physicians. In describing negative experiences with medical providers, clients used the words and phrases 'stressful,' 'mean,' 'nasty,' 'evil,' 'horrible,' 'irritating' and 'brushing me off.' At least two clients expressed regret about not calling their PSP early enough while in labour and expressed feeling like that decision resulted in a more negative experience. One called the ambulance rather than her PSP, and characterized her negative experience with 'the little evil ambulance drivers … Worst decision ever.' [#8] The client recognized that her PSP would have provided a calm atmosphere for her, but the ambulance staff did not.

3.5 | Feeling disrespected, ignored or invisible

Clients felt disrespect was communicated in a few different ways, but several referred to medical providers' negative attitude, particularly nurses'. One client said her time at the hospital 'was stressful,' and the nurses were 'irritating.' She said,

> It was one nurse, I did not like her attitude … She was ignoring most of my questions. I had to get my dude to ask the questions all over again with a little bit of bass in his voice 'cause, apparently, my squeaky, in pain voice didn't help.' [#20]

Two other clients described their nurses 'nasty.' One said, 'that was just her disposition. So we just treaded around everybody, but got along, got results.' [#2] The second client described how she did not feel like her providers took her seriously. 'I felt like they were brushing me off, the pain that I was in. They were horrible people/humans.' [#5] Clients felt frustrated by feeling unseen and unheard by their medical team.

Another client said disrespect was expressed through the disregard of her birth plan. She said she had a distinctly 'horrible experience' in which the hospital 'didn't follow the plan.' She was told that a lot of people were having babies that day. The client had hoped to be in the hospital tub, to relax, 'have the lights cut down low, listen to my music.' But instead, she said, 'it was just chaotic. They didn't pay no attention to me. None. I had to keep pressing the button for them to come.' She said she was being monitored, but there was something wrong with one of the machines, and no one ever came to fix it. The client said 'I felt like they (the hospital) didn't care about me. They wasn't trying to help me.' [#9].

This sense of medical providers being 'hands off' at times was appreciated but was also described as negative when it veered towards neglect. One client said her providers did not do much during her delivery, including failing to notice her increased blood pressure until her PSP intervened. Another client said she 'barely talked to the nurses' [#14] that they only checked her vitals and asked a few standard questions. Another client said she had her baby without her doctor in the room because he did not listen to her when she told him how fast she was progressing. After he checked her, she said he declared 'Oh

this is just nothing. You're just gonna transition,' and when the doctor left, she gave birth to her daughter. Other clients echoed this experience, saying they felt their doctors did not hear and/or trust them. One client said she was feeling her contractions come faster, but the doctor dismissed her. The client said her PSP stepped in, asking the doctor to adjust the fetal monitor. 'Come to find out, they were like a minute apart, and I'm like "Yeah. I know what I'm talking about, lady."' The client had told her doctor 'I know what I'm feeling,' but not being listened to was frustrating. Her PSP's ability to 'say it to the doctor in a different way' [#3] had been helpful. While the PSP was able to advocate for the client to get the care the client needed, it troubled the client that her voice, without the PSP's intervention, had gone unheard.

3.6 | Feeling pressured and/or rushed

Feeling pressured or rushed was another manifestation of disrespect for clients. The introduction of interventions that the client perceived as unnecessary or premature fell under this category and included administering Pitocin and breaking the clients' water. One client said she felt pressured to get an epidural at a certain point because it was convenient for the anesthesiologist. The client said she looked at her PSP who told her, 'If you don't want it, just say no.' [#1] Another client said she felt coerced into treatment. 'The physician literally said to me she refused to treat me [unless I got a spinal tap] basically in preparation for the epidural.' [#13] Another client described the pressures that she felt when she was not dilating as quickly as the doctors wanted. She said, 'Everything was all good until it came time to them wanting to give me drugs.' She said her team of residents got 'a little pushy, and it's like impatient,' and her Pitocin level was increased without her consent.

> It's like 'What is your rush?' I don't understand. I feel like they get the paid the same … I just didn't understand why they wanted to keep upping up, just rushing the process. 'Just let it mellow. I'm not in distress.'

The client said her contractions were inconsistent, and she was not dilating, and her medical team moved 'to taking all the needles.' However, the client felt supported by her PSP along the way:

> So I felt like it would've been perfect, if they hadn't been rushing. When they rush you or make you feel like 'Something can go wrong, if this goes on too much longer,' that's a point of anxiety, and that is how I was feeling when I wasn't dilating … <Baby> just was chillin' like he didn't wanna come out, and the doctor's like, 'We gotta get him out. We're gonna get him out.' [And I was like,] 'You're not gon' do nothing, 'cause my doula not gonna let you. <laughter> So we'll sit here until he wants to come.'

Overall, the client said her medical team was 'not necessarily respecting of really the process that I really wanted to take.' [#2].

Another client described her distrust of medical providers, saying she felt they were uncaring and 'feel like they own you' with an attitude of, 'If I say you're gonna take this medicine, you better take it, and who do you think you are to disagree with me?' She continued:

> These medical professionals are doing a lot of things to women, Black women, that are medically unnecessary (that could be) killing our babies, I don't know, messing up our insides…I feel like the attitude and the opposition that you get over your own body is very scary, and it's unnecessary, and when you don't have anybody there to help you that can say why, or not that you should have to say way, but maybe if you're not educated, you'll let people do anything to you. [#18]

This client was one of only few who outwardly acknowledged a general distrust of medical providers and the risks women like her faced in seeking medical care.

3.7 | Disrespect of PSP

Clients experienced medical providers' disrespecting their PSPs as stressful. Although overall, clients said their PSPs and the medical staff interacted well, some said the interactions were not as good. One client said 'I felt like they were a bit intimidated by <PSP> because she was very vocal, like "This is her birthing plan. This is what she wants to do," and I don't think they were expecting her to come out like that.' While the client explained that her PSP was 'not aggressive,' she felt that the hospital staff did not 'like her … so that kind of put a damper on it.' The client described a specific negative interaction between her nurse and PSP during transition when the client asked for an epidural. The client explained that 'the nurse thought that [the PSP] was forcing me to do these things that were on my birthing plan, and that wasn't the case.' The client said the PSP knew and respected the client's wishes, but that the nurse would 'kind of look past her and look at me like, "You're the patient. What do you wanna do?" She would completely disregard her, so that kind of rubbed me the wrong way.' When the PSP was out of the room, the nurses would ask the client again about her wishes. The client said, 'So it was like they were kind of going behind her back and kind of sabotaging some of the stuff that she wanted to do for me. So I didn't really appreciate that.' [#6] The client felt the nurse disrespected the PSP's position and that disrespect both distracted from and adversely shaped the client's experience.

4 | DISCUSSION

Black women participating in a perinatal support programme and accompanied by PSPs at their births described both positive and negative experiences in interactions with their medical providers. Medical

providers perceived as positive and helpful respected clients, PSPs and the clients' birth plans, whereas negative experiences were characterized by medical providers having negative attitudes, working on their own schedules and with their own agendas rather than the clients' and not hearing and disrespecting clients, their birth plans and their PSPS. PSPs served an important function in their ability to connect deeply with clients and bridge communication gaps between clients and their medical providers, including speaking up for clients when they felt they could not speak for themselves. Clients' trust in the PSPs (and for some, distrust in medical providers) helped smooth the birth experience. This study provides the unique perspective of Black women involved in a perinatal support programme that extends birth support from pregnancy, during labour and 1-year postpartum. The programme's intention to foster the relationship between the PSP and client prior to the labouring experience supports the value that a support non-medical team member can present during delivery to reduce and prevent adverse maternal birth outcomes.

This is one of only a few studies exclusively qualitatively examining Black women's birth experiences. Building a strong understanding of first-person experiences and the meaning of those experiences is important in terms of valuing and lifting up voices of colour, a tenet of critical race theory (Delgado & Stefancic, 2001). Our findings fit with much of the previous research. Davis, taking a Black feminist stance, argues that maternal and IM may be due to obstetric racism, which 'includes, but is not limited to, critical lapses in diagnosis; being neglectful, dismissive, or disrespectful; causing pain; and engaging in medical abuse through coercion to perform procedures or performing procedures without consent' (Davis, 2019a, p. 562). Several of our participants' experiences fit with Davis's argument. Our findings are also consistent with recent large-scale survey research indicating mothers of colour report more mistreatment by medical providers; women with Black partners were more likely to report mistreatment (Vedam et al., 2019). With regard to participants' reporting that their medical providers did not take their pain seriously, research has documented false beliefs among the general public as well as medical students and residents that Black people are more pain-tolerant, and this has resulted in providers making inadequate treatment recommendations (Hoffman et al., 2016). Research has found that the ignoring of symptoms and discrediting Black women's voices are perceived as discriminatory (Cuevas et al., 2016).

Our research is also consistent with findings of a recent systematic qualitative review of 35 studies in 19 countries finding that women value non-medicated birth involving as few interventions as possible and want to give birth in situations that include 'kind, sensitive clinical staff, who provide reassurance and technical competency' (Downe et al., 2018, p. 6). Bringing a sense of intimacy as well as decision-making power in institutionalized settings that medicalize birth (Hunter, 2012, p. 315) demonstrates the importance of women's psychological experiences and the role caring and having a voice can play (Abbyad & Robertson, 2011).

Our research supports previous qualitative studies in this area. As one participant in one study focused on examining client experiences from a culturally tailored programme noted, 'care during pregnancy should not be based solely on physical, medical care, but rather on intangible supportive care that nourishes the soul to achieve mental health' (Nypaver & Shambley-Ebron, 2016, p. 562). Indeed, the emotional, physical and spiritual support conveyed by approaches to labour birth that move beyond the clinical and medical have been identified as critical in improving the experience (Hunter, 2002, 2012). This was true for our participants.

Helping Black women achieve a sense of power through relationships with a perinatal support provider may help mitigate the psychological distress uncertainty in medical situations can introduce, particularly for Black women. It is critical to note that the experiences described here were the experiences of clients who had been accompanied by a PSP. It may be instructive to consider what happens in the majority of cases when a woman is *not* accompanied by a professional support or advocate. How many women's voices are being ignored and/or silenced, and how many more women are being rushed, pushed into interventions, intimidated, frightened by their medical providers and have no one to speak up for them, empower them, encourage them and calm them? The positive experiences presented here provide some hope and concrete recommendations, including that having a support system like a PSP to buffer interactions and advocate for women and families could reduce negative experiences in the childbirth process, costs and interventions and improve birth outcomes.

4.1 | Limitations

The data discussed here focused on one group of women interviewed one time within a specialized programme. The views presented thus represent the views of women motivated enough to enrol in and remain engaged in a programme like this. They also represent the views of women who had working phones and could be contacted. We did not ask our participants about their perceptions of racism as being at the root of their experiences, nor did we ask about experiences with racism or racism stress, issues indicated to be at the root of infant and maternal mortality. Indeed, only one participant mentioned this. It is possible that the participants did not mention this due to the interviewers' race matching their own (Gibson & Abrams, 2003). Thus, while racism is clearly a critical issue in infant and maternal mortality, future work should directly address perceptions of racism underlying medical interactions.

4.2 | Implications

4.2.1 | Practice implications

Healthcare providers could benefit from understanding that their attitudes and behaviours play an important part in a woman's birth experience, and conveying respect and caring for the person, for their birth support person and for the birth plan can go a long way in improving the birth experience. Beck et al., (2020) argue that medical

providers must recognize their complicity in health disparities vis-a-vis lower quality care given to Black patients and argue that medical providers must not only 'follow up' but also 'follow through' with healthcare recommendations. We join others in advocating for medical providers to better understand the impact their attitudes and behaviours have on patient experiences and the impact a helpful and supportive approach can have (Abbyad & Robertson, 2011).

Culture shifts are essential, and patients must be considered expert parts of the care team to help identify issues and possible approaches to remedy them, and bidirectional conversations between community partners and health care providers might be one way to better meet patients' needs (Beck et al., 2020). Teams should be formed based on principles of integrated care, recognizing and valuing patients' expertise within systems that address mental health, educational and social determinants of health. Research has indicated the importance of including Black voices from the community in efforts to improve care, including service coordination and advising on culturally appropriate service delivery (Cotton et al., 2019). Education regarding the benefits of continuous labour support is also essential; nurses and physicians must understand that continuous labour support is associated with more positive birth outcomes and thus consistent with goals of ensuring a healthy mother and baby. For patients who do not have a dedicated labour support person, recent research has found training nurses about continuous labour support and skills is related to providing improved services (Murn, 2019).

4.2.2 | Policy implications

Despite the wealth of research evidence that labour support in childbirth results in more positive birth outcomes, doulas or other perinatal supports are not being universally implemented. It is essential that hospitals, government and private insurers alike recognize not only the cost benefits of doula care but also the societal benefits of improved IM rates (Lunda et al., 2018). Doulas should be categorized a preventive care service and services covered by insurance. Hospital systems should educate their staff on the history of racism in the medical system, and the specific challenges Black women face with regard to infant and maternal mortality. They should also be trained on the necessity of treating pregnant women with care and respect, allowing them choice, voice, with the understading that such care is likely to lead to better outcomes. One way to do this is to fully embrace continuous labour support as a policy and an essential member of the birth team (Lunda et al., 2018). Rushing childbirth and utilizing unnecessary interventions should be penalized, and situations in which providers who fail to treat patients with respect should be thoroughly investigated and, when necessary, held accountable and disciplined.

4.3 | Research implications

This study included only qualitative data. We did not systematically collect standardized data on women's stress levels with which we could examine qualitative experiences alongside quantitative measures. Future research should include mixed methods to provide a more comprehensive description of women's experiences. For example, to what extent were women's experiences stressful as measured using a well-validated standardized scale? Additionally, previous research examining Black women's perceptions of racism, stress and pregnancy-specific stress (Dominguez et al., 2008) suggest that having such measures can be useful in fully understanding negative birth outcomes. Integrating the quantitative data sources would have strengthened our findings.

5 | CONCLUSION

Birth outcomes for African American women in the United States are among the worst of developed countries and are related to the stress of experiencing racism over the life course as well as in the birth process itself. Excessively high Black infant and maternal mortality rates in the United States must be taken seriously and necessitate the pinpointing of specific factors that might play a role in such rates and the identification of effective interventions. This study examined the potential role of interactions with medical professionals in Black women's birth experiences. Using the theoretical lenses of symbolic interactionism and intersectionality, we found that medical providers played a meaningful role in the birth experience, and having a PSP helped mitigate negative experiences with medical providers. Without strong, decisive, radical actions to improve our rates, we will continue to fail to meet some of our society's most basic goals of equality, and without a healthy population, we cannot fully prosper.

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CONFLICT OF INTEREST

We have no known conflicts of interest to disclose.

PEER REVIEW

The peer review history for this article is available at https://publons.com/publon/10.1111/jan.14941.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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