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The Lived Experience: Collective Realities of Black Maternal Healthcare

A Dissertation

Presented to the Faculty of the

Department of Public Policy and Administration

West Chester University

West Chester, Pennsylvania

In Partial Fulfillment of the Requirements for the

Degree of

Doctor of Public Administration

By

Rhonda Parham

December/2022

Dedication

In loving memory of:

Diane Parham

&

Ronald Crawley

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My appreciation for my advisor and committee chairs' patience and input is inexpressible. I could not have made it this far without the help of my committee, who kindly shared their knowledge and skills. I would also like to thank all my fellow student peers who have helped me and guided me through my doctorate degree. Altogether I want to thank everyone for their kindness and patience as they supported me in any way during my doctoral journey. I would not have been able to accomplish anything without your support.

Abstract

Maternal health has become an increasingly important public health issue in the United States due to the country elevated levels of maternal mortality rates. As the patient experience which entails a wide variety of interactions between patients and the healthcare system becomes more associated with patient outcomes, it is important to explore how the patient experience is affecting maternal health outcomes. This study consists of in-depth interviews to investigate their experience receiving maternal healthcare in Southeastern Pennsylvania. The study aims to figure out what are black women experiences while receiving maternal healthcare in southeastern Pennsylvania and are those experiences negative. Understanding how their negative experiences affected their health outcome and how often people have negative experiences and negative outcomes. The study showed that half of the participants had positive experiences while the other half did not. The half with negative experiences faced racial comments and microaggressions. Within the sample of participants that had negative experiences, 3/5 of those participants had negative health outcomes. The need for the maternal experience to be explored needs to be expanded so that the disparities with maternal mortality statistics can be explained and eradicated.

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The Lived Experience: Collective Realities of Black Maternal Healthcare

Chapter 1: Introduction

“Women do not have to give up their life in the process of giving us a new life. Maternal mortality has been eliminated or nearly eliminated in many countries in the world. Where the scandal persists, it is not because women are dying from diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving.” (Fathalla, 2011). Society, especially the healthcare system, has neglected the humanity of many mothers in the country. Racism ingrained in many aspects of American life and culture has left many black mothers disproportionately facing higher rates of maternal mortality rates compared to other races in this country. The healthcare system has turned its back twice on black mothers in this country by not closing the maternal mortality rates gaps between rates and decreasing the among of overall preventable maternal deaths. America has romanticized the idea of giving birth in this country but has failed to make it safer for mothers in this country to deliver their babies healthily. A healthcare system that spends the amount of money like the United States should produce better maternal healthcare outcomes.

Seven hundred women walk into a hospital in the United States every year expecting to deliver their child but end up dying. About two-thirds of the deaths are completely preventable. Fifty thousand women a year have life-threatening complications of pregnancy. Not only is this an issue for all pregnant women in the United States but certain groups are higher at risk of dying during or after childbirth. Black women are three to four times more likely to die during childbirth than white women (Racial/Ethnic Disparities, 2019). Even educated and wealthy black women are still more likely to die of childbirth complications than white poor uneducated women. Further, for every maternal death, eighty-four women suffer from severe complications.

There are many reasons why a mother might die during or after childbirth. As stated, before most of these reasons can be prevented.

Black women giving birth at hospitals predominantly serving minorities are at a higher risk. A study published in 2017 found that seventy-four percent of black babies were born at the twenty-five percent of hospitals serving the highest proportion of black individuals, and women delivering at these hospitals were significantly more likely to suffer severe complications than women delivering at lower black-serving hospitals. (Metcalf et. al, 2017). The study author concludes that delivery hospital accounts for nearly half of the difference between black and white maternal mortality rates. A study in 2017 found that more than half of all rural counties in the United States, with 2.4 million women of reproductive age, have no hospital obstetric services and face primary-care physician shortages (Metcalf et. al, 2017). It was found that these counties were more likely to have a higher percentage of non-Hispanic black women, to have lower median household incomes, and to be in states with more restrictive Medicaid eligibility.

In the United States, the government permits individual states to implement laws on the state level to address the state's needs. This will cause different states to handle their maternal mortality issues differently. Therefore, different states have different maternal mortality rates, and their rates reflect how well their maternal policies work. The state of California has worked hard to implement the California Maternal Quality Care Collaborative (CMQCC) in 2006. By 2013, the state's maternal mortality rate was reduced by half to an average of 7 deaths per 100,000 live births (Hayes et. al, 2019). Notably, most of the reduction was driven by reduced mortality rates among black women, and while a disparity between blacks and other races still exists in the state, the difference has significantly declined since the program's creation.

The CMQCC is a collaboration between hospitals, clinicians, state agencies, insurers, patient and public groups, and other stakeholders that requires four key components: linking public health surveillance and proactive action; mobilizing collaborative public and private partnerships; creating a data system with a low administrative burden to support improvements; and establishing multi-stakeholder interventions that connect providers with relevant health services.

The combination of mortality reviews, stakeholder engagement, and data has provided a blueprint for improvements targeting performance and quality metrics. The implementation of these large-scale interventions is the driving force behind California's improvements in maternal mortality rates and could potentially have similar effects if administered at the national level across various states to aid in maternal mortality rate reductions.

Negative and positive patient experiences are influencing the maternal care provided in the United States. It is critical to determine the patient experiences of mothers in this country.

- What is the connection between patient/doctor relationships and increasing maternal mortality rates in America?
 - Is the experience of women of color who give birth in the United States more negative compared to other races?
- What exactly are patients experiencing when they navigate through the maternal healthcare system in America?
- Are black mothers facing racism and bias in the United States healthcare system?

California is a prime example of a state that uses stakeholder engagement to decrease maternal mortality rates. If the program were implemented nationally, it could potentially cut Maternal Mortality rates (MMR) down nationwide. Since patients are one of the main stakeholders in a hospital, they must receive the best care possible. The design of the research is

phenomenological. MMR is rising in this country, but the experience of these mothers needs more documentation. Understanding if there is a lapse in patient care that is causing these rates to go up can explain why the rates are going up.

America is facing a maternal mortality public health problem. Internationally speaking, America's MMR exceeds other, high-income nations. America is an incredibly unique country because it has extremely high healthcare expenditures but still has many negative outcomes in areas like maternal health. Americans are paying higher costs for negative healthcare outcomes. Not only is the MMR high in this country, but the rates are also still rising. The burden of this problem is impacting the healthcare system and many families across the country. America is leading an extremely poor example of how to control its elevated levels of MMR. It is also reflective of how deeply racism is impacting the healthcare system and is exacerbating the maternal mortality crisis (Hayes et. al, 2019).

When the maternal care system is not built to meet the needs of the women having birth, there becomes a severe problem. In America where racism is ingrained in many different systems, it is exacerbating the maternal mortality crisis. California is headed in the right direction to help alleviate the crisis but that is only one state out of fifty in America. Each state is handling the problem differently, which is not helping the situation across the board nationally. Each state has its factors that influence maternal care, so maternal care must improve nationally and become more uniform. America needs to address the issues of racism because it is interfering with the quality of care that is being provided to its citizens.

1.1 Background of the Problem

The American Healthcare system has seen many changes over the past decades. It is important to note the role that healthcare plays in American lives. As technology and medical

advances improve, people expect to live longer, and Americans value better healthcare coverage and access. Moral values are changing, and more Americans view healthcare as a right that should be accessible to everyone. The problem is that America is heavily under the influence of capitalism even though it is considered a mixed market. Certain aspects of American life are impacted so much by capitalism such as the healthcare system. America currently operates a mixed market economy that has capitalistic and socialistic values. The country's market operates under economic freedom when it comes to the use of capital but there are instances when government intervention in the market happens.

Even though more Americans view healthcare as a right, there is still a battle over who should foot the bill. The argument from a lot of Americans is that the government should not foot the bill. The idea of a single-payer system funded by the government is something that has forced more political pressure and has caused some lawmakers to fight more for legislation to promote a single-payer system. Some argue that a single-payer market goes against the free market while others believe a single-payer system will alleviate some of the medical burdens faced by patients in America. The fact that Americans are stubborn about changing the way they view the market is affecting how legislatures approach the healthcare crisis. No matter how progressive Americans can get in various aspects of life, Americans still seem conservative when it comes to policies that are deemed socialist (Markowitz & McLeod-Sordjan, 2021). Many Americans hold the belief that the single-payer market will kill competitiveness and decrease the quality of care. Americans do not seem to want to sacrifice the costs of a single-payer system to increase the quality of care for all citizens.

Six values have shaped the U.S. (United States) health care system: physician autonomy, patient autonomy, consumer sovereignty, patient advocacy, high-quality care, and access to care

(Johnson et. Al, 2010). The healthcare system has only embraced one of the values completely, which is physician autonomy. The other five values have not been as fully implemented as physician autonomy. Patients love autonomy because they feel in control of their healthcare. They have enough information to make informed decisions and feel like they are in control of their destiny. When it comes to consumer sovereignty, patients want their needs and outcomes to be prioritized over the profit of the healthcare system. Patient advocacy allows patients to have people on their side who can help patients connect with their healthcare professionals to obtain the information they require to make healthcare decisions. Patients want high-quality care and access to care that would allow them to have the best health outcomes possible. These values need to be embraced more by the healthcare system to change the habits of their patients. Americans have not been prioritizing their health as they should be.

A study conducted on American thoughts about their health revealed that among 10,000 Americans, only about 44% are likely to put their health first in their lives. These Americans are doing this by seeking treatment, disease prevention, and seeking different opinions of medical advice (Wolek et.al, 2020). This reflects that there are still a lot of Americans who do not emphasize prioritizing their health first. More than half the country is not prioritizing its health. It is troubling that more than half of the citizens of a wealthy country like the United States are not putting their health first (Brennan et al., 2016). America has more than enough money and resources to treat all its citizens yet more than half of the people will not prioritize seeking medical care. Strangely, a market that promotes competition is supposed to give consumer sovereignty and high-quality care, but there are still a lot of people out there who put their health on the back burner. Why would so many American delay treatment or completely avoid it if the healthcare market is so great? It is concerning those other countries with a single-payer system

have better health outcomes than the United States especially since it is a core belief that competition in the healthcare market will provide a better quality of care.

Americans have reservations about a single-payer system because of the costs but the irony is that Americans spend more on billing and insurance-related activities compared to other countries with a single-payer system (Moffit, 2020). The United States has the highest administrative costs in health care for any country at \$200 billion. The U.S. healthcare system is a complicated one that includes private and public insurance, pharmaceutical companies, and a web of health networks that make the costs and quality of care complex (Moffit, 2020).

“According to Mark Pauly, Wharton professor of health care management, ‘the design of a country’s health care system and the performance of it are very dependent on a specific country’s culture, ethnicity and a whole lot of factors that have nothing to do directly with health care but have everything to do with health outcomes.’” (Wolek et. Al, 2020)

If Americans want better healthcare outcomes, then the country should reconsider having a single-payer system. American believe that having a competitive market will increase the quality of care given by providers. That is only the case if people can afford it. While the costs of healthcare increase, they become unaffordable to more Americans. There is no point in having such high-quality healthcare if it is too inaccessible to low- and middle-class Americans. Having the best healthcare does not matter if it is not producing positive health outcomes for the people it is supposed to be covering.

Americans have been obsessed with being the best and having the best but at times they sacrifice the good of the collective. Americans will put their beliefs over the benefits of the consumer. Instead of having a single-payer system that makes the healthcare system more effective, Americans would rather let the healthcare system operate in a system where it allows

pharmaceutical companies and insurance companies to take advantage of their patients. It appears that American societal and political culture would rather have a healthcare system that has excessive costs and promotes competition instead of one that has a single payer that provides everyone access.

1.2 Statement of the Problem

America has always been proud of being number one or having the best version of something, but it has come at a cost. America's healthcare system is blatantly ignoring the humanity of many women and especially black women when it comes to maternal care. How can society explain the disparities between races when it comes to maternal healthcare outcomes when its healthcare system is so great? If competition creates innovation and excellence in the healthcare market, then why are health outcomes not improving? American society must ask itself how much more people are willing to sacrifice in the spirit of a free market. Societal and political pressure play a role in passing legislation that could decrease these disparities and give more Americans access to better healthcare outcomes.

Healthcare providers must tap into their own biases and recognize how their prejudice can impact the intricate U.S. healthcare system. They must also realize what level of racism they are perpetuating when they interact with their patients. Providers can have a level of internalized or interpersonal racism that can severely impact the interactions that they have with their patients. Having negative internalized racial beliefs is going to influence the level of care provided to a patient. In facilities and institutions, they must be wary of institutionalized racism. Healthcare networks need to be aware of how certain rules create inequities among patients. Sometimes these health networks can be filled with employees who are unaware of their bias which created an atmosphere that is not beneficial to all types of patients.

America's reputation for its healthcare system is not matching the patient outcomes, especially in areas like maternal medicine where most of the deaths are preventable. Healthcare networks and hospitals need to start holding their providers responsible for the inconsistencies in the outcomes of their patients. Providers need to focus on the patient experience to improve the nature of the patient-to-doctor relationship. When there is more trust on both sides of the relationship then maybe the quality of care can improve. Doctors and other health professionals can decrease the number of preventable deaths that occur. The patient-doctor experience is an especially important relationship to develop because it influences the patient's health outcomes and how they respond to their treatment.

There have not been a lot of women who have had maternal healthcare services that have been able to tell share their experiences in maternal healthcare studies. There have been maternal mortality review boards to analyze the data but not a lot of data that records a woman's experience. Reviewing vital statistics, death certificates, and chart reviews are not going to reveal what is occurring during these maternal near misses, maternal deaths, or during a woman's maternal care. Trying to obtain the experience of these women is paramount to understanding the maternal mortality disparities between different races in this country. Navigating the healthcare system can be difficult, and it is important to collect data on the patient experience to learn how to improve it.

Collecting data on the experience of patients can help their doctors understand how their doctors' interactions impact the patient's experience. Using a qualitative methodology to collect the experience of women during their maternal care will be instrumental in solving the maternal mortality issue in America. Understanding what these women are going through during the childbirth experience will add to the current data and statistics and help better explain what the

problem is. Gaining a deeper knowledge of a patient's health beliefs can assist healthcare personnel in identifying gaps between their own and the patient's comprehension of his or her state of health. Therefore, treatment options that are more acceptable to the patient's expectations and requirements are needed desperately to improve health outcomes.

Understanding the experience of women is especially important because their lives affect their maternal outcomes. Their background, education, residence, and cultural factors impact their maternal care. It is important for policymakers, doctors, researchers, and others to completely understand what different women are going through because it can influence their quality of care. Using qualitative methodology will make people understand the role that each stakeholder plays in these maternal deaths. Doula's, healthcare providers, community engagement, patients, patient's families, lawmakers, and different support systems all play a role in the maternal healthcare outcome of every woman in this country. Understanding how each stakeholder influences and impacts different decisions that are made by pregnant women will help make future decisions about maternal care.

1.3 Significance of the Study

The importance of this study is to examine and highlight the experiences of black women in Southeastern Pennsylvania. There is plenty of research on maternal healthcare outcomes. The literature describes a very disturbing story. A white woman with a high school diploma has better health outcomes when it comes to maternal mortality than a Black woman with graduate education. That is deeply troubling because obtaining an education in this country is supposed to secure better social and economic outcomes. When a person has better economic outcomes, it is supposed to improve their quality of life including their options for healthcare since the U.S. healthcare system is a competitive market.

This is not what is happening to Black women in this country. When comparing the maternal outcomes of all other races in America, Black women still are at the bottom. Even though getting an education and having economic advantages are giving Black women better maternal health outcomes. There appears to be distrust coming from the patients and the doctors. Patients have mistrusted doctors because of some of the unethical medical experiments that have happened in this country and some doctors hold beliefs that patients of color do not adhere to treatment advice. For example, one unethical medical experiment called the Tuskegee Experiment saw many black men die because they were infected with Syphilis (Scharff et. al, 2010). These men were not told the true nature of the experiment which was to monitor the effects of Syphilis when gone untreated.

Another sad case of mistreatment from medical professionals is the case of Sara Baartman. Unfortunately, at 20 years old she was forced to participate in a freak show attraction across Europe. This freak show attraction was meant for audiences to gawk at her body in particular her large buttock. In some cases, patrons were allowed to touch Baartman if they paid the right price. In the early 1800s, while in France, Baartman was the subject of scientific and medical research. She remained in European custody for the rest of her life for scientific reasons despite the numerous legal battles fought for her freedom. After she died, researchers kept her sexual organs, brain, and parts of her skeleton to put on display at the Musee de l'Homme in Paris. (Howard, 2019)

This study will humanize black mothers and show that they are just like any other patient. It will highlight some of their concerns that may not be acknowledged due to cultural or social differences. Every single woman giving birth is going through an experience. It is important to associate their negative or positive healthcare experience with their health

outcomes. Understanding how their experience can be negative or positive will give insight into the actions and behaviors of healthcare professionals can affect the patient experience. It is known that the patient experience can influence the patient's outcome. Thus, it is imperative to understand what the patient is going through during the healthcare experience. Instead of focusing on customer service aspects of the healthcare industry that influence profits, researchers can focus on the patient's experience and how that influences health outcomes. There is plenty of data collected about how satisfied patients are with the healthcare system, but there is not a lot of data on the interactions between patients and healthcare providers.

Healthcare interactions shape healthcare decisions made by the patient. Having a negative experience will change the health-seeking behavior of a patient and ruin their trust in the healthcare system. Identifying which patients are having negative experiences can help policymakers locate where the quality of care can improve. Acknowledging the patient's experience can help improve clinical settings by identifying weak areas of communication that lead to poor patient outcomes. Patients stress how important it is for them to be involved with their care, have their concerns addressed, and feel in control of their condition. Proper interpersonal communication, counseling skills, and a positive attitude can help providers give their patients a positive experience.

The main significance is to humanize and let their stories reflect their maternal healthcare experience. Women are going through things and are not baby incubators that are only here to reproduce and further the human population. Childbirth should be safe and a positive experience for everyone involved. This study will reveal how certain interactions make women feel less than human, and it can show how healthcare provider interaction has some underlying racial bias. It will reveal how patient and provider interactions have an influence on the patient experience and

it shapes future maternal healthcare decisions. The disconnect between patients and doctors is impacting the level of care that is being provided to patients. Understanding a patient's experience as they navigate through the maternal healthcare system will give a clearer picture of the external factors that are influencing patient decisions.

Healthcare providers can learn from their peers' interactions and how some harmful exchanges can create distrust in the healthcare system. Patients can be a good indicator of the care that they receive. Their experiences are important to gauge where a provider can improve on the patient's experience. The only way to improve the clinical outcomes of maternal care is to dive deep and start understanding the experience of women giving birth. Ignoring the patient's experience can lead to putting the patient's safety at risk. Around two-thirds of maternal deaths are preventable, so there must become a focus on improving the maternal experience in the US (United States) healthcare system.

Policy changes and implementation can make a dramatic change in the maternal mortality crisis in America. Policy makers can expand Medicaid through legislation and improve health care access gaps for pregnant women in this country.

1.4 Conclusion

America must solve this public health crisis immediately. The healthcare system has the technology and resources to prevent many maternal deaths a year, but it does not. Many women are being put in danger during the process of childbirth because the healthcare system refuses to address this issue. The impact of personal bias is too great in the healthcare system, and it is costing many lives. It is essential to start understanding the patient experience and provider interactions are intertwined. The provider has a responsibility to understand what they say and do makes an enormous difference in a patient's life.

The high mortality rates, the preventative deaths, and the disparities in maternal mortality rates between races cannot be fully explained or understood. Policymakers and healthcare providers need to understand how to solve this problem. The issues of racism are impacting the level of care provided and this must end immediately. The problem of race has always been an issue, but it cannot be ignored in the healthcare system anymore. The deaths of Americans that could have been prevented need to end. America has more than enough money, resources, expertise, and knowledge to have the same maternal mortality rates as other high-income countries. There needs to be an intervention in the healthcare system to address these deaths and near-death misses.

Chapter 2: Literature Review

Giving birth is an event that should happen safely and have extremely low mortality rates. Modern medicine has progressed, which has given people access to a higher quality of healthcare. Unfortunately, in America this is not the case, and women are facing different challenges in the delivery rooms all over the country. This is leading to a public health crisis and having people lose their lives. Many of those lost lives were preventable. The unnecessary loss of American lives is disrespectful to their humanity. The U.S. has enough resources to address maternal healthcare issues and their disparities.

Maternal mortality is a concerning issue in the United States. The issue is a paradox because of the status of America. This country wields a lot of economic and political power. It has allowed to resource to not be properly spread across the country leaving communities with lack of access to proper healthcare. A country that spends so much money on healthcare expenditures certainly should not have such a high mortality rate. Especially when you compare the mortality rate of the United States with other smaller and less developed countries, the numbers are close to each other. How can a country with so much money has maternal mortality rates so high? It is time for America to address the underlying issues associated with the country's high mortality rates to truly fix the problem.

The Maternal healthcare crisis in America is one that has gotten out of control. America is a developed country with the resources to provide adequate healthcare to every single individual residing in the country. Racism is ingrained in the criminal justice system, legal system, healthcare system, and educational system. People's prejudice and bias are resulting in the unnecessary loss of American lives and that is completely unacceptable.

African Americans have fought many battles to obtain equal rights and to end racism in the United States. Through the civil rights movement, African Americans were able to gain some legal victories. This would improve the lives of African Americans in different areas of life such as education, employment, and healthcare. African Americans had to force the government to comply with the constitutional mandates of the Equal Protection Clause of the Fourteenth Amendment to make African Americans less vulnerable when seeking healthcare services (Yearby, 2018). African Americans throughout history have faced violence, rape, unethical medical experiments, and limited access to resources and education.

Slavery in the American colonies set a precedent for the treatment that black people would receive in this country. As shown in Table 1 of the Appendix A, from 1619 to the present day the ramifications of slavery are present and affecting the lives of black Americans today. The period of slavery in America, which lasted over two hundred years, legally allowed for black people to be murdered, raped, abused, and treated like property by their owners. Enslaved people had no rights because they were made property by law. Due to these people being legally treated as property, enslaved people faced unethical medical experimentation. Enslaved people worked for no wages and had limited access to healthcare and education which created levels of generational poverty that are still evident today.

After slavery, black people faced laws such as the Black Codes and Jim Crow laws, which legally and social did a lot of damage toward black people in America. Segregation diverted well needed resources from black communities. Left black communities vulnerable to racist attacks and gatekept black communities from certain financial resources like home loans. Black people transferred from being property in America to being citizens with extremely limited civil rights. Through these laws black Americans were forced to accept facilities,

services, education, and healthcare that were separate from White people and these separate accommodations were very subpar. The federal government allowed states to separate public accommodations such as employment, public transportation, housing under the guise that the different facilities were equal but there were not. This inequity created from limited healthcare access and employment opportunities created large economic and health inequities between races. Segregation and resource deprivation created many disparities between different races in this country. Black people faced extreme disparities in healthcare access, educational resources, employment opportunities, income potential, and housing opportunities. Even after the civil rights movement, black people still faced some of these problems. The history of racism has impacted the quality of healthcare available to black people in this country, and it is evident in the disparities between the races in the maternal healthcare system.

Even after the civil rights movement, African Americans still face the negative consequences of enslavement and racism in America. In 1962 there was a lawsuit against two hospitals in North Carolina (*Simpson v. Cone Hospital* 1963). African American physicians, dentists, and patients sued those hospitals because the hospitals were refusing patients based on the color of their skin and they were receiving federal funding. Congress sided with the patients, which led to the passing of Title VI of the Civil Rights Act of 1964 to put an end to “separate but equal” access to healthcare (Yearby, 2018).

This is significant because at the time the amount of federal funding that went to hospitals was limited, but in 1965 the Medicare and Medicaid act was passed expanding the amount of federal funding to hospitals. If hospitals want to keep receiving federal funds, they will have to stop engaging in discriminatory practices.

It was mandatory to comply with Title VI of the Civil Rights Act of 1964 to gain access to any of those federal funding. Legally forcing nursing homes and hospitals to not discriminate to get more federal funding ended up alleviating some of the disenfranchisement that African Americans were experience while seeking healthcare. Having hospitals integrated was easier because they had to get access to the money the government was giving out. Hospitals heavily relied on those funds, so they had no choice but to comply. These facilities are businesses, and they should not miss the funds because they will lose profits. There have not been any recent legal cases that have alleged that a physician gave their white patients in similar circumstances better treatment than the treatment provided to the black patient (Mathew, 2018).

Between 1965 and 1971, there was a decrease in maternal mortality rates in African Americans after desegregation. Unfortunately, the laws are flawed. Title VI of the Civil Rights Act of 1964 banned discrimination in hospital but it did not force individual healthcare providers to. Individual providers are to be exempt from complying with the discrimination portion of the law. A specific doctor could practice discriminatory practices when it comes to treating a patient, but the hospital could not reject that patient from having services. Hospital facilities can still collect government funds for accepting black patients while their individual providers can deliver subpar healthcare to black patients because of their biased beliefs. The individual providers would not be penalized because the Civil Rights Act of 1964 because the law only ensures that the healthcare facility does not discriminate.

Having those racial biases and prejudices are impacting the level of care that providers can give to their patients. It not only influences the level of care that African Americans are receiving, but it deters other people from seeking healthcare. Due to the ongoing racism in the healthcare system, it is estimated around 22% of African Americans postpone seeking medical

help and around 32% have individually experience discrimination in the healthcare system (Yearby, 2018). These racist interactions are affecting health outcomes among black patients. Patients should be free of racist interactions during their healthcare People are going to share their experiences with their family and friends and give a negative review of their healthcare experience. The goal should be making their experience as positive as possible so that they will let their inner circle know to use healthcare services at that facility.

Studies have shown that primary care physicians' perception of patients was influenced by the patient's race and sex. It even affected the recommendation provided by the physician when the provider was referring to them for cardiac catheterization (Yearby, 2018). In addition, African Americans were less likely to have a provider refer them for cardiac catheterization compared to other groups. There are countless other studies that reflect the bias in the healthcare system, especially when it comes to cardiovascular care (Yearby, 2018). In every study these healthcare disparities remained even after the researchers have considered socioeconomic differences.

Unfortunately, Surveys of physician perceptions of patients show that they believe African American patients are less intelligent. Further, physicians believe that African American patients are less like to listen or follow their medical advice. Those negative beliefs persisted even after the patient contradicted their assumptions (van Ryn et. al,2006). When the study was completed again later by the same researchers, in 2006, the same prejudiced beliefs abouts African Americans was still present. This resulted in less African America male patients being referred for a coronary bypass compared to white males (van Ryn et. al, 2006).

There is compelling evidence to support health care disparities among certain racial and ethnic groups that are present in different cardiovascular care studies. These studies have shown

that the health disparities are not stemming from racial variations of certain diseases. For example, it assumed that African Americans face higher rates of cardiovascular disease due to socioeconomic status, poor diet, or low levels of exercise. That is not what is truly reflected in these studies, it is showing that it is the quality of care that is leading to health disparities in different cardiovascular settings. Health practitioners biased caused African American patients not to receive the proper procedure or care.

The American Journal of Economics and Sociology noted that African Americans when it came to renal transplants were not only less likely to be evaluated for the procedure. When factors such as person preferences, socioeconomic status, the kind of dialysis facility patients used, perceptions of care, health status, the purpose of renal failure, and the presence or absence of coexisting illnesses African Americans were still less likely to be put on the transplant waiting list compared to their white counterparts with similar situations. That reflects the bias that providers have for their patients. The American healthcare system must address the constant bias implemented by individual providers and how those influences health outcomes.

There is anecdotal evidence to support health practitioner bias. A New York health practitioner who was serving African American patients wrote about his own struggles to overcome his own personal biases and the racial prejudices of his colleagues (Green et al. 2007). Sadly, this resulted in a lot of their African American patients not getting the proper access to healthcare. In another study there were several doctors who had been given hypothetical medical situations and the only thing that was different between these hypothetical cardiology scenarios was the race of the patient. The doctors never admitted to being racially biased, but they ended up less likely to suggest African American patients in the scenario the same treatment for a coronary heart attack than their white counterparts.

Race even impacts the lining of questioning that a doctor will ask their patient to determine the proper treatment. Even though it has been proven that African Americans are smart and compliant, there are still healthcare providers that believe otherwise. It is still believed that African Americans will not adhere to medical advice. When doctors believe that their patients will not listen to their advice, they do not feel inclined to give the best advice all the time. Thus, forcing African American patients into this viscous cycle where they face bias against them which results in the patients not seeking care when they should, having interruptions in their care, and flat out mistrusting and avoiding the American healthcare system. (Sabin et al. 2009: 907).

To highlight the importance of the impact of racial bias in hospitals the life expectancy rates of African American males and Caucasian male were examined. It showed that in 1950 the life expectance for both African Americans and Caucasian males was 65 years old. Fast forward to 1995 and the mortality rates were quite different. When it came to ailments and other causes of fatalities such as cancer, diabetes, suicide, cirrhosis of the liver, and homicide, the mortality rates for African American men were higher. It was found that in 1985 there was an excess of deaths happening in African American and other minority communities. In 2002 it was estimated that around 83,570 African Americans died that year that would have not died if the mortality rates between African Americans and Caucasians were the same. “There has been no sustained decrease in black-white disparities in age-adjusted mortality (death) or life expectancy at birth at the national level since 1945.” (Yearby, 2018)

Several publications are dedicated to exploring and studying the economic and sociology patterns in America. Unfortunately, black people in America will face higher death rates compared to their Caucasian counterparts because black people face a higher frequency of

preventable death. Black people's frequency of preventable risk has not been diminished by the amount of racial equality in access that has been ingrained in the system. With such prevalence to preventable risk, African American face a greater risk of being injured and killed. Structural racism in the healthcare system is contributing to the disadvantage black people face when seeking healthcare in America. Any time a healthcare provider gives Caucasians an advantage by giving them adequate care and giving other people of color less care than what was provided to white people is putting all other patients at a disadvantage.

The Medicare act prevents hospitals from discriminating against patients if they want to continue to collect federal funding. The consequences of racial biased has impacted Medicaid enrolled patients. It was investigated that African American Medicare enrollees compared to Caucasians received less thorough care which caused the African American patients to see a decrease in primary care visits, mammograms, flu shots but an increase in hospitalizations and mortality rates (Douthard et. al, 2021). This investigation controlled the wealth factors of the research participations. These trends were still prevalent no matter how much African Americans made.

Starting in the 1990s the U.S. Department of Health and Human Services (HHS) stated their focus was reducing Maternal Mortality Rates (MMR) because they wanted to promote an agenda for a healthier America. (Douthard et. al, 2021). To do this they used several different systems to track MMR in America to detect future threats and trends to MMR. The National Vital Statistics System (NVSS), which is controlled through the Division of Vital Statistics (DVS), and the Pregnancy Mortality Surveillance System (PMSS), which is dealt with the aid of the Division of Reproductive Health (DRH), are both used by the Centers for Disease Control (CDC) to track Maternal Mortality (MM). The DVS uses the term MMR while the DHR uses the

term PRMR. The entities DHR, DV, and many municipal Mother Mortality Review Committees (MMRCs) play a vital role in discovering the causes of preventable maternal deaths. As of 2018 there are MMRCs in 45 states and the District of Columbia.

Several Factors have contributed to the decline of MMR in the 20th century. Environmental interventions; breakthroughs in clinical medicine; increases in education; improvements in nutrition, disease surveillance and monitoring, access to health care, and standard of living; advances in clinical medicine; and the implementation of technical and political changes that were implemented resulted in the decrease of MMR. For example, the shift in of women choosing to have their children in hospitals, the creation of Medicaid, and the advancements of medicine such as antibiotics made improvements to the quality of maternal care. Around 1985 the MMR trends started to reverse and over time ended up doubling in 2003. Also, Pregnancy-Related Mortality Ratio (PRMR) trends more than doubled from 1987 to 2016. The evolution of medicine has complicated the collection of MM data and coordination of reporting facts. For example, the cause of death for MM changed from IDC-1 to ICD-10 and now medical examiners have the option of indicating someone was pregnant on their death certificate. MM discrepancies by means of race, ethnicity, age, education level, marital status, fitness insurance, and geographic locations have been seen throughout local, state, and national data levels. Regardless of how the data is collected and how the terms are defined there have been MM disparities for the last 80 years.

PRMR rates among different racial groups in America are noticeably different. For black women, the PRMR rates increased the disparities between Black and white PRMR widened. The PRMR rates did not drop despite an increase in the education level of African American women. Non-Hispanic white women have less MM rates compared to African American women of all

ranges of income and education. There is this theory called “weathering” which alludes to claiming that black women’s health declines faster due to the cumulative impact of behavioral, economic, and environmental stresses associated with the societal and racial pressures that black women face.

Geographical area impacts maternal healthcare access. Before in rural areas, they were already lacking healthcare access when it comes to the physical locations of healthcare facilities. Sometimes people had to travel long distances just to get to the hospital. Unlike Metropolitan areas where there are more healthcare facilities located in the area and they have more access to public transportation. There has been an increase in the closure of gynecological and obstetrical care facilities. In rural areas where maternal treatment can be sparse the closure of maternal facilities does not help. The MMR in rural areas was 29.4, 1.6 times greater than the MMR of 18.2 in big, core urban areas, according to a 2015 examination of country wide data. MMRs for women with no insurance and women with Medicaid have been 3.5 times higher than women with personal insurance. Respectively, women with private insurance saw costs about 12 times higher than women without private insurance (Glazer, et. al, 2021).

It is noted that these deaths are unnecessary and preventable. It is imperative that healthcare providers step in and check their biases. These avoidable deaths are happening in all different sections of the healthcare industry. Women are not the only ones at risk. There have been healthcare disparities seen in cardiovascular and renal healthcare. Giving birth is something that must happen. There is no way of avoiding it, so healthcare providers should be working on a remedy to get rid of these disparities in maternal care.

Racism in America has penetrated the healthcare system and has poisoned it. The presence of bias and racism can be seen in many differently specialties in medicine. Prejudice

and bias are affecting the level of care provided to patients. It is imperative that the experience that women are going through when they receive maternal care be explored. Learning how provider interaction impacts the patient's experience will give insight to potential unknown biases. Understanding how patients interpret their experiences with health care providers can improve communication between patients and providers. Thus, giving providers an insight into what behaviors offend their patients and how to manage their relationships better.

This study will expose the patient's experience from the view of the patient. Literature provides insight on who and how these women are becoming maternal mortality statistics. This study will provide a story from the patient's point of view so that healthcare providers can understand how their actions affect their patients. The words, terms, actions, suggestions of healthcare providers directly impact patient outcomes. Using this study to understand how the actions of healthcare providers create negative or positive interactions for their patients and how these interactions affect maternal healthcare. This study will support other research that gives a more statistical description of the maternal healthcare crisis in America while this study gives a more anecdotal description of maternal healthcare services in Southeastern PA.

Through public policy there is an opportunity to improve health outcomes. Implementing the proper policies that create better healthcare access and health outcomes is possible. Different levels of the government can execute different policies and programs that can save many lives in this country. It is the duty of policy makers to prevent the unnecessary deaths that are occurring. There has already been legislation enacted to combat the maternal mortality crisis which establishes the connection between maternal mortality and public policy. Provisions in the American Rescue Plan Act of 2021 (Public Law No: 117-2) give states the option to extend Medicaid and Children's Health Insurance Program (CHIP) eligibility to pregnant people for 12

months postpartum rather than the current law's 60 days (Federal Public Policy and Legislative Solutions for Improving Maternal Health 2021). States that choose this option must offer the entire Medicaid benefit to individuals who are pregnant or just gave birth for a period of 12 months after delivery. The government when they feel compelled can step in and intervene. They have proved it in different ways. When the government does feel compelled to step in, it usually means that the issues probably need some serious attention.

There is an effort to address the maternal mortality healthcare crisis in America. Different agencies and organizations are actively working to decrease preventable deaths and lower mortality rates. United States Department of Health and Human Services have an action plan to improve maternal health in America. Three of the bureau's objectives are;

- Improve access to high-quality prenatal care and delivery services for at-risk populations
- Advance a research agenda to identify effective, evidence-based best practices in maternal health, including those addressing clinical, environmental, and socioeconomic factors
- Enhance maternal health surveillance by improving data collection transparency, timeliness, standardization, and stratification by risk factors.

This study focuses on the experience that black women are having during their maternal healthcare services. The at-risk population in this country are black women due to the exacerbated maternal mortality rates between different races in this country. Understanding their experience during healthcare services can help researchers understand any lapse or gaps in the quality of care that black women are receiving. Knowing what gaps to fill in coverage will help policy makers adjust measures to improve overall quality of care for women. The government

has the power to improve the quality of care through policy change and implementation. It is imperative that policy makers have data so that they can accurately make informed decisions about the policies they create.

Learning the experiences of black women during their maternal healthcare services will help public administrators serve black women in many communities all over the country. Enhancing the services provided will advance the common good and create a positive change. Understanding how certain clinical, environmental, and socioeconomic factors are negatively impacting patients, especially the black patients is very critical to address the maternal mortality crisis. Policy makers cannot create policies that will truly make a difference if the core issues are not fully understood and addressed. This can be done through creating and implementing new maternal healthcare policies that will target the inefficiencies in maternal care services.

United States is facing one of its greatest public health inequalities. Giving birth is something that has been occurring since the beginning of time. It is surprising that in a developed country like the United States the maternal mortality rate is increasing. In an age of technology and the amount of resources America has, the rate should be decreasing. The circumstances surrounding the increase of the rate and the fact that most of these deaths are preventable is alarming.

“Black people’s nerve endings are less sensitive than white people’s.” “Black people’s skin is thicker than white people’s.” “Black people’s blood coagulates more quickly than white people’s.” (Sabin, 2020). Such statements sound so silly when spoken aloud. Truth be told these are the thoughts of many medical students and residents. It is shocking that in the 21st century. According to a study published in the Proceedings of the National Academies of Science, half of medical trainees believed in at least one of those inaccurate notions. The revelation that medical

professions are having these thoughts is disturbing. Especially since they come from individuals who are providing health care to black patients. This kind of bias is impacting the quality of care provided. Which can create treatment disparities for different people. Treatment disparities can lead to healthcare issues such as maternal mortality (Newcomb et. al, 2021).

Physicians are directly involved in the patient's experience and their outcomes. The impact of healthcare provider's biased on their patient's experiences and outcomes are documented. Patients have been coming forward more with their own experiences with biases which is allowing. A study from 2015 noted that half of pediatric residents who experienced mistreatment did not know how to respond. Also, that at higher rates medical student's mistreatment based on their race and LGBTQ status. Racial microaggressions can get worse for residents during their procedural training. For example, a black resident might not be selected to participate in the surgery, but the patient wants the resident's white attending surgeon (Newcomb et. al, 2021).

Altogether, there is a direct association between health outcomes and certain capacities of governance. It is imperative to understand how society structures itself and the impact that the effectiveness of current policies in place. Key steps in lowering maternal mortality include policies and programs that address and guarantee the sustainability of high-quality medical care and that enhance the coordination between hospitals and health centers (Ruiz-Cantero et. Al,2019). The government has a duty to use its power to improve the lives of the people they represent. Through public policy implementation, policy makers can save a lot of American lives. It is imperative that they collect and use the proper data before creating new policies.

One way of fundamentally understanding how the maternal mortality crisis is got to the current status it is in, it to understand the experience of maternal healthcare patients. It is

important to gather accurate and appropriate data that authentically depicts the layout of the maternal healthcare services provided. Through governance, policy makers can solve the maternal maternity crisis by changing policies that affect health care quality and access for patients all over the country.

It is very crucial for researchers and policy makers to work together to drive positive health outcomes for the citizens in America. It is on researchers to collect and share data uniformly and jointly with different organizations. Then, it is up to policy makers to rely on that data to create and implement new policies. After that it is up to policy makers to stay on top of research in order to amend policies. As dynamics change in law and policy, policy makers must rely on current data to make those changes and implement the changes properly. To properly advance the common good, public administrators must rely on accurate and thorough data.

2.1 Measuring Implicit Bias

Implicit bias affects the healthcare system because providers can be prejudiced without being conscious about it. One way of measuring implicit bias is through the Implicit Association test (IAT). This tool measures the association between people and stereotypes or evaluations. The IAT tool is a computer-based tool that asks people to link pictures to words. Making people associate certain words with certain pictures exposes their bias. Test takers are asked to make the association in an instant to prevent them from thinking too hard on it. The test wants to take the first initial instinct of the test taker to truly assess their conscious attitudes towards the pictures. The test will monitor how long it takes a person to negatively connect bad words with certain pictures.

The Race Attitude IAT evaluates how lengthy it takes a person to categorize snapshots of African American and European American faces, as nicely as mixtures of those faces with

fine and negative descriptors. The closer to zero the reading gets, the more neutral a person is to black and white preferences. If a test score has a higher IAT rating, then that shows that the test taker has more prejudices towards blacks and more favor towards whites. A low IAT shows a favor towards black people and shows anti-white biased. There have been several projects mapping the implicit biases views towards different races in America. (Mathew,2018)

The Harvard Project Implicit researchers have taken several results and found that there is a strong preference for white Americans over black Americans among all people who have taken the IAT. When it came to physicians taking the test, the results were the same. Female test takers still showed a preference for white over blacks, but it was weaker compared to their male counterparts. The same results were evident with the female physician text takers. This team of researchers even found that people who are race neutral still can hold negative implicit biases. This is important because these beliefs can carry over into physician-patient relationships and impact the level of care given to patients of color. Biases are affecting the decision making going on in the healthcare system.

It is hard measuring someone's unconscious bias. That is why the IAT is criticized for meeting key scientific test of validity. Many people against IAT argue that bias is unconscious and unintentional, and it does not meet statical standards (Maina et. Al, 2018). Regardless of if the bias is intentional or not it needs to be addressed because it is causing a decrease in the healthcare provided to patients. Over the past years the IAT has not been the only tool used to measure implicit bias.

Using the IAT and other tools has only reinforced the notion that healthcare facilities have let racial bias impact the level of care provided. The IAT and other tools have shown that there is racial favoritism when judges and lawyers make courtroom decisions, when juries make

decisions, and when teachers and administrators make decisions on disciplining children. What is more surprising that there have been IAT scores that show African American test takers with high IAT scores which indicates antiblack biases. These test takers were more likely to choose a white partner than a black partner for intellectually challenging tasks.

The CDC defines pregnancy related death as the death of a woman while pregnant or within a year of the end of the pregnancy. These deaths can be labeled pregnancy related regardless of the duration or outcome of the pregnancy if the death is not accidental or incidental. This can become difficult to classify the death as pregnancy related vs pregnancy associated. This makes it difficult to have uniformity across the nation. Each state has their own policies and procedures for records maternal death which results in different data sets from different states. There is no federal or national standard for hospitals to report maternal deaths to the CDC or any other health agency. This can create many problems for the data collection process of reviewing maternal death in America. Hospitals in this country are not even required to perform reviews on maternal deaths.

There are instances where hospitals do not review what went wrong during a maternal death. That means there is no data collected and there is no way to improve the situation or to learn from it. There is a need to add more reliable information to vital statistics. States usually use death certificates to identify maternal deaths. Death certificates use keywords and checkbox information to identify maternal deaths. Keywords typically relate to pregnancy or postpartum conditions, and the checkbox information flags cases of women who died during pregnancy or within a certain period after giving birth.

Death certificates for women of reproductive age are typically linked to birth or fetal death certificates, which can help validate the information on those documents, especially when

it comes to marking the pregnancy box. Multidisciplinary maternal mortality review committees (MMRCs) are common in the US, with two-thirds of states having them. These committees review deaths that may be related to pregnancy or only pregnancy-related deaths. Reviewers have a variety of sources of information, including medical records, autopsy reports, reports from the state's Prescription Drug Monitoring Program, and police or social service reports. State-based MMRCs are considered the most reliable source of data when it comes to measuring maternal health conditions in the United States.

The evaluators have access to other sources of information, such as medical records, autopsy reports, reports from the National Prescription Drug Monitoring Program and police or social service reports. Most parent companies review all pregnancy-related deaths, while larger countries either opt for a portion of the deaths for review or limit their review to pregnancy-related deaths. To obtain a wealth of information on maternal deaths at the national level, all states in the United States need to establish functional motherhood, use standardized methods for the identification and review of maternal deaths and input data into a common data entry system. CDC and Prevention and, more recently, the Health Resources and Services Administration have made important investments in the development of these State-based committees.

2.2 Maternal Mortality

“The International Statistical Classification of Disease (ICD 10) defines maternal death as the death of a lady while pregnant or within 42 days of termination of pregnancy, from any cause associated with or aggravated by the pregnancy or its management, but not from accidental or incidental causes” (Small et. al, 2017). What is not included in the review of maternal deaths are accidental deaths or suicide on an international level but in America they are included in maternal mortality review.

By measuring the health disparities in maternal care, as a community it can measure how much further the healthcare system must go to strive for the best quality of care for everyone. At the same time focusing on some people who have a higher risk of poor health and aiming for more resources to help those people. Maternal deaths are identified when the cause of the death on the death certificate matches the ICD coding for deaths due to complications of pregnancy or childbirth.

“Pregnancy-related deaths, adopted by the CDC Pregnancy Mortality Surveillance System, extend the timeline after delivery to include any death within 1 year of pregnancy, with qualifying causes including pregnancy complications, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.” (Small et. al, 2017).

Another indicator of maternal health care outcomes is Maternal Near Misses (MNM), which are females who survived a maternal complication that could have resulted in death. These near misses occur very frequently, almost 100 times more often than maternal deaths. The people that survive these near misses are important because they can retell their experience. They can give insight to more indicators that are driving the maternal mortality rates up. In America, maternal mortality rates are rising but that is not the case all over the world. In Europe, the rate has gone down by sixty-four percent since 1990. Even in Africa, they have seen a decrease of forty-four percent (Castellucci, M. 2015). There needs to be more efforts to decrease this rate in America for the sake of our mothers in this country, families, and the babies in this country.

2.3 Covid-19 Pandemic Impact on Healthcare Access

In 2020, the world was ravaged by the Covid-19 pandemic. The pandemic has caused extreme damage to America and all over the world. America was already dealing with their own

issues and the Covid-19 outbreak exacerbated a lot of the problems the country was facing. The healthcare system was vulnerable to the impact of the coronavirus pandemic. African American and Latino populations across the nation felt the worse of the damage. African American people faced increased risk of hospitalization. The pandemic aggravated the many circumstances in the lives of African Americans in many ways. African Americans in this country have faced higher risk of contracting heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, and HIV/AIDS and the pandemic did not help ease that risk.

Timely diagnosis, appropriate care, knowledge, attitudes, and relationships with healthcare providers are all issues that were problematic to the level of healthcare that African American patients were receiving. The shutting down of the country and this world decreased the level of care that every individual was receiving. During the Covid-19 pandemic, healthcare professionals choose using telemedicine as a method of seeing their patients to limit the exposure of Covid-19. Using telemedicine is a great tool for healthcare professionals to use because it gives them easier access to their patients if they have internet connection. The only problem is that the use of telemedicine has created a divide between the people who have access to the internet and those who do not have internet access. Even though it is 2022 and it has become more affordable. There are financial, social, language, and other barriers preventing some people from obtaining internet connection.

Telehealth sessions are great for reaching out to patients who would not have been able to travel to the doctor which can decrease healthcare disparities for the people in rural or remote areas. Telemedicine has unintentionally created more healthcare disparities due to its widespread implementation during the Covid-19 pandemic (Chunara et. al, 2021). African Americans were already facing issues with their healthcare while visits were still in-person. The swiftness of the

country shutting down and the execution of telemedicine during 2020 have exacerbated some healthcare disparities. Patients who faced socioeconomical issues and lacked technical expertise when it comes to using the internet or computers were just left to hurry up and figure out how to use Telemedicine during the pandemic.

The pandemic forced the country to shut down, which resulted in fewer patients seeing their providers and less staff present at the hospital and it changed what kind of healthcare services people were seeking. In early 2020, hospital in Philadelphia saw an increase in women who were choosing to have elective inductions (Destine et. al, 2020). Early in the pandemic there was a heightening sense of fear about being outside and being in hospitals. Woman who was picking these elective inductions were attempting to have more control over the amount of time spent in a hospital which could expose them to Covid-19. This is unfortunate because having these elective procedures without medical need can expose the mothers and the fetus to increased risk of uterine rupture, caesarean births, and fetal death.

Induced labor can create a risk of different complications and makes patients need more pain management. The American College of Obstetricians and Gynecologists and the Association of Women's Health has supported the notion that elective inductions are problematic due to the risks that are elevated during these procedures. This association has also supported the use of doulas and their involvement in creating more positive birthing experiences and outcomes for women. Women giving birth in hospitals with doulas could encounter shorter labors, decreased medical interventions, and increased satisfaction with the labor experience.

Covid-19 makes this an issue because of the restrictions that are in place during the pandemic. For some women they were only allowed to have one other person in the delivery room with them while giving birth and that makes it difficult to have the doula and other people

there to be supportive. The changes during the pandemic did increase the negative outcomes that black people experience during maternal care. The uncertainty of the pandemic and its implication on the future created a lot of negative stressors for people. Those negative stressors can create fear and anxiety within people, especially patients trying to navigate through the healthcare system. Seeking healthcare services during the Covid-19 pandemic started to become a burden for some people. The pandemic drastically changed the healthcare system and the changes created distress for patients.

2.4 Causes of Maternal Mortality in America

The CDC reported that maternal deaths were caused by pregnancy complication or other factors that were exacerbated by pregnancy. There are other components outside of race that are contributing to high maternal mortality rates. “Unmarried women were more likely to die of a pregnancy-related issue than married women, while women who had only graduated high school saw higher death rates than women with either lower or higher education levels” (Gavin, 2019). There were 232 maternal deaths between 2013 to 2017 that could have been avoided if there were at least one reasonable change that occurred at their healthcare or community level. Some of these deaths are occurring because of a lack of timely action from the healthcare provider. In the first six days after delivery, hemorrhaging, high blood pressure, and infections were the most common causes of death. According to researchers, about 31% of pregnancy-related deaths occur during pregnancy, nearly 36% occur on the day of delivery or within six days after delivery, and 33% occur one week to a year after delivery among the 2,990 pregnancies that were known to researchers when the women died (Gavin, 2019). Heart disease, stroke, and infections caused more than a third of pregnancy-related deaths, while obstetric hemorrhaging was responsible for 11.2% of deaths. This is not surprising the research has shown healthcare cardiovascular and

renal disparities. It only makes sense that these issues would trickle into maternal care and exacerbate the pregnancy of many women.

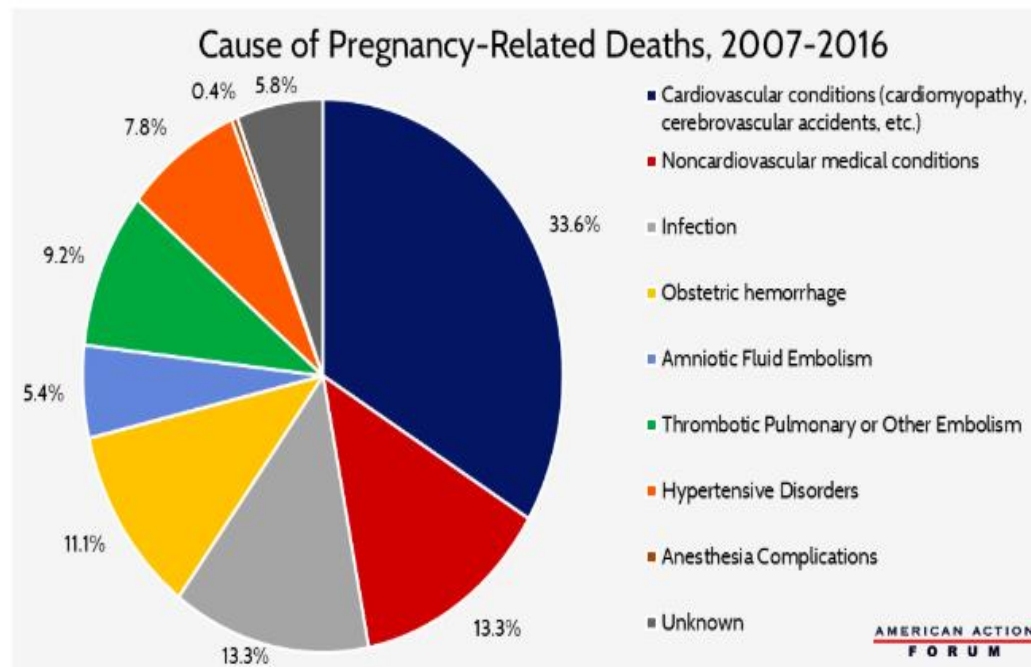
There are several questions to consider the disparities between the mortality rates between black women and other races in America and the overall increase of mortality rates in the country.

- Are pre-existing conditions contributing to an increase in mortality rates?
- Is the overuse of cesarean section procedures resulting in complications during birth?
- Is racial bias in the hospitals causing medical staff to overlook complications in patients of color?
- How much is racism in the healthcare system and society affecting the level of care that is provided and accessible to black people in America.

After answering some of these questions, a discussion on how to educate and implement certain rules and information to save the lives of many mothers in the United States.

Further, for every maternal death, there are 84 women who suffer from a severe complication. There are many reasons why a mother might die during or after childbirth. Below in Figure 1, the chart shows the different pregnancy related deaths. Many mothers bleed out or have an embolism, infection, or have a cardiovascular condition. Have pre-existing conditions are leading to an increase of maternal mortality rates. The level of health insurance and prenatal care is a direct factor in the chances of a mother becoming a victim of a pregnancy related death.

Figure 1: Cause of Pregnancy Related Deaths



(Hayes, et. al, 2019)

According to the graph in figure one, cardiovascular disease is the main cause of maternal death in the United States, and Black women had greater risks of pregnancy-related heart attack, stroke, peripartum cardiomyopathy, and pulmonary embolism. Women in America have chosen to have babies later which is evident in the growing maternal age of expecting mothers. More women are starting their pregnancies with chronic medical illnesses and cardiometabolic risk factors such as obesity, high blood pressure, and diabetes. Women who suffer pregnancy problems such as preeclampsia, hypertensive disorders of pregnancy, and/or gestational diabetes are at higher risk of both unfavorable pregnancy outcomes and cardiovascular disease after pregnancy. The next leading cause of maternal death is non cardiovascular conditions. Diseases such as diabetes and obesity are causing issues for expecting mothers outside of cardiac diseases that are contributing to poor maternal outcomes. Following cardiovascular disease and non-

cardiovascular conditions are the leading causes of maternal death, are infection and obstetric hemorrhaging. After that, the leading cause is Thrombotic pulmonary or other embolism and hypertensive disorder. Cardiovascular issues play a huge role in the number of maternal deaths that are happening in America.

Health coverage impacts the kind of healthcare a mother receives before, during, and after her pregnancy.

“A recent University of Michigan study found that there was a nearly 40 percent higher prevalence of chronic conditions (specifically those conditions which pose a risk for mothers and babies) among pregnant women in 2014 than in the decade prior, with the greatest increases occurring among low-income women and women living in rural areas.”

(Lang et. Al, 2008)

People who are an economic disadvantage are at a higher risk of complications and death when it comes to delivering babies. People in the United States seem to have much higher rates of chronic conditions than people in other developed countries. “A recent study found that 60 percent of adults in the United States have a chronic condition.” (Hayes et. al, 2019). People in the United States tend to delay care for several reasons such as financial and employment implications. The excessive cost of the healthcare system and the socioeconomic status of the middle class and lower class deters many Americans from seeking healthcare right away. Depending on a person’s job, it will determine what kind of healthcare coverage they have access to. There are several factors that impact what kind of health insurance that Americans have and when they decide to utilize their insurance.

2.5 Issue with Maternal Mortality

Between 1990 and 2013, the maternal mortality rate went from twelve to twenty-eight maternal deaths per hundred thousand births. That is higher than the rate in Iran, Libya, and Turkey. About twelve thousand women suffer complications during a pregnancy or childbirth that prove fatal and about sixty thousand are near fatal. The surprising fact is in 2012 that maternity care in America exceeded sixty billion dollars. There is a lot being spent on healthcare expenditures in America for women to give birth, but they are still at risk of having complications and dying at high rates (Agrawal, P. 2015).

This reflects inconsistent obstetric practice, the lack of healthcare, healthcare access, data collection, lack of attention to complications of pregnancy and childbirth before it happens. Hospitals across the country do not have a standard approach to managing obstetric emergencies. Sometimes, complications from giving birth are found too late by health professionals. Another problem is that many mothers have chronic conditions. Health professionals need to focus on promoting healthier lifestyles in their patients. America has a serious obesity and diabetes problem. Educating people and mothers about the pregnancy complications associated with chronic diseases would be helpful. After educating these women, monitoring them more closely is also beneficial. There needs to be better case management on these higher risk pregnancies.

Reaching mothers in their communities is paramount in decreasing the maternal mortality rates. Providing more community-based services that promote preventative health care and family planning services will help. America also has a health insurance problem. When women who do not have health insurance, they are three to four times more likely to die from a pregnancy related complication than women who are insured (Agrawal, P. 2015). America has several issues that they need to address on the community level when it comes to maternal

mortality. The country needs to implement more programs that provide more maternal support outside of hospitals.

More shockingly, around 52 percent of all fatalities occur after the day of birth, with about a third occurring during pregnancy. Refer to Appendix b figure 1 where maternal mortality deaths are considered deaths during pregnancy and up to 42 days postpartum that are related to pregnancy. Pregnancy-related mortality are the deaths during pregnancy and up to one year postpartum that are related to pregnancy and pregnancy-associated mortality are the deaths during pregnancy and up to one year postpartum. These definitions make it harder to accurately determine maternal mortality fatalities must be recorded since each state treats deaths differently when reporting them. If more than half of all deaths occur after birth, how are the various governments tracking that information?

Significant efforts have been made to enhance clinical care, yet initiatives focusing on birth hospitalization will only tackle a piece of the problem. To improve outcomes, it will also be necessary to address maternal mortality causes during pregnancy (such as hypertension, or high blood pressure) and postpartum (such as cardiomyopathy or weakened heart muscle) through improvements to women's health care before, during, and after pregnancy. There needs to be a focus on women's healthcare well beyond giving birth due to the total recovery time necessary for a woman to recover from giving birth.

2.6 Southeastern Pennsylvania

Southeastern Pennsylvania is comprised of five counties: Philadelphia, Bucks, Montgomery, Chester, and Delaware. Each county provides their own maternal healthcare through hospitals and health networks. This area is significant because of the birth rates and trends seen in the area over the years. Philadelphia county has seen a reduction in birthing

hospitals from 1997 to 2009; the number went from 19 to 6. Reducing the number of hospitals did not decrease the number of births of the residents which at the time was 23,091 (Hospital obstetrical capacity in southeastern Pennsylvania, 2010). This resulted in these hospitals going over the recommended occupancy rates. Medicare actually paid for about 42.7% of those births. In Montgomery County, that area saw a reduction from nine hospitals to six. In 2010 there were 14,346 births from hospitals and 9,107 were births from residents. Medicaid paid 12.6 percent of those births (Hospital obstetrical capacity in southeastern Pennsylvania, 2010).

After 2003 in Delaware county there were only three birthing hospitals left in the county. In this county there are around 6,083 hospital births and 5,513 are births from residents. Medicaid pays for 9.4% of the births in that area. In Chester County, after 2008, there were four birthing hospitals left. One of the hospitals called Chester County Hospital accounts for 41% of all the births in this county. Altogether the county sees 6,083 births, and 5,513 are from residents of the county. Medicaid pays for 9.4% of the births (Hospital obstetrical capacity in southeastern Pennsylvania, 2010).

Finally, Bucks County only has four birth hospitals after closures of others backs in 2000. In total this county sees about 5,991 births a year of about 5,779 births is from residents. Medicaid pays for 18.04% of births (Hospital obstetrical capacity in southeastern Pennsylvania, 2010). The closure of hospitals and access to healthcare are particularly important too when it comes to positive patient outcomes. The closure of other hospitals puts strain on the ones that remain open, causing their occupancy rates to go increase. When occupancy rates go up, it impacts the level of care very patient is getting. These different counties have different settings. Philadelphia is way more urban than Chester County. Philadelphia hospitals can increase the number of patients, but Chester County hospitals will feel more strained.

2.7 Healthcare in Southeastern PA

According to the Hospital obstetrical capacity in southeastern Pennsylvania report, the region of southeastern Pennsylvania is a remarkably diverse one. There are people of all different shades living there and they speak many different languages. Almost 20% of Philadelphia households are homes where English is not the primary language. In the suburban regions, that number is almost 10%. The variety of languages are astounding, people in this region may speak Spanish, Portuguese, Hungarian, Romanian, Arabic, Italian, Vietnamese, Korean, French, Tamil, Mandarin, Khmer, or one of numerous West African languages. Medicaid also provided emergency insurance to undocumented immigrants. In southeastern Pennsylvania, the program covered 1,200 undocumented immigrants in 2005. The number of Medicaid covered births in Philadelphia is greater than the other four counties in the area. The Hospital of the University of Pennsylvania, which is one of the larger hospital networks in Philadelphia, see about half of their births covered by Medicaid.

The closure of hospitals in the area with an increase of social and medical problems are threatening pregnant women in the area. Chronic illnesses and socioeconomic issues are exacerbating the maternal mortality crisis in southeastern Pennsylvania. The American healthcare system is very intricate. Not all hospitals accept the same insurance providers, and some doctors can be out of network causing the patient to pay more money. Women who pregnant and have chronic diseases need their care coordinated between their providers. This can be difficult to have all the same doctors covered by your insurance and have these providers accessible to the patients. In rural areas, there are not as many hospitals as urban areas which makes it difficult when coordinating care. When an area is prone to hospital closures and fewer hospitals that means there are even less maternal healthcare options for patients. In result, creates

another obstacle to overcome in order to obtain proper healthcare for some women (Hospital obstetrical capacity in southeastern Pennsylvania, 2010).

2.8 Elements of the Patient Experience

Clinical effectiveness, patient safety, and patient experience are three components of quality healthcare in this country. Measuring patient experience helps gauge the strengths and weaknesses of healthcare delivery. Patients deserve humane and empathetic care, and measuring their experience is a keyway of improving healthcare. Respecting patient's backgrounds and concerns can lead to patients being more involved in the decisions about their healthcare. Providers need to create a more respectful environment to build a better rapport with patients. Improving the patient's experience can lead to more engagement in personal care, medication adherence, adherence to prescribed therapy, and prescription and dosage monitoring. Collecting data on the patient experience can give direct insight into everyday clinical care. Given the structural fragmentation of most healthcare and the multiple services with which many patients encounter, measuring patient experience may assist give a whole-system view that more discrete patient safety and clinical efficacy measurements may not provide.

While health care companies are increasingly using surveys to gather input from patients about their experiences, patient experience scores can provide a limited view of service. Detailed information regarding specific aspects of patients' experiences is expected to be more beneficial for assessing hospital department and healthcare facility performance. Listening to patient narrative accounts about care experiences can give insight on care expectations, frequently in a more engaging manner for health care workers.

Patient satisfaction and patient experience are two different things. Through improving the patient experience, doctors can encourage an environment that increases patient engagement.

When patient engagement goes up, then the patient plays a bigger role in the healthcare decision making involved with their treatment. More engaged patients take control of their health and work with healthcare practitioners to achieve the greatest possible health results. This is different from patient satisfaction, which subjectively measures how pleased patients are with the services provided by their healthcare facility. It does not promote the acquisition of information, skills, ability, and willingness to control one's own health and care and make decisions unlike the patient experience.

A positive patient experience involves interactions with effective communication lines between the provider and patient, collaboration with provider and the education of the patient. Patients want to be more autonomous and informed to maximize the healthiest outcome that can be achieved. Providers can ease a patient's worries and strengthen the provider – patient relationship by improving communication channels. The provider should work with the patient to better understand the patient and coordinate health plans with the patient. Lack of communication and engagement between the provider and patient can cause errors. Patients are more inclined to trust healthcare practitioners with their well-being when they have access to resources and feel supported across the continuum of treatment.

2.8 Racism in America

This brings us to America which has a history of racism and discrimination towards African American people. In one study, it was shown that “having higher trust in physicians was independently associated with less perceived racism in healthcare in our cohort of patients.” (Vina et. al, 2015). African Americans sometimes have a tough time trusting physician due to the history in this country. For example, the father of gynecology, J. Marion Sims performed experiments on enslaved women without anesthesia (Sartin, 2004). Using enslaved women for

these experiments without their consent questions the morals of this physician. These questionable acts developed the field of gynecology at the unethical expense of enslaved women's humanity.

Due to the status of black people in America, enslaved people did not consent to be a part of medical experiments. Enslaved people were seen as property with no rights which allowed for white people to medically experiment on black people with no ethical repercussions. After slavery these kinds of unethical experiments continued, for example like the Tuskegee experiment, participants were misled. In this experiment, participants who were black men were told they were joining an experiment to treat bad blood when the purpose of the experiment was to observe the effects of syphilis in untreated black populations (Scharff et. al, 2010).

The sad reality is unethical medical research did not stop there. African Americans under the supervision of prestigious academic institutions still faced unethical experimentation as late as the 1990s (Scharff et. al, 2010). Researchers at a prestigious American institution recruited African American boys for a study that theorized a genetic etiology of violent conduct. They were successful in convincing parents to enroll their sons in a study that involved the participants to live under strict conditions. These conditions include stopping all medications, consuming a low protein diet, staying overnight without their parents, not giving the boys water, hourly blood draws, and giving the boy fenfluramine. That is a drug known to increase serotonin levels and suspected to be associated with aggressive behaviors. America has a long and sad history of exploiting African American people for the advancement of medicine and research.

Developments in medicine have resulted in a decrease in maternal mortality rates in developed countries across the world except for America. Unfortunately, the maternal mortality rate in America is increasing and action must occur immediately. America is the only developed

country where the mortality rates are increasing, and it has doubled in the past thirty years. The mortality rates in African American women are higher than any other race in this country. One of the issues with the healthcare system is the racism issues that plagues America. The United States has put into place systems and structures that perpetuate racism and classism (Carter et.al,2021). The solution so far has been to attempt to change the behavior of the patient. For example, try to make patients trust their doctors more or encourage patients to see their doctors more. Instead, there needs to be a focus on bias from healthcare providers and getting rid of the institutions put in place that hinder certain races.

A case study shows how group prenatal care could be one option for achieving this change. Group prenatal care has been shown to improve pregnancy outcomes among black women. Group prenatal care works by increasing the amount and quality of time spent together and by facilitating communication between the patient and practitioner. There are many stories about how reproductive health inequities affect black women in the United States. Black women are twice as likely to deliver a premature baby and are 3 to 4 times more likely to die of pregnancy-related causes than white women. Two times as many Black babies die before reaching their first birthday.⁴ In spite of a clear definition of the scope and prevalence of the problem, the literature and our professional societies fail to provide a solution-driven path forward (Carter et.al,2021).

2.7 Racial/ Ethical Disparities

Several factors can contribute to the rising maternal mortality in the United States. Clinicians have focused on the proximate medical factors contributing to the problem while mostly neglecting the social aspects that might also affect a mother's health before and after childbirth. Health researchers have noticed that there has been a decrease in the common cause

of maternal mortality rates such as hemorrhaging. There are several deaths due to complications of cardiovascular disease on the rise. More mothers are now giving birth with chronic diseases such as diabetes, obesity, and hypertension. These pre-existing conditions contribute to complications while giving birth.

It is important to acknowledge the America has many disparities facing different regions of the country that are affecting the data. The rural areas of the south do not face the same problems that the east coast, the west coast or the Midwest might face. The issues plaguing the low income and rural population have increased over the years which is affecting the data of maternal mortality rates. It can also explain some of the racial disparities in maternal mortality and morbidity. Race-based implicit bias, institutionalized racism, and segregation impact certain areas more than others and pose a risk to maternal medicine. Even though more mothers are giving birth with chronic disease and sometimes more than one chronic disease at a time, this issue does not explain why the race is still affecting the maternal mortality rate. (Bernet et. al, 2020)

2.8 Race/Ethnicity Pregnancy Related Deaths

African American women are three to four times more likely to die of childbirth related complications compared to white women. Refer to appendix a figure 2, compares the childbirth related deaths per hundred thousand births between Hispanics, blacks, and non-Hispanic whites. Every year between 2007 and 2016, black women died the more compared to their counterparts when it came to pregnancy – related death. Black women are leading when it comes to pregnancy related deaths when you compare it to other races in this country. Race might not be the specific reason for the maternal mortality rates but a reflection of the social constructs in America. Culture, economics, and baseline health, which might more directly relate to the

availability of, seeking for, and receipt and benefit of health care. Black women over the age of twenty-five are four times more likely to die of childbirth related deaths than white women (Serbin. J & Donnelly. E, 2016).

Black women giving birth at hospitals serving minorities are at a higher risk. A study published in 2017 found that seventy-four percent of black babies were born at the twenty-five percent of hospitals serving the highest proportion of black people, and women delivering at these hospitals were significantly more likely to suffer severe complications than women delivering at lower black-serving hospitals. (Metcalf et. al, 2017). The study author concludes that delivery hospitals account for half of the difference between black and white maternal mortality rates. A study in 2017 found that more than half of all rural counties in the United States, with 2.4 million women of reproductive age, have no hospital obstetric services and face primary-care physician shortages (Metcalf et. al, 2017). These counties were more likely to have a higher percentage of non-Hispanic black women, to have lower median household incomes, and to be in states with more restrictive Medicaid eligibility.

2.9 Contributing Factors of Maternal Mortality

The leading cause of maternal mortality with pre-existing conditions in the U.S. is cardiovascular disease, which accounts for fifteen percent of deaths. Right behind that is diabetes, which accounts for fourteen percent. To put it in perspective infection and sepsis account for the same percentage of deaths. All of this is according to the data presented by the Centers for Disease Control and Prevention. (Castellucci, M. 2015)

The CDC (Centers for Disease Control and Prevention) has been tracking maternal mortality rates since 1987. Since then, the deaths have increased from 7.2 deaths per 100,000 live births in 1987 to a high of 17.8 deaths per 100,000 live births in 2009 and 2011. (Castellucci, M. 2015).

One of the chronic diseases such as obesity presents a big problem in maternal medicine. This disease does not only put unnecessary pressure on the mother's body, but obesity is related to other chronic diseases such as diabetes, high blood pressure, and other illnesses that can harm the mother and baby. Sepsis-related deaths are also more likely to occur among women with diabetes or obesity (Castellucci, M. 2015).

Cesarean sections, a procedure to deliver the baby through an incision in the abdomen can cause mothers to hemorrhage. Hemorrhaging causes about eleven percent of the deaths of mothers who gave birth in 2011. In 2013, about thirty-two percent of births were cesarean sections. This is unusual because the World Health Organization (WHO) recommends only about twenty percent of births should be cesarean sections. America has a higher average of cesarean sections which is troubling due to the high number of mothers with pre-existing conditions, and a country with such a high maternal mortality rate.

Maternal mortality rates differ between states. The trends are not uniform throughout the country, which is a good thing. The federal government can learn how to solve this issue by studying how the local and state government has been handling maternal medicine. For example, California has seen a decline in deaths related to giving birth due to the implementation of certain programs while Texas has seen an increase. Texas has been under the spotlight because the maternal mortality rate in Texas doubled between 2011 to 2014.

It is unclear specifically why the rate doubled but the state of Texas is known for its poor family planning services in their clinics. In 2013, only half of the state's clinics offered reproductive services or abortions because of regulations that passed. Some of the funding for reproductive and family services were cut and forced clinics to close. (Gerdt et. al., 2016). This

issue is important because about half of the pregnancies in the United States are unplanned. Which can result in lack of pre-natal care and preventative care.

Suggestions have been made to decrease the maternal mortality rate. Such as including everything from favoring pregnant women for public housing to ensuring that doctors only conduct C-sections when medically required. Extending Medicaid coverage to pregnant women during the first year following delivery will help new moms. This could be instrumental in certain low-income states and some rural areas.

Congress allocated \$60 million over five years to finance state review boards to "save and preserve the health of mothers during pregnancy, delivery, and the postpartum period," according to a statement released in December. State legislators have also promoted maternal mortality measures, such as in New York, where the state's 2019-2020 budget included funds to establish its own maternal mortality review board. New York City launched a strategy last year to minimize pregnancy-related fatalities and problems, which included better data collecting and analysis. However, many states do not keep good track of pregnancy-related deaths, and a September investigation by USA Today discovered that state review boards frequently neglect to investigate the role of medical errors in these deaths (Gavin,2019).

2.10 States that Take Different Approaches to Mortality Death

This is not the case in every state in the country. California has taken measures to decrease their maternal mortality rate. Refer to appendix a, figure 3 the mortality rates in California are compared to the to the national average of maternal mortality rates. The state of California has worked hard to implement the California Maternal Quality Care Collaborative (CMQCC) in 2006. By 2013, the state's maternal mortality rate was reduced by half to an average of 7 deaths per 100,000 live births (Hayes et. al, 2019). Notably, most of the reduction

was reduced mortality rates among black women, and while a disparity between blacks and other races still exists in the state, the difference has significantly declined since the program's creation.

The CMQCC is a collaboration between hospitals, clinicians, state agencies, insurers, patient and public groups, and other stakeholders requires four key components: linking public health surveillance and proactive action; mobilizing collaborative public and private partnerships; creating a data system with low administrative burden to support improvements; and establishing multi-stakeholder interventions that connect providers with relevant health services. The combination of mortality reviews, stakeholder engagement, and data has provided a blueprint for improvements targeting performance and quality metrics. Implementation of these large-scale interventions is the driving force behind California's improvements in maternal mortality rates and could potentially have similar effects if administered at the national level across various states to aid in maternal mortality rate reductions.

2.11 Rural Areas in America Facing Maternal Mortality

The American College of Obstetricians and Gynecologists (ACOG) states that rural America is about seventy-five percent of the country's landmass and about twenty-three percent of women eighteen and older live in rural areas (Phelan et. al, 2018). Having that number of women in such a huge landmass can be a recipe for healthcare disparities. Health outcomes and care can be limited for anyone living in rural America and women are especially at risk. Throughout the country, the levels of rurality are a factor in the maternal mortality rate. States like Pennsylvania have the third largest rural population in the country but states like Alaska and Montana have small rural populations over larger geographic areas. Meaning that difference

between the types of rural areas in this country will affect the healthcare provided to the population of the area.

It is proven that rural women are less likely to receive health screenings and preventative care. Slightly less than half of the women living in a rural area are less than thirty minutes away from a hospital with perinatal services (driving distance). A portion of ten percent must drive a hundred miles or more to get these services. (Phelan et. al, 2018). Wyoming does not have tertiary care centers for pregnant women. These rural areas have people who are more likely to incur obesity, cancer, cardiovascular disease, opioid use, and violent deaths. If people in rural areas are having trouble getting access to healthcare for the diseases mentioned above, then it would be hard for pregnant women to get access to maternal care.

There is no surprise that rural areas are facing closures of hospitals and lack of health staff. In 2010, the ACOG reported that forty-nine percent of the nation's countries lack obstetrician-gynecologists. Which means that ten million women in the world are without an obstetrician-gynecologist (OBGYN). In a rural setting where sometimes a woman must travel one hundred miles to get maternal care compared to women in an urban setting where the driving distance to maternal care is shortened to ten miles, the lack of OBGYNs hurts women in the rural communities the most. The maternal mortality rate is higher in these rural communities. Since the rural community is large in this country, it can be attributing the increase in maternal mortality rates. This problem exposes the challenges people face in these communities. The socioeconomic difficulties presented show that it affects health outcomes for rural populations. Improving the quality of healthcare in a rural setting alone could make positive changes in the maternal mortality rate.

Maternal mortality (MM) in the United States has become increasingly more of a healthcare problem in United States since 1987. More importantly, the disparities have persisted since 1935 (Douthard et. al, 2021). Despite the large healthcare investments and many maternal health stakeholders, this problem is only getting worse in the United States. The maternal mortality crisis in America is multifaceted because different patient demographics factors are creating maternal health disparities. Social and economic determinants are also playing a role in this crisis. It appears being educated or having a certain economic status does not matter if you are of a certain race. There are many different tasks that public policy needs to address to decrease the number of women dying in this country

Please refer to appendix a, figure 4 to see the graph depicting that the maternal mortality rate in America has reached 20.1 deaths per 100,000 live births. Each state has its mortality rate. With some states doing better than others. In the figure below, the chart depicts each state's maternal mortality rate. Louisiana having the highest maternal mortality rate following Indiana and Georgia. While states like Vermont, New Hampshire, and Delaware had the lowest rates. Some rural areas are predisposed to certain ailments such as obesity and cancer. These areas are also plagued with a public health crisis such as opioid abuse. Before the Covid-19 pandemic, rural areas were already facing closures of hospitals and a lack of health staff. Back in 2010, the ACOG reported that 49% of the nation's counties lack obstetrician-gynecologists (OBGYN) (Products - health e stats - maternal mortality rates in the United States, 2021). That is very problematic for the women in rural areas who sometimes must travel one hundred miles to seek maternal care.

2.12 Reducing Maternal Mortality Rates in America

The Human Development Index (HDI) is an analytical tool for determining a population's degree of well-being and quality of life. The HDI, which was first published by the United Nations Development Program in 1990, examines three factors: education, health, and income. The adult literacy rate represents the education component, life expectancy at birth represents the health component, and per capita gross domestic product (GDP) represents income in this aggregated index. ⁷ The HDI has been used to rate various countries around the world, with previous research demonstrating that countries with higher HDIs had better illness outcomes and a lower overall burden of avoidable causes of mortality, like certain infectious diseases. (Nuhu, et. Al, 2018)

The amount of money spent on health care as a proportion of GDP has also been linked to better health outcomes. Nations that spend a larger proportion of their GDP on healthcare have been found to have better health outcomes than countries that spend a lower percentage of their GDP on healthcare. The MM and newborn mortality (NM) rates are two key healthcare indicators used by organizations like the World Bank and the WHO to measure a country's overall health and quality of life.

Quality of healthcare may not have been a significant contributor to neonatal and maternal deaths in developed countries, such as the United States, Canada, and some Western European countries, where the initial MM and NM are already low, even though these rates are higher among individuals of lower socioeconomic status. These facts highlight the relevance of distant criteria like education and income levels in influencing health insurance status and, by extension, health-seeking behaviors, and access to available quality treatment among the poor and uneducated in these nations.

In Boston, the Harvard Chan School has a task force that has provided many different recommendations to address certain concerns such as the racial disparities between maternal mortality rates (Maternal mortality fact sheet - planned parenthood, 2019). They have helped all people who needed help finding access to affordable prenatal and postpartum care, as well as to a delivery environment where staff are trained and equipped to address complications. This task force recommends diverse training and hiring a more diverse staff. There is an organization called Black Mamas Matter Alliance which offers a detailed set of policy prescriptions. This includes involving the leadership of black women and black women-led organizations to create policies, creating a mechanism to address racism in the healthcare system, and expanding healthcare access. There are plenty of organizations speaking out such as The Center for American Progress. They focus on the importance of increasing healthcare access, improving healthcare, and enhanced care for families.

From a media perspective there has been a lot of coverage of this social issue. Even a famous athlete like Serena Williams has had a near life-threatening experience during maternal services.

"Serena Williams' birth story as she told Vogue magazine, is any indication. She had a previous history of blood clots and suffered one shortly after giving birth. She suddenly became short of breath and recognizing the symptoms immediately told her doctors she needed a CT scan with contrast and Heparin. Her concerns were initially dismissed. Only after she vehemently insisted and time was wasted with a test that did not show anything, that they finally performed the CT scan which confirmed what she told them in the first place. The biggest complaint among Black women, relating to their maternal health, no matter if they are in urban, suburban, or rural areas, is they feel as if they are not heard." (Scatliffe, 2021)

Someone with as much money and the size of Serena's platform still was not able to be properly heard by her doctors and she almost died. There are many stories all over the country like Serena

Williams and because she has a large platform this is the story that gets blasted all over the media. It exposes anger and outrage from the citizens of the country. This was an example of providers not listening to their own patient and it almost cost Serena her life.

Serena's experience was one that was very uncommon. The 36-year-old Black woman just had her first baby, which is unusual since the average age for a first birth is 25. Her birth was special because she was viewed as having a higher risk of a maternal mortality crisis, in the last seven years earlier she had experienced a pulmonary embolism. The fetal monitor readings detected a decrease in the baby's heart rate, which led to an emergency cesarean. The next day, she experienced shortness of breath that made her fear another embolism, in part because she had been taken off her anticoagulants since her cesarean. Her concern was founded, as research has shown that pulmonary embolisms to be the fourth-leading cause of maternal deaths among Black mothers.

Based on her previous experience, the nurse went to the nurse's station and requested a CT scan and an IV blood thinner. The nurse thought her pain medications might be causing her to be confused, so she called in a doctor. The doctor ordered an ultrasound on her legs, which found nothing. At the patient's insistence, she was given a CT scan and blood clots were found in her lungs. She was then given the IV she had initially requested. This story has a unique pattern, but it is becoming more common among black patients. The struggle for them to be heard and listened to is happening too often. A national survey of new mothers found that 21% of non-Hispanic Black mothers experienced mistreatment during their hospital stay because of their race.

Lawmakers need to address the difference between mortality rates in urban, suburban, and rural settings. They need to distinguish the similarities and differences in the causes of

morbidity in these different settings before implementing any program locally, statewide, or federally. When it comes to the issues of hemorrhaging during/after birth it would be beneficial for birthing suites to have carts ready with the medication needed to stop the bleeding. Or have a health professional ready to get blood right away for the patient. This idea could be extremely beneficial for people in rural areas. In rural areas hospitals can be scarce, so preparing the birthing suites with everything they need beforehand could save a lot of lives.

One of the issues in maternal mortality research is data collection. Rural areas have smaller populations, which take longer to collect better data samples. Since states are different in their data collection processes and terminology, it is hard to collect and use data from maternal deaths across state lines. The difference in data collection makes it harder and longer to collect accurate data in certain states while at the same time the maternal mortality rates are rising. Before any lawmakers can truly create policies and have them implemented, the value of the data needs to improve.

The socioeconomical and geologic disparities can have been explained but disparities between races still are a big problem. Most proposed solutions can help decrease an individual's risk of dying in childbirth but does not decrease the pregnancy-related death by race. Maternal mortality review committees were created to figure out why these disparities between races occur (Kramer, M. p 609). Even though these committees have the qualifications to investigate this matter, they may lack insight. Without the ability to understand and identify community-based issues, because of the lack of conceptual framework, data, and evidence these committees cannot serve properly.

2.13 Efforts from Lawmakers

The context of how women live needs to be understood more by policymakers. How women seek healthcare, receive healthcare, work, go to school, and take care of their families before themselves needs to be brought to perspective. The issue of maternal mortality has many different layers. It starts with the factors that affect a woman in her community all the way up to the factors that affect women in the healthcare system. Community issues for an African American woman can be more detrimental to her health compared to other people from different racial backgrounds. Lawmakers and committee members need to address some of the life altering issues that affect mothers on a community level to utterly understand the issue of maternal mortality and morbidity.

There are public health programs that have used their services to help women and these services extend from a clinical setting to a social setting. These programs address some of the multi-level problems of maternal health. For example, the Sheppard-Towner Act of 1921, which increased spending on public health education programs targeted at reducing infant and maternal mortality (Bernet et. al, 2020). Even though this act was passed almost one hundred years ago, it recognized that home visits from a health professional after giving birth helped reduce mortality rates in nonwhite mothers. Due to the difference in health literacy and health access, the presence of a home visit from a nurse benefitted nonwhites. Not only do these programs help nonwhites, but they bring awareness of the racial disparities of certain groups in this country.

Back in the 1920s in America, of course there were going to be racial disparities. It was only about sixty years after the end of slavery and Jim Crow was still legal. That does not explain why there are still disparities between races today. There was a study that examined the black-white mortality gap during a more recent period, 1993 to 2005. They compiled county-level information for a national sample from various data sources and identified 10 specific local

health department service domains. After investigating, which of these services were significantly associated with the racial disparity gap in all-cause mortality rates across the United States, they concluded that maternal and child health activities were one of the two service domains significantly associated with drops in the black-white mortality gap among 15- to 44-year-olds (Bernet et. al, 2020).

More recently, Kamela Harris (D-CA) introduced the Maternal Care Access and Reducing Emergencies (CARE) Act. This is a great initiative that should be followed further. The CARE act is aimed at decreasing the racial disparities in maternal mortality rates. There will be a focus on bias training in medical staff. This will be done by giving grant money to medical, nursing, and other health care training programs to implement bias training. The other aspect of the act is to give grants to certain states to provide home services to new mothers. It is aimed to relieve maternal health outcomes.

Evidence suggests that policy factors alter the maternal healthcare outcomes of some patients. There have been more laws passed recently that have restricted rights to abortion (Vilda et.al, 2021). The United States has repeatedly been attacking women's reproductive rights. Abortion is a part of reproductive health, and it does affect maternal healthcare outcomes. Due to the different policies and laws of different states, access to abortion varies all over the country, which overall impacts the level of care provided nationally. In 2015, approximately 400 abortion-restricting legislation were discussed in 46 states, with 17 states passing a total of 57 additional abortion restrictions. More recently the Supreme court case Dobbs vs. Jackson overturned Roe vs. Wade decision and now ruling that is no constitutional right to abortion (Bauer, 2022).

A recent study found that implementing gestational age limits for abortion was associated with a 38 percent increase in maternal mortality, and a 20-percentage change in Planned Parenthood clinics was associated with an 8 percent growth in maternal mortality, using data from the National Vital Statistics System from 38 states and the District of Columbia from 2007 to 2015 (Hawkins et. Al, 2020). Moreover, growing evidence has linked abortion restrictions to various maternal and child health outcomes, such as newborn mortality, child homicide deaths, unfavorable mental health outcomes among women denied abortions, and adverse birth outcomes.

Directly and indirectly, abortion laws are making the challenge against high maternal mortality rates more difficult. The passing of these restrictions are leading women to go seek unsafe medically supervised abortions. Depending on the state it can even be illegal to get an abortion after 8 weeks (about 2 months) and people can get a reward for turning someone in for getting an abortion. Law makers have failed to realize how much this jeopardizes maternal care given in this country. These laws could potentially force someone who is not healthy enough to carry a child, putting the mother's health at risk.

2.14 Maternal Data Maintenance in America

States need to come together and form a coalition that will be dedicated to collecting data to help mothers in this country. Only half of the states in this country have maternal mortality review boards. The data collected is not always used to make changes that could decrease morbidity. The states have no national way of sharing their best or worst practices when it comes to preventing maternal deaths. There is not a data place or storage cloud nationally where health professionals can learn from their mistakes or gain knowledge on the subject. Hospitals and health professionals need to organize on a national level to manage approaches to combat

maternal mortality. After organizing nationally, hospitals and health professionals can collaborate with communities more. This way, a woman's health will be monitored and managed way before giving birth and long after giving birth.

In 2010, antenatal and maternal care were included as essential health benefits that insurance plans must cover. By doing this many women in low-income areas got the coverage that was desperately needed. This was a great initiative but more needs to be done. In 2015, a project called "Building U.S. Capacity to Review and Prevent Maternal Deaths" worked with the CDC and the AMCHP to unite the efforts of the different MMRCs and collect data on maternal deaths in formats that are both consistent and comparable. (Phelan et. al, 2018). More initiatives like these need to be implemented nationally. In 2017, the ACOG District VIII launched a Maternal Mortality Task Force in rural settings. District VIII is made up of twelve states as well as Guam, American Samoa, Alberta, British Columbia, and Central America (Phelan et. al, 2018).

The goals are to collect data and combine it by using the structure of the MMRIA database. This taskforce uses the standards of the standards developed by the Centers for Disease Control (CDC) and the Association of Maternal and Child Health Programs (AMCHP) and employed by the national Maternal Mortality Review Information Application (or MMRIA) database (Phelan et. al, 2018). Included in the data that will be collected will be the patient's circumstances and record a narrative of the patient's pregnancy. This will hopefully allow the data to be collected in a more standardized way and get an insight into the patient's world. It will be important to understand the patient and the community that she belongs to.

2.15 Conclusion

America, unlike other developed countries, is seeing an increase in maternal mortality rates. This can be attributed to several reasons. The fact remains that a black woman with a higher education degree is more like to die during childbirth than a white woman with a high school diploma. Issues with healthcare access, medical preparedness, pre-existing conditions, and prevention methods are occurring. Despite the millions of dollars spent on healthcare expenditures the maternal mortality rate is still increasing

Another issue to be noted is the data collection to research this problem. One assumption can be made that researchers have not properly studied this problem. Without collecting the proper data on the crisis how can it be solved? The data collection process is unorganized, and it is making it take longer to collect the proper data to study this growing problem. Different states collect data differently making it hard to organize it for studying.

The problem of race remains. If hemorrhaging, sepsis, embolisms, infections, and preexisting conditions complications are the main reasons for maternal mortality rates then why are there racial disparities? Different races should not be more at risk than others if this is just a healthcare issue. The problem is deeper than just lack of preparedness and lack of healthcare access. There is a racial issue present, and it must be presented for lawmakers to implement policies to change the maternal mortality issues. Women across the country are at risk of dying or facing near death pregnancy complication. It is imperative for researchers and policy makers to step in and find the underlying cause of this disturbing crisis.

Chapter 3: Methodology

The purpose of this study is to examine the overall experience that women are experiencing while giving birth in Southeastern Pennsylvania and reviewing these experiences to determine if they what these women are experiencing is negative. It will be possible to gain insight into the patient's feeling about certain topics and aspects of healthcare. Some doctors hold biases about patients' beliefs without even getting to know some of their patients. This study is a chance to highlight different interactions received during the healthcare services in southeastern Pennsylvania. Hopefully, these experiences will help further research into exploring some of these negative occurrences that are happening during maternal health care in southeastern Pennsylvania. Connecting the relationship between maternal mortality and healthcare services provided could be instrumental in decreasing the mortality rates in the southeastern Pennsylvania area.

America is the only developed country where maternal mortality rates are going up. Unfortunately, with America's tools and resources, the country should have lower maternal mortality rates. A bigger issue within the alarmingly high maternal mortality rates is that African American women are almost four times as likely to die due to childbirth-related complications compared to their white female counterparts. The purpose of this study is to examine the relationship between patients and their doctors and explore the experience of African American women during their maternal care. It is to explain the nature of patients' and doctors' behavior and discover if there is a connection between that behavior and the maternal mortality rates. Positive patient experiences are imperative to the health care system. Positive patient experiences impact patient retention rates. Therefore, it influences the business that the hospital conducts. It is also particularly important because it affects how much a patient is engaged in their health

care. Being more engaged in your health care will lead to patients being more engaged in their health outcomes. Studies have connected higher levels of clinical outcomes to a focus on patient experience. (The Impact of Improved Patient Experiences, 2018). It is important to incorporate these beliefs when it comes to maternal health. Creating more positive experiences for birth mothers will increase the chance of better healthcare outcomes.

The maternal healthcare system needs to be designed for the women who are giving birth. It needs to service these women better to have better maternal outcomes. This study will explore the experiences of women who have given birth and what they went through while seeking maternal and emergency care while being pregnant. The exploration of how these experiences shaped their perception of maternal healthcare and how it impacts decisions made about their healthcare will be discussed. For some of these women they were able to compare prior experiences and how that experience was similar or different to the care that they received in southeastern Pennsylvania. It will show how they were treated in different medical settings while receiving maternal care.

3.1 Research Question

The racial disparities between African American woman and other races when it comes to maternal mortality rates have transcended education level and economic status. Despite earning more money or increasing education level, black women in this country are still more likely to succumb to pregnancy complications near or after delivery compared to other races in this country. To understand the situation better, it is imperative to understand their maternal care and experience during their maternal care. Negative and positive patient experiences are influencing the maternal care provided in the United States. It is critical to determine patient experiences of mothers in this country.

- What are African American women experiencing during their maternal care and delivery in the United States? Are these experiences negative or positive?
- Are African American woman facing bias or racism during maternal care?

Exploring how their experiences are negative or positive can explain any underlying issues that have not been examined yet. Patient care is imperative to positive patient outcomes. Discovering if any negative experiences are impacting patient care could be imperative to improve maternal mortality rates for African American women.

3.2 Research Sample and Methodology

Participants in this study were African American women. In total there were ten women that will take part in an in-depth interview individually. These women did not necessarily have to live in the southeastern region of Pennsylvania but had to receive maternal healthcare in one of the five counties: Philadelphia, Bucks, Montgomery, Delaware, or Chester. The sample of women must either be currently pregnant or have given birth in the past five years. Candidates also must have given birth and sought medical treatment in this southeastern Pennsylvania. All participants were over the age of 18. Advertisements will be posted online to get participants for the sample. In order to attract participants, there will be online advertisements that will be posted in maternity and mother groups on Facebook. This will allow for a broad range of people to attract to this study and make it easier to send electronic correspondence. Participants have the option of communicating strictly through Facebook or email once they express interest. There will be no compensation for contributing to this study.

Some of the candidates were selected through snowball sampling. The candidates that participated in this study received maternal care in southeastern Pennsylvania. All the interviews were done over the internet through the zoom application. Even though the criteria to participate

was restricted to receiving care in Southeastern, PA the interviews were performed virtually due to Covid-19.

3.3 Sample

Below in Table 1 is the demographics of the participants of this study. The participants in this study resided in three of the five counties in Southeastern PA; counties are Philadelphia, Montgomery, and Delaware county. All the women were in their 20s or 30s. Half of the participants had babies during the Covid-19 pandemic while the other half had babies before the pandemic.

Table 1: Demographics of Participants

Participant	Age	City of Residence	Last Year of Maternal Care	Location of Maternal Care
Interviewee #10	30	Philadelphia	2021	Philadelphia
Interviewee #9	33	Philadelphia	2020	Philadelphia
Interviewee #8	28	Philadelphia	2020	Philadelphia
Interviewee #7	29	Ardmore	2016	Plymouth Meeting/ East Norriton
Interviewee #6	28	Philadelphia	2017	Philadelphia
Interviewee #5	25	Philadelphia	2016	Abington
Interviewee #4	24	Glenolden	2020	Philadelphia

Interviewee #3	24	Sharon Hill	2021	Philadelphia
Interviewee #2	35	Philadelphia	2018	Philadelphia
Interviewee #1	38	Philadelphia	2017	Philadelphia

This study was a qualitative phenomenology research design. It consisted of ten in-depth interviews. Due to Covid-19, all the data collection will be taking place online. The interviews will be semi structured and performed on Zoom. Each potential participant will have to answer a few questions to see if they qualify to participate in the study (refer to Appendices C: prescreening questionnaire). Potential participants answered the questions through email and after a participant qualified, they will schedule an interview. Before the interview began there was a screening of pre-interview questions to make sure that the participant is not experiencing elevated levels of stress (refer to Appendices C: pre-interview questionnaire). Recalling maternal healthcare experiences can be difficult for some people so it would be best to determine if the participant is fully ready to talk about those experiences.

The interviews started off with some demographic questions, recapping the prescreening questions. Then, the rest of the questions were the in depth interview (refer to Appendices C: in-depth interview questions). Interviews were saved and recordings were transcribed for their accuracy. The recordings were transcribed through a software application. After transcription, the transcripts were reviewed manually one more time to ensure that every single word was transcribed correctly.

Each interview was recorded and transcribed with computer software. After transcription, the program provided statistics which can be seen below on how accurate each description was.

After the interview was transcribed through the software, it was manually transcribed to ensure that every single word was captured. The software that transcribed the audio provided statistics on each interview that was transcribed. There were three levels of confidence that the software used to measure how accurate each transcription was. The three levels are; very confident, confident, and slightly confident.

All the interviews had most of their words transcribed to the very confident levels determined by the transcription software. In the very confident level in every interview the percentage level is over 90 percent. In the slightly confident level only two of the interviews were scored over 1 percent level. While the other eight interviews had less than one percentage level in the slightly confident level.

Table 2: Transcription Statistics

PARTICIPANT	LEVEL	STATISTICS
Interviewee #10	Very confident	95.98% 1957 words
	Fairly confident	3.38% 69 words
	Slightly confident	0.64% 13 words

PARTICIPANT	LEVEL	STATISTICS
Interviewee #9	Very confident	92.35% 1824 words
	Fairly confident	6.23% 123 words
	Slightly confident	1.42% 28 words

PARTICIPANT	LEVEL	STATISTICS
Interviewee #8	Very confident	93.89% 123 words
	Fairly confident	3.82% 5 words
	Slightly confident	2.29% 3 words
Interviewee #8 Part 2	Very confident	94.50% 2489 words
	Fairly confident	4.94% 130 words
	Slightly confident	0.57% 15 words

PARTICIPANT	LEVEL	STATISTICS
Interviewee #7	Very confident	93.50% 978 words
	Fairly confident	5.74% 60 words
	Slightly confident	0.76% 8 words

Interviewee #6	Very confident	92.93% 2394 words
	Fairly confident	6.33% 163 words
	Slightly confident	0.74% 19 words
Interviewee #5	Very confident	95.61% 3050 words
	Fairly confident	3.82% 122 words
	Slightly confident	0.56% 18 words
	Very confident	92.93% 2394 words

Interviewee #4	Fairly confident	6.33% 163 words
	Slightly confident	0.74% 19 words
Interviewee #3	Very confident	92.93% 2544 words
	Fairly confident	7.139% 183 words
	Slightly confident	0.62% 16 words
Interviewee #2	Very confident	92.93% 2794 words
	Fairly confident	5.01% 140 words
	Slightly confident	0.78% 22 words
Interviewee #1	Very confident	92.93% 2238 words
	Fairly confident	8.623% 193 words
	Slightly confident	0.35% 8 words

After transcription, each individual answer to the question were coded for phrases with negative or positive connotations. Body language and tone were deciphered as well. Comments were categorized into groups and subgroups corresponding to the question asked.

Phenomenological approach is appropriate because the study consists of examining the details of the lived experience. This approach helps to investigate how a person makes sense of a certain experience. It also allows for the account of the participant to be understood and helps people make sense of their experiences. Understanding the interrelationships between providers and their patients and how that relates to the patient experience will expose some of the patterns that occur during negative experiences.

Phenomenology is an approach that was started by Edmund Husserl and later developed by Martin Heidegger, seeking to study the experience of living human beings and how things are perceived and conscious (Smith, 2013). The descriptive phenomenological approach's overarching goal is to investigate the nature or structure of the experiences that occur in our awareness. As a result, the explanation of experience is firmly tied to the evidence and is unaffected by external theory. Husserl's phenomenological philosophy serves as the foundation for this method. Epochs, purposeful analysis, and intrinsic reduction principles are all part of this. Simply defined, researchers require a phenomenological mindset that incorporates or eliminates prior information and assumptions.

Interpretative phenomenological analysis (IPA) is also stated to be fundamentally idiographic in that it is devoted to the extensive exploration of an occurrence (Smith, 2013). It pays close attention to each instance, providing extensive and nuanced analysis and valuing each case on its own merits before going on to the broader cross-case analysis for case convergence and divergence. Researchers should adhere to this idiographic methodology throughout the analytic process to conduct a rigorous comprehensive evaluation of the commonalities and differences of the participants' experiences. An IPA approach involves the researcher playing a key role in the analysis and interpretation of the participants' experiences. As a result, the researcher strives to examine the surface meanings instinctively by reading between the lines for deeper understanding.

This research approach seeks to understand the participant's inner perspective from the participant themselves. In the process, during the maternal care process unanticipated patterns between the interactions of healthcare providers and patients will be uncovered. The interpretive nature of this approach allows researchers to use curiosity, openness, empathy, and flexibility to

gather insights from respondents and hear people tell stories in the natural environment. You can see if their experiences and actions are social, cultural, and economic, and the historical world is shaped by the context of their lives.

3.4 Strengths and Limitations of this Study

There are assumptions about the healthcare system and that is evident in the responses of some of the participants. The United States is heavily known for its racism and the healthcare system has not been able to avoid that stigma as well. People are also aware of the medical experiments that the United States government funded and some of the medical experiments that highly celebrated physicians have done on Black people. So, there is a heavy assumption among black communities that the healthcare system cannot be fully trusted. There is a feeling that people who have darker skin have less value in the eyes of the healthcare system. Another assumption was about the Philadelphia area. The area is believed to be poor and heavily populated by Black people. A participant said that was the reason behind the mediocre quality of her care. Another participant expressed leaving the Philadelphia hospital because the quality of care was not up to par.

Another assumption is that people would be extremely willing to talk about their maternal experiences. Social media gives the impression that many people are open and willing to discuss many traumatic events that occur. The current social climate makes it appear as though everyone is willing to talk about the negative experiences in their life. Getting people to open up about their medical past was more difficult than previously thought. The stressors of the pandemic and the technology barriers made it more difficult to secure people who wanted to speak about their maternal experiences. Covid-19 exposed more racism in this country which was triggering for some people. The pandemic presented an incredibly stressful and traumatic

time for a lot of people. It was not the best time to ask people to talk about past traumatic experiences when people are going through the pandemic.

Covid-19 was an unforeseen limitation that in result caused another technology limitation. Covid-19 impacted the study due to the entire world virtually shutting down. Not only did the virus impact how data was collected but it affects how patients interact with their providers. The pandemic forced the country to go on a restricted lockdown which forced all the interviews to occur over the internet through a specific software application. It forced people to have to either work from home or not work at all. It completely rearranged people's normal schedules which affected how they scheduled interviews. The Covid-19 pandemic changed people's feelings. This period was very emotional for people because the disease was causing casualties all over the world. This study is asking women to be vulnerable about a traumatic experience during a very triggering and traumatic pandemic. Getting people to want to discuss maternal mortality during a global pandemic became a more challenging task.

The Covid-19 pandemic changed the way patients interacted with their doctors which changed the dynamics of their relationships. The virus limited the interactions of doctors with their patients, so it became easier to exacerbate some of the healthcare access issues the country was already having. The pandemic put fear into people which made some people want to be more in control of certain aspects of their lives. Certain aspects of life become a priority for people.

During a pandemic when people must connect through the internet, it can become difficult to collect data. There was already a percentage of people who did not have access to the internet or have computer. The financial strain of the pandemic made that number larger. People were stressed during this pandemic, and they might not have had the time to participate in an

interview. The political atmosphere and other world issues made it difficult for people to discuss their maternal healthcare, especially when people are having such horrific experiences. It was a tough time to attempt to collect data from a sample because of everything going on in the world. Previous research is incredibly detailed on the who, what, where and when portion of the details about the maternal healthcare crisis but not so much of the why portion. Why are women in America having such poor maternal healthcare outcomes? Why are black women dying at higher rates compared to their counterparts? Why are there health disparities among these different races in healthcare? Researchers have not deeply explored how patients feel during their healthcare treatment, how patients feel during their interactions with their doctors or how hospital staff supports the patient experience.

This study left some participants feeling vulnerable talking about their past maternal experiences. Getting people to expose their traumatic events and experiences can be overwhelming and can deter people from wanting to talk about those experiences. The challenging time during the pandemic can put more stress on them and not make them want to open about their healthcare experiences. Potential bias can come from being a black mother myself. My background can create bias during the research and analysis of the data. My initial interest in conducting this study were inspired by my own maternal healthcare experiences. Also, the current political and social climate played factors in my personal bias.

Chapter 4: Results

4.1 Introduction

There are facts that show there is biased and racism in the American healthcare system, but the problem is who is accountable for the present racism. The Medicaid Act refuses federal funding to hospitals that discriminate but does not punish specific providers. That is the problem with bias in the healthcare system. Individual providers must hold themselves accountable for their prejudices and preconceived notions. They must work tirelessly to improve the patient's experience. Health care providers must realize everything they say and do impacts the whole experience of the patient. For a lot of these patients, it is an unnerving experience for them. Healthcare providers need to be more aware of the effect their words have on their patients. Each of the questions asked during the interview was meant to engage the participant about their healthcare experience. The first two questions are to understand why the participants chose the facility that they picked to receive healthcare. Attempting to understand the reason behind some of these patients' choices might help providers understand their patients' decisions better. There are other questions asking about the patient's experience during their visits and labor and delivery.

Also, there is a question about how the other staff supported the participants during healthcare services. The questions are attempts to get the participant to talk more about their feelings and how it impacted their experience during labor and delivery. Below in Table 3 shows the major theme categories discussed by participants in this study. Each theme category is broken down into subcategories that were common elements that showed up in discussion.

Table 3: Coded Themes

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Categories	Subcategories
Health Issues	<ul style="list-style-type: none"> • Medical diagnosis brought on by pregnancy • High Risk Pregnancy • Previous pregnancy health issues • Exacerbated health issues • Current issues impacted the quality of care provided • Preeclampsia • Heart failure
Lack of support	<ul style="list-style-type: none"> • Lack of support from hospital staff • Inadequate support from family • Requests were not listened to or acknowledged • Support from partner was not adequate • Lack of appointments (especially face-to-face appointments during the Covid-19 Pandemic) • Lack of post-partum appointments/support
Distress	<ul style="list-style-type: none"> • Anxiety • fear • Losing hope • Emotional pain • Straining relationships • Depression • Shame • Sense of abandonment • Feeling there is not enough information to make the proper decision • Confusion • Post-partum
Feeling Misunderstood/Unheard	<ul style="list-style-type: none"> • Doctor's not listening to the needs of their patients • Symptoms being ignored

	<ul style="list-style-type: none"> • Providers ignoring patient's concerns and worries • Providers assumed information about patients • Provider ignored certain requests • Problems with getting a second opinion • Losing self-identity
Covid-19 Pandemic	<ul style="list-style-type: none"> • Hospital Restrictions • Not being able to request the provider that is preferred by the patient • Increase in telemedicine visits • Decrease in physical hospital visits • More testing and an increase of hospital anxiety • Only allowed to have one person in the delivery room • Extra person in the delivery room had to leave after a certain time period. • Providers were accessible through telemedicine easily • Closures of hospital facilities • Less provider options to choose from
Positive Experiences	<ul style="list-style-type: none"> • Providers open to birthing plans • Providers listening to the needs of the patient • Provider being flexible and understanding of the patient's needs • Baby was born with no complication • No emergency services were needed. • Being able to have midwives as well as doctors • Coordinating care with birthing centers • Addressing patient concerns
Preconceived notions about racism in the healthcare system	<ul style="list-style-type: none"> • Did not experience racism during healthcare services

	<ul style="list-style-type: none"> • Aware about racism in the healthcare system • Experienced racism in the healthcare • Healthcare professionals witnessing bias from their peers • Participant's friends and family have expressed racist encounters in the healthcare system
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4.2 Findings

The data shows some of the participants had negative experiences. Some participants faced microaggressions and had providers ignore their complaints. Fortunately, some participants did have positive experiences. These experiences gave insights into how the patients received those interactions between providers. Some of these interactions were beneficial to strengthen the patient and doctor relationship. Around half of the participants were seen in the same area at the same hospital.

Other participants had positive experiences. They felt supported by the hospital staff and felt safe. These participants felt as though their needs and concerns were addressed. There was not anything that they could not discuss with their providers. The participants with positive experiences felt that all levels of the staff in the healthcare facility treated them well. From the front desk to the OB/GYN, every single interaction during healthcare services was respectful. It fostered a more relaxing environment for the participants to seek maternal healthcare, and it improved their birthing experience. The average age of the participants was about 29 and most of these women live in the Philadelphia area. Each individual woman has had their own individual maternal experience despite living in the same area.

4.3 Results

There were eight fundamental issues or feelings that recurred in each interview. The first notion was health issues. This is obviously a hot topic during the Covid -19 pandemic but before this virus took over the world there were people with preexisting conditions. Those conditions can and did affect some of these participants' pregnancies. One participant had a high-risk pregnancy due to the nature of her previous pregnancy. Covid-19 makes it scarier to have children because of how rampant the disease was in the beginning. The topic of the pandemic became a frequent topic of discussion because of the way it changed how healthcare services were provided. The unknown implications of contracting or spreading the disease heightened all negative emotions such as uneasiness.

The participants that experienced maternal care during the pandemic had a unique experience compared to the participants who had children before the pandemic. Women who sought out maternal care during the pandemic had fewer personal face-to-face interactions compared to women who had given birth before the pandemic. Fewer face-to-face interactions changed the patient's experience during the pandemic and raised more fear and anxiety in participants because of the uncertainty of the pandemic.

One thing that every participant did agree on is that they were aware of racism in the healthcare system and maternal care provided. Even though some of them expressed that they were aware of the bias and racism but did not experience it firsthand. It reflects that there is a level of awareness among people that there are biased interactions occurring in the healthcare system.

Distress

For the people who experienced maternal care during the Covid-19 Pandemic felt a heighten sense of fear and anxiety stemming from the lack of information presented. Giving a

birth was a new experience for most of these women and no one them really knew what to expect besides the obvious (the baby). It was a nerve-wracking experience. Due to the experience being new for so many the feeling of losing hope was present because of their uncertainty there was a potential of losing hope about encounter a positive experience.

Strained relationships became another theme in this study due to the lack of support their partner was feeling. Sometimes this lack of support came from physical distance due to the Covid-19 restrictions. If a woman was alone in the hospital room after giving birth because of Covid-19 restrictions she felt less supported. There was also a theme of strained relationships between the patient and doctor. One of the participants decided to part ways with her first doctor over communication issues. She could not see eye-to-eye with her provider, so she decided it was best to part ways.

There was confusion about provider selection and birthing options/plans. People just did not know the plethora of information out there and how it could be utilized to their advantage. Looking back, some of the participants regretted their lack of knowledge about maternal care. The Covid-19 pandemic exacerbated the depression felt in this study. When someone is pregnant, they host a baby shower, gender reveal, or baby reveal and all those events could not happen during the pandemic especially under the tightest restrictions. The financial impact of the pandemic also left a lot of people less financially supportive of other people or babies. This can make people feel a sense of abandonment and they get sad from the loneliness. Even without the financially support, the pandemic limited a lot of the physical support that is garnered to expecting mothers and babies. The dissatisfaction with lack of physical support is apparent when participants discuss the impact of fewer face-to-face appointments.

Medical Issues

There were participants who have had medical problems brought on by the pregnancy. These women were generally in good health with no chronic conditions. That was a challenge for some of the participants who had to face a new disease that caused complications in a pregnancy while they fight for their lives. Patients like to have control over their bodies, and it can create anxiety within a person when they feel as though they are losing control of their bodies.

Dealing with that by itself can be overwhelming for certain women. Imagine the anxiousness and anxiety that can stem from disease brought upon by pregnancy. One participant had congestive heart failure that was caused because of the pregnancy. It had gotten so bad for her that she could not walk to her kitchen without being out of breath. It can create a high level of fear with a person when your body begins to fail you like that because of the stress pregnancy can cause to the body. It is exceedingly difficult being pregnant but having heart failure at the same time almost cost this woman her life. Being pregnant can bring on a string of medical issues that scare women.

Another participant had preeclampsia during her pregnancy which caused her to deliver her baby earlier. This was very discouraging because it impacted her birth plan and made her feel like she was not in control. It made her baby come two weeks early which is an adjustment. She was not expecting to have a baby that early while trying to battle the effects of having high blood pressure during the last portion of her pregnancy. She did not have high blood pressure before, so this experience was something new a nerve wracking to her.

Giving birth and being pregnant has really been romanticized to the point that people are not aware of what really can go wrong during pregnancy and the toll it takes on the human body. When woman unexpectedly get medical issues during pregnancy it can take an emotional toll. The process of the body healing after a normal pregnancy and delivery can be around 18 months.

These women who experience medical issues during pregnancy must face a more difficult recovery process which can cause them more stress.

Support from Staff

Half of the participants felt the support of the staff while the other half did not. Lack of support doctors was a common theme. Participants felt as though they did not really see a physician that much. When it came to appointments, participants usually encountered the technicians and nursing staff that assisted the doctors with taking lab results, weighing the patients, and collecting medical information from patients.

All the participants expressed of gratitude towards the support staff. Participants felt a connection to the medical staff that gave out brochures and information or scheduled appointments. Participants felt that the support staff really contributed to the patient experience because participants would usually take their questions that they forgot to ask their doctor or could not ask their doctor and ask the support staff. The reception desk is usually the first and last thing that the patient sees before leaving the office, and all the participants had warm experiences with the supporting medical staff.

Participants felt as though doctors were not listening to their problems. During one interview, Interviewee #6, She went to visit the emergency room after having some contractions and the doctor left in her room, in pain with a medical student. The doctor suggested that the medical student get more patient care experience. The doctor kept making the resident ask her arbitrary questions so that the resident could get some learning experience. It was embarrassing for the participant because she was in so much pain, and she could not understand why no one else would acknowledge her pain. The only problem is that the participant was in early pre-term labor, and she was having contractions so difficult she could not really speak comfortably. At

that moment, the doctor thought it was more important for his medical student to get experience than to reach out to the patient and understand her level of discomfort. That left the participant feeling like the ER doctor did not care about her well-being and did not prioritize her health at the moment.

When she was examined, she was in excruciating pain but the nurse that came in to monitor her contractions hooked up the machine wrong. The nurse became confused because the monitor was reading no contractions and the participant was still in a lot of pain. Finally, the nurse figured out that the monitor was wrong, and that the participant was in preterm labor. This left the participant angry and embarrassed. She just felt as though it was highly incompetent to hook up the monitor wrong. She expressed sadness because the experience was unnecessary. She could not understand why if a patient comes into the ER in so much pain that they can barely speak they would be forced to answer questions under so much duress.

Participants spoke highly of administrative support, lab technician, and some of the nursing staff. In the end they felt as though the doctor or nurse practitioner would not listen to some of their needs. For example, the interviewee #2 who had heart failure explained to her doctor multiple times about her exhaustion. She told her doctor she could not even walk to the kitchen without being out of breath. Her doctor brushed off the participants' concerns.

Interviewee #2 eventually went to seek a second opinion which was not as easy as she thought it would be. She felt as though her OB/GYN supported her more, then it would not have taken so long to see a cardiologist.

“I sought out a cardiologist who I thought was, you know, well-respected, had good patient satisfaction scores, you know, research and, you know, maternal cardiac issues. And so I went to this particular provider, also affiliated with Pennsylvania Hospital. And I sought her advice now for cardiology. It took maybe three or four months for me to be able to even see the cardiologist. You know what I want to say? It's even longer than that. I want to say it took maybe five to six months, but if my OB-GYN was on board with

what I needed, I feel she could have asked a cardiologist for a professional courtesy to see me a little bit sooner.” – Interviewee 2

The participant eventually had to go to the ER. The patient at that moment did not get the support she needed from her doctor. The doctor should have examined the patient more thoroughly. Being pregnant is not an excuse for someone to feel like they are about to pass out from walking to the kitchen. That doctor could have killed their patient. When the participant went to the ER, she was told if she waited any longer than she would have died. It is scary for these patients to have to advocate for themselves and see a second doctor because it could mean the difference between life and death for some people. If she had listened to her OB/GYN then she could possibly be dead today as well as her baby.

Support Network

Lack of support from the providers can be very discouraging for some patients because it can be experienced from their partners or families as well. In one interview, Interviewee #6 was frustrated because her doctor ignored her pleas, and her partner had a nonchalant attitude about it. The doctor did not care so the partner did not care either. It left the participant feeling isolated and alone during the childbirth experience. There seemed to be a lot of distress and anxiety going through these participants' heads. Interviewee #8 expressed to their doctor that they just want to make out of this experience alive. Once that participant expressed the sentiment of wanting to live her doctor said all the right things to reassure her. Those words were only words to that patient. Unfortunately, it did not give the level of reassurance to the interviewee that she wanted. That is a lot to handle for a person. It can make the childbirth experience more negative.

Participants felt is that there needed to be more than one post-natal appointment. These women formed a bond with their providers over the last several months and after the baby is born there is one post-natal appointment six weeks later. Since women are prone to post-partum

depression, there needs to be something put into place to check up on these women after they give birth. Women deal with a variety of issues after pregnancy, and there needs to be network in place where woman can reach out to get the help that they need. All this attention is stripped away from the mother because she is no longer pregnant, and the focus is diverted to the baby. The care of the mother after giving birth is just as important as the care of the baby. Mothers need more than one post-natal appointment six weeks after giving birth.

Another thing some of these women experience is that they did not have enough information to decide about their healthcare. They did not know much about the health insurance and healthcare network institutions. With such a competitive health insurance market and intricate healthcare network it can be hard to navigate. Interviewee #8 felt as though she no choice when selecting her doctor. She tried to find an African American OB/GYN, but during the pandemic that became exceedingly difficult. The information on alternative birthing centers or doulas was not readily available. During the pandemic while facilities are shutting down, people felt as though their options were diminishing and they had no choice but to pick the quickest option.

Covid-19 was brought up among interviewees #3,4,8, 9 and 10 because these women had their babies during the pandemic. For the women having their first baby, the experience was different because of the Covid-19 restrictions. For one participant, the hospital only allowed one person to be in the delivery room and that person could stay for the remainder of the inpatient hospital stay but could not leave. Her partner had to leave to go to work. She felt alone and depressed for the remainder of the stay. These women were going through so much physically that people forget that simple things like support can make a difference to these women mentally. Covid-19 did a lot to ruin the patient experience. It even disrupted pre-natal schedules for

everyone, even people with high-risk pregnancies. In person contact was limited during the Covid-19 pandemic therefore decreasing the cherished amount of face-to-face time with providers.

Some of the participants had positive experiences, they felt supported and any needs from their doctors were met. received. That is the kind of patient experience that everyone should get. They felt as though they were heard, and all their concerns and considerations were acknowledged. For some of them it was hard to form an opinion about racism in the healthcare system because of how well previous doctors has treated them.

Preconceived Notions about Racism in the Healthcare System

Participants expressed awareness about the issues of racism in the healthcare system but at the same time expressed that nothing racists had ever happened to them during their maternal care. The most direct racial experience occurred when interviewee #5 overheard two nurses talking about her. The nurses were discussing which pain medication route to take with patient, and one nurse said to the other “look at her last name, she can take pain.” The patient was extremely offended by the statement. No one’s last name can determine their pain tolerance. No medical professional should be making statements like that. There are instances where little exchanges like this can make a difference in patient experience and patient outcomes. If that is how the medical staff makes medical decisions about their patients, then it makes more sense that patient outcomes for black women in maternal care are so poor compared to their counterparts.

Racism in the Healthcare System

One of the participants was unique because of her background. Not only was she a mother but she was also a nurse. She had the experience of delivering her baby to the same

hospital. Since she was a nurse, she had witnessed and experienced bias from her colleagues. The quote below reflects how being on both sides of the healthcare experience can expose you to a lot of bias.

“Oh, it's terrible. I experienced it firsthand being someone who's in the health care profession. I witnessed it for myself and you know, for some of my other my friends who have also who are also black or people of color, and they have experienced some of the same things that I've experienced. I'm sure we'll get into later. I think that, you know, it's it's very unfortunate that black women are dying three to four times more likely than their white counterparts. I think that that's terrible. And I think that, you know, just off the data that there is no difference in socioeconomic status. You could be wealthy and black and still have the same type of situation. Racist situation, rather. And it can affect your child or yourself. There are several stories and several articles out there. And being a black woman in America, I think that a lot of black women, I can speak anecdotally. I think a lot of black women, a lot of my friends or scared when they're pregnant because they're not sure how the outcome will be or what the outcome will be”

This participant later expressed her struggles with bias during her treatment and how her past maternal experiences affected her current pregnancy at the time.

“Sure, I won't even say it was racism. I'll say it was more unconscious bias for my provider. The provider that I saw was a young white girl. She had great ratings with maternal not only maternal mortality, but just overall patient satisfaction. She had great scores. And so that's why another reason why I decided to go to her and you know, from the very beginning of my pregnancy, there were issues,”

She went to a specific provider based on reviews provided. She did everything correctly and did her research about who she wanted to treat her, and she still had problems. It shows how subjective reviews can be.

One of the issues with the healthcare system is that a many healthcare providers have great reviews and great customer service praise, but they are still coming off as biased to their patients of color. The healthcare system works off customer service surveys and reputation to help attract patients but how can one person just go off subjective reviews.

4.4 Quotations

Direct quotes (please refer to Appendix D) from the interviews give insight into some of the fears and ideas some of these participants have. It is imperative to understand where these

patients are coming from so that providers can understand how to help them. Healthcare providers can put people's fears at ease if they know what is scaring their patients. If doctors assume they know what the problem is, they are not really helping their patients. It also shows the need for more black providers. The patients want to see more people like themselves on the treating end. This shows how important representation is in medicine.

Quotation 1 really expresses the fear in these women's mind's when they are going through the maternal care process. "I want to survive this pregnancy. I want to survive the hospital." The level of anxiety that created because hospital have failed to address the inconsistencies in maternal care when it comes to black women. Black women end up fearing not surviving the hospital. Being pregnant is not a battle that someone should not have to survive. Giving birth should be a welcoming experience and if something does happen, people should be confident that the hospital should be able to handle the situation. Women are looking at the birthing experience as a life-or-death situation.

Another quote that is interesting is number five. The participant states that in Philadelphia they have poorer care compared to the DC/Maryland area where she is from. The DC/Maryland area is more racially diverse, so the care is better. She also expressed that the hospitals in the Philadelphia area provided less than adequate care for their black patient while other areas are more mixed and middle class, so the care is better. It is interesting because is it because people are poor or black that they are receiving worse care? Or is there a correlation between socioeconomic status and racism in this country? If people are making that connection, then they should be able to figure out how to fix the bias in the healthcare system.

Quote 10 speaks to how important representation is to patients. Black patients want to see black doctors and they want more black people attending medical school. It is important for more

black doctors to fill more clinical spaces to make black patients feel more at ease. Some black patients are more comfortable with black providers and the reasoning is not rooted in racism. Black patients seek out black doctors because they feel as though a black doctor will have more of a cultural understanding of how the patient operates. For example, some black patients may speak in African American Vernacular English (AAVE), which can be lost in translation in other cultures. Having a doctor that understands black culture can mean the difference to a patient.

Interviewee #3 had a doctor that did listen to her every concern and wishes, and she expressed that it made her birthing experience better. She stated, “So it was nothing that I considered and brought to her attention that she didn't also that she didn't.”, and she also talked about how well her birthing experience was because of how the doctors treated her and listened to her. She was grateful to the staff for listening to her, and it improved her relationship with her provider. She was able to gain trust and be assured about the whole maternal care process. This participant was able to do her own research about giving birth and maternal health care while her provider affirmed her throughout their whole relationship.

Doctors being able to build a rapport with their patients makes a difference in the quality of care provided, and it can leave the patient feeling more supported. When doctors garner the trust of their patients, they can build better connections and put their patient's worries at ease. It also improves the reputation of doctors in the eyes of the patient. This participant stated in the interview that she was aware of racism in the healthcare system but had never experienced any of it. When patients have positive interactions with their providers that reinforces their beliefs that they have not experienced racism in the healthcare system. Building better relationships between the patients and their providers will improve health outcomes.

Quotation six really reiterates how important it is for healthcare providers to treat their patients properly. The participant compared it customer service and how it is easy to tell how people feel about you by the way that they treat you. Health professionals need to be mindful of their interactions with their patients because their patients are picking up on certain behaviors and tones used in their presence. There are other people around witnessing different interactions between patients and healthcare professionals. People are watching how patients are treated so it is imperative for doctors to be mindful of who is observing their interactions.

4.6 Reputation of Healthcare Facility

Researchers must inquire about the healthcare decisions that people do make. If people have so many different options when it comes to choosing a healthcare facility, why do they pick the ones that they do? In this study, the main reason respondents chose their treating facility was because of its reputation. Some participants chose their hospital because they knew someone who had delivered their baby at the same facility. Three participants chose their healthcare facilities for different reasons. One participant did not like Philadelphia healthcare facilities, so she decided to use a midwife's group. Another woman had no vehicle, so she picked the closest hospital to her house. Another participant was tired of the hospital in Philadelphia, so she transferred to a hospital in Montgomery County.

Many participants choose the same healthcare network in the area based off its reputation. For example, the University of Pennsylvania is a large healthcare system in southeastern Pennsylvania that many people utilize in the area. The healthcare network has a great reputation and people in the area like to make it their go to hospital to seek health services. In the Philadelphia area one health network has a particularly good reputation in the public and the medical community. For some of the participants they knew other people who had babies at

the same hospital so they just assumed that they would receive the same treatment that other people they knew experienced.

Figure 2: Reasons Why Health Care Facility was Chosen



Reputation was a popular factor that contributed to the reason some of these women picked a particular healthcare facility that they choose. In some instances what they experienced was not something they would expect from a hospital with such a good reputation. For example, interviewee #6 had the contraction monitor place on her incorrectly. That incident is something that is not expected from a hospital with such a great reputation. Also, allowing medical student to ask unnecessary questions to a woman in preterm labor is something expected from a more novice hospital.

Interviewee #5 who experience her racial encounter regarding her pain tolerance with the nurses only picked that hospital because she did not have a car and wanted to pick the hospital closest to her house. It is interesting to think that maybe if she was able to travel further how much different her maternal care experience would have been. It shows the power in money. Money can allow someone to afford a car or the best health insurance so they might not have to experience such direct racism in the healthcare system.

4.7 Birthing Plan

According to the patient, the birthing plan is directly connected to the patient experience and patient outcomes because of how important it is to the labor and delivery process. Some patients felt more in control when their birthing plans were flowed strictly while others did not have a birthing plan. It can give comfort and ease to the patient when the doctors respects and tries to follow the patient's birthing plan. In this study, there were three participants who did not have a birthing plan at all. They had multiple children before and felt it was not necessary to have a birthing plan. To be honest one, interviewee #1 was quite "fed up" with the whole birthing process because it was her fifth child and she had delivered four before with no complications. So having a birthing plan when she was not a high-risk pregnancy was unnecessary to her.

Interviewees #6 and #9 that did not stick to their birthing plans were the ones with the most serious maternal care issues. These were the women who had heart failure and went into pre-term labor. The one participant with pre-eclampsia had to readjust their plan to accommodate delivering their baby a couple weeks early. The rest of the participants were able to stick to their plan and have the birthing experience that they wanted.

Figure 3: Participants Birth Plans

PARTICIPANTS WHO WERE ABLE TO STICK TO THEIR BIRTHING PLAN



4.8 Healthcare System Bias

Many of the participants expressed that they have not experienced any bias in the healthcare system but have acknowledged that bias in the healthcare system does exist. Other participants were not so lucky. Participants experience d minor microaggressions that they did not like. Interviewee #5 heard a racist statement being made about her pain tolerance. People's actions and the way that they treat black women can mean all the difference. Seeing a black woman in pain to the point of where she could not speak should have been enough for anybody to stop their lining of questioning and see if that person is truly ok. That did not happen for one of these participants. The medical student valued getting through the line of questioning more than he valued the patient's pain level because the doctor instructed the student to get more

experience. It showed a lack of humanity on the medical student's side. It is time that black women's humanity be respected.

Figure 4: Participants Experience with Healthcare Bias



4.9 Advice for Medical Professionals

One tip of advice that all the participants agreed on is that they want medical staff to listen to their patients before making decision. It was a recurring theme during the study that doctors are hearing their patients, but they are not listening to them. For one person in this study, that almost cost her the life of her baby and her own life.

Another thing that medical professionals can do is advocate for more than one prenatal appointment. Seeing a patient one time after giving birth and possibly never seeing them again does not sit right with some women. Some women need a better support system, and that can come from the hospital. This would be an opportunity to build a better rapport and a stronger

relationship with patients. If there is some level of distrust going on, to alleviate that doctor should consider having more face-to-face time with their patients.

Figure 5: Advice for Medical Professionals



Medical professionals need to realize that they are building a relationship with their patients and these patients are trusting them with their lives and their babies' lives. Medical professionals need to be constantly aware of all the A patient's mental health really needs to be prioritized when thinking about how a doctor is going to interact with their patients. For example, the one participant who heard the nurse make a comment about her pain tolerance being high because of her last name.

There is no way to build trust or make patients comfortable when healthcare providers make those kinds of statements during their interactions with patients. Why would patients want to keep coming back to see providers that make those kinds of comments? Assuming if

someone's last name means they can take a lot of pain then how can a provider accurately manage the pain of this patient?

There is already tension within African American people when it comes to the healthcare system so alleviating that anxiety so that providers can build more trust is imperative. How can patients listen to someone they do not trust? Providers must be held accountable for their comments and conducts during their patient interactions not just their interactions but the interactions of their peers. One patient just does not see one doctor their whole entire life they see a variety of providers. It can take one provider with bias to ruin the patient perspective of the whole healthcare system. All providers need to be aware of what they say and how they say it.

4.10 Covid – 19 Impact on Healthcare

The Covid-19 pandemic ravaged the medical community and put a severe strain on the overall healthcare system in this country. Unfortunately, maternal care suffered as well in many ways that negatively impacted the patient. The first negative impact was the restrictions on capacity inside of buildings; To limit the exposure of the virus to people, the country shut down and there was a lockdown which impacted maternal care.

Usually, patients are put on a prenatal schedule depending on their pregnancy; high risk pregnancy patients have more doctor's visits. Covid-19 forced a lot of these visits to become virtual, which meant less time was spent in actual clinical settings for people who were pregnant during the pandemic. The telemedicine visits felt less personal to some of the participants.

When it came to labor and delivery, Covid-19 ruined that as well. It restricted the labor and delivery room to one person. Generally, that person was not allowed to come and go; they had to stay for the duration of the hospital stay. That was impossible for some families that have to leave to attend to other children, work, school, or other commitments especially for people

like Interviewee #3. It left some participants by themselves as such a vulnerable moment. In addition, that these patients had to handle the fear of possibly catching the Covid-19 virus or their newborn baby catching the virus.

4.11 Maternal Care in Philadelphia vs. Outside of Philadelphia

The southeastern area of Pennsylvania is a remarkably interesting one because of the city of Philadelphia. That city of Philadelphia is a massive area that it can be considered its own region. The culture, the influence, and the people are one of a kind, and that can impact the difference in the services between Philadelphia hospitals versus the other regions in Southeastern PA. Participants who went to Philadelphia hospitals felt as though there were many options, but the healthcare network was disorganized. It was hard to gather the proper information to make decisions about healthcare when it came to these facilities.

Interviewee #7 changed providers because of the communication issues and ended up in a hospital outside of Philadelphia and ended up liking that care better. Her perspective is valuable because she was able to see both sides of the healthcare system in the area. She gave special insight about the Philadelphia hospitals because she compared her other childbirth experience from when she delivered in the DC/Maryland area. In her mind, better patient care occurred when there was more diversity and Philadelphians are being exposed to bad care compared to DC/Maryland area patients.

The two participants who sought maternal care outside of Philadelphia had great things to say about their experience. They loved the fact that their doctors listened to them, and they felt support from all levels of the medical staff. They had positive things to say about their experience. Even though one of those participants had her baby a couple weeks early she expressed that she always felt safe with them. She felt as though she was in good hands.

Figure 6: Maternal Care in Philadelphia vs. Outside of Philadelphia



4.12 Emergency Services During Maternal Care

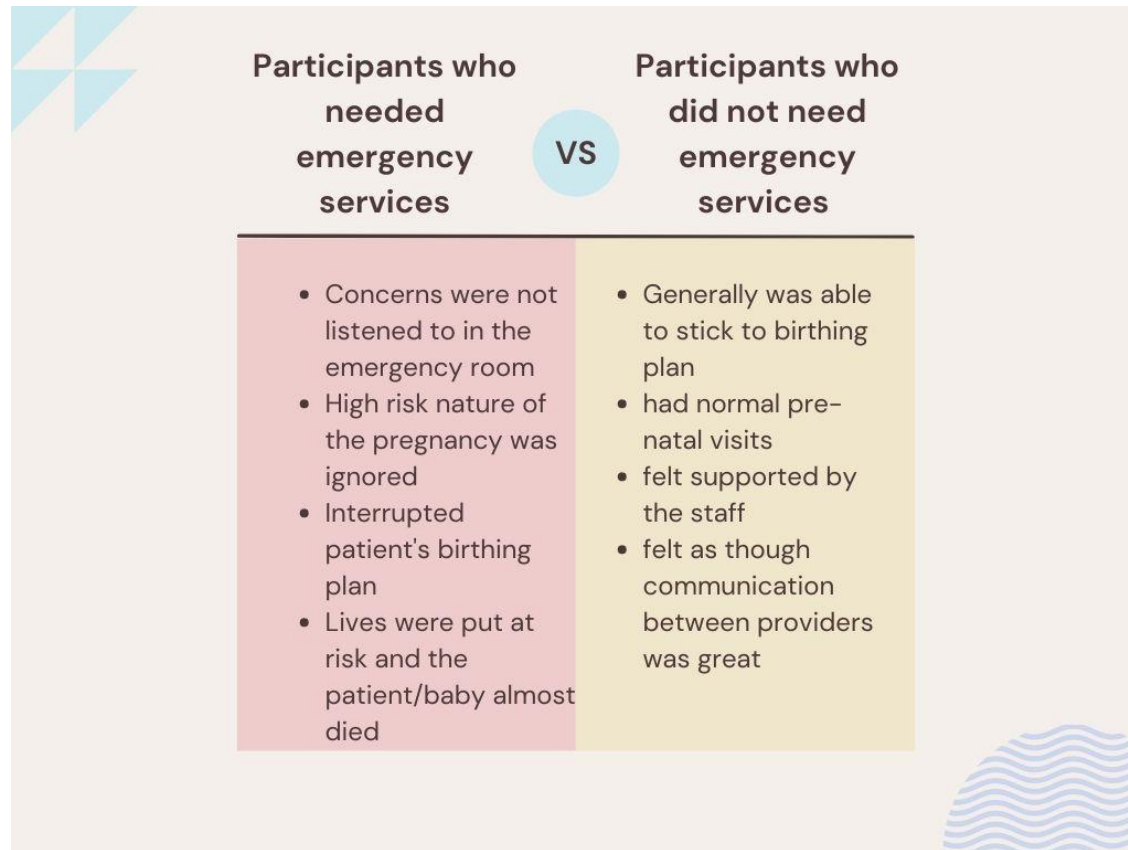
There were two cases in this study where doctors did not listen to their patients and their concerns. One woman was treated in the emergency room at the hospital where she was seeking maternity care at. Another interesting fact was that this was not her first pregnancy at this hospital; she sought care there before. The hospital was aware that she was a high-risk pregnancy because her previous pregnancy was high risk as well. Her medical chart should have contained that information present in there.

When this participant went to the ER with contraction pains, her concerns were not taken seriously. She feared going into preterm labor and eventually that did happen. Doctors should

have tried to prevent the labor from happening. At the time of the labor the chance of the baby surviving was very small. It was a scary experience for this woman, and it was disheartening. One of the participants with heart failure was glad she went to the emergency room. When her OB/GYN was ignored her complaints of exhaustion, the participant decided it was time to get a second opinion. When she went to the ER and they ran tests, the medical staff discovered the patient had heart failure. The doctors were able to devise a plan to have the baby delivered safely. The mother and the child were perfectly fine afterwards. When patients stick to their intuition instead of the medical advice of their doctor, it ends up saving their lives in certain circumstances.

Both participants had to rearrange their birthing plans because of the ER visits, which made them feel less in control. Even though both children and the mothers were fine, both situations were very scary. It is hard to fathom that other people are going through similar experiences when it comes to maternal care. It can be frightening when your life is a risk, the baby's life is at risk, and you feel like people are not listening to you.

Some of the patients in this study felt as though they were not understood. Giving birth can be a stressful situation, and for some of these women it was even more stressful because of their past maternal experiences. Health practitioners need to be aware of this when engaging with their patients. There were at least three participants who expressed specific concerns to their providers, and they felt as though their concerns were not being fully addressed. When health practitioners engage with their patients, it is important to show that you care and that you know them. Some patients from this study were left feeling as though they were losing their self-identity and their concerns did not matter.

Figure 7: Participants Who Needed Emergency Service vs. Participants Who Did Not

4.13 Giving Birth During the Pandemic

The Covid-19 pandemic, patients saw a rise in telemedicine and a decrease in face-to-face appointments which cause some patients' stress. One of the participants expressed extreme anxiety about the situation.

“So I think maternal health care in general is just. It's subpar, I really feel like in particularly, I think my pregnancy was unique because it was during the pandemic, so it was even less involved because they didn't really want me come into the office to avoid kind of getting sick. So I had quite a few of my appointments over Zoom, which didn't feel super personal, and it kind of felt like I didn't necessarily have the support of the medical staff that I would have wanted. So it kind of felt like they were there. But if I really had any questions or concerns, I really kind of went to just people in my family or like Facebook groups more than I would go to like my doctor and my primary care.”

Women were leaned of their family or people from online because of they lacked personal access to their doctors. It is sad that people must lean on the advice of non-medical professionals for

medical advice. The pandemic strained the doctor-patient relationship more because people could not physically see their doctor. It is important to note how important face-to-face interactions are for human beings, especially when it comes to them seeking medical treatment. With black communities already facing healthcare access issues before the pandemic, patients within these communities were forced during the pandemic to decrease in person interactions with their doctors. Fewer in person interactions exacerbated the healthcare issues black patients are facing in this country.

4.12 Conclusion

Overall, half of the participants had negative experiences during their maternal care while the other half did not. This study exposes how important patient and provider interaction is important. The Covid-19 pandemic exposed how desperate patients want and need to see their provider face to face and how important these interactions are to the patient experience. These interactions were a critical part to providing care.

Another factor that needs to be reiterated is that providers need to be aware of what they say to their patients. Racists comments are harmful to patients ruin the patient experience. The patient experience is not indicative of a positive health outcome, but it can influence some factors in a clinical setting. A provider is not only supposed to provide care, but they are supposed to ease the patient's physical comfort, help them understand the treatment process, and give emotional comfort.

For some of these participants those things did not happen, and it negatively impacted their maternal experience. Within those negative maternal experience, there were some women who encountered some traumatizing experiences. It reflects on some of the issues happening in the maternal care process. Many maternal morbidities could have been prevented. Focusing on

what prevents these morbidities will help decrease mortality rates. Starting with the provider-patient relationships will help not only improve the actual experience that these patients are going through but might prevent future morbidities from happening.

Chapter 5: Discussion

Maternal healthcare can present some multifaceted issues for black women in southeastern Pennsylvania. To improve the experience and outcomes, there needs to be a full examination of the structure of the healthcare system and the racial bias that affects black women when they seek maternal care. From the moment that these women seek treatment to the end of their care, they are in the hands of medical professionals. Medical professionals and healthcare networks need to be held accountable for failing to provide unbiased care to their patients. The current bias that is affecting the healthcare system should be the ultimate priority for policymakers and healthcare professionals.

Even though half of the participants did have positive experiences, they were aware of the racism in the healthcare system but were incredibly happy that they did not have to experience those negative encounters. Some health professionals are aware it happens, and black patients know as well. Black people must start to recognize racist behaviors coming from health professionals and make them take accountability for their actions. These racist actions are ruining the reputation of the whole maternal healthcare system. There are several factors of the U.S. healthcare system that is allowing for these negative encounters to keep happening, and it is costing women their lives. It is noticeably clear through the data that bias is affecting the treatment decisions of providers which in return is producing negative patient outcomes. The patient's experience is related to the patient's outcome. Providers must recognize how their bias and racism contributes to the negative outcome of a patient's experience.

The participants with negative experiences were not so happy with their patient experience at all. They felt bias and racism in their interactions. For one participant that had heart failure almost died because her OB/GYN would not listen to her. These negative interactions are

causing people to lose faith in the healthcare system. Even though half of the participants had positive experiences, some of them mentioned hearing stories from family members or friends about negative patient experiences. When patients do have negative experiences that they survive, from they are able to share those experiences with others which ruins the reputation of the healthcare system.

Providers and patients can come from diverse backgrounds. Providers need to grasp the concept of social cognition and racism. This allows them to better comprehend their thoughts, feelings, experiences, and objectives. They can empathize and consider things from an unfamiliar perspective. Understanding racism will allow for providers to comprehend how their actions and decisions impact their patient and if these decisions are made based off racial ideology. It also allows them to go back and forth between their own point of view and another patient. In return, it will allow them to make better suggestions for their patients and make medical decisions that are better for their patients' lives.

5.1 Summary of Findings

The journey for motherhood for some women in southeastern Pennsylvania included negative experiences that are rooted in racism. This study showed the need to prioritize black women's birthing experience in southeastern Pennsylvania health professionals must work together to get rid of the negative encounters that they have with patients and check their own biases. Participants that had negative experiences also encounter negative patient outcomes. When the women in the study were able to stick to their birthing and felt as though their provider listened to them, had positive experiences. When the provider ignored the patient's concerns is when other health issues started to arise in the participants. Negative experiences can reinforce the mistrust in the healthcare system and fuel the negative preconceptions that patients have.

Participants were aware of bias and racism in the healthcare system, and some of them experienced it firsthand. Experiencing racism and bias can create negative stressors for patients. Those stressors can create trauma that is persistent and ongoing. The effects of racism and bias can instill fear and anxiety into people. It can lead to other psychological issues that impact healthcare. The long-lasting effects of racism on patients need to be further explored. How racism impacts the patient experience and can ruin the doctor-patient relationship needs to be explored more. There is research that supports that some doctors have a bias towards their patients and that changes the recommendations that doctors make for their patients.

Patients face racism inside and outside of the healthcare system. The trauma from experiencing racism outside the healthcare system impacts the decisions patients make when seeking healthcare. Those negative experiences can bring about depression, fear, and anxiety in patients, and it will influence how they navigate through the healthcare system. For them to also experience racism within the healthcare system is disheartening. When studies show that white doctors believe that black patients do not listen to their medical advice, white doctors need to learn to empathize more with their patients. Understanding some of the societal and cultural influences that affect patients will help providers understand how to help their patients better. Participants expressed that they did not feel safe or supported by the medical staff during their care. How can a patient be receptive of medical advice from people who they feel do not support them or make them feel safe?

There are a lot of preconceived notions on both sides of the relationship. Data has shown that medical professionals admit to being biased and believing that black people do not listen to medical advice. Patients believe that medical professionals can be biased and racist. The emotional turmoil that is caused by racism in the healthcare system is sabotaging a lot of patient

and doctor relationships. When both sides prejudge each other, it does not help to foster positive relationships. It leads to the quality of care that the patient receives to be compromised.

Customer service side of healthcare that needs to improve. Healthcare access, locality, and money impact the maternal healthcare that a person received. In Philadelphia, there are numerous women who use Medicaid as insurance which helps expand coverage to low-income women. There are socioeconomic factors associated with being low-income and qualifying for Medicaid. Decision to seek care, access to care, and timeliness and quality of care are all affected by income. Those key factors impact the maternal care provided. When patients seek new providers, they use reviews and other customer service reviews to help find the right healthcare facility. These reviews can be subjective and lead the patient to find the wrong provider to serve them. This results in more negative experiences for the patient.

One participant only chose to seek services at a particular hospital because of its location, and she could not afford transportation. She experienced racism at the hand of her nurses. If only she was able to afford more hospital options, she would never have gone through that. That mental anguish could have been avoided. It is worth noting how much finances heavily influence healthcare. Medical professionals need to be more aware of the connection between finances and healthcare and how those influences patient decisions.

Participants called for ongoing post-partum treatment. They felt as though one appointment, six weeks after giving birth, was not enough. Participants urged for more than the standard one post-partum appointment that is recommended for patients. Patients and provider build this rapport for forty weeks and it is centered around the health of the baby. Patients have an urge to build stronger relationships with doctors because they feel as though their interactions with some providers can come off as cold. It is hard to trust a provider when there is not a strong

relationship between the provider and patient. Being just as invested in the health of the mother as it is of the health of the baby during this period would be beneficial to the mother.

The irony of the study is that most of the patients gave birth at the same hospital, but they still had negative and positive experiences. It shows how important every healthcare provider plays a role in the patient's outcomes. Many participants chose the hospital because of its reputation, or they gave birth there because other family members did. Within this one facility there were various levels of care being provided by the staff. Even though overall the reputation of the hospital was good there, there were still providers in that hospital that have bias and negative encounters with their patients.

5.2 Discussion

Black people need access to an antiracist healthcare system. As it pertains to this study, black women need access to antiracist maternal care. Right now, the U.S. healthcare system is allowing for provider bias to be unchecked even though it is causing many negative patient outcomes. The maternal care system needs to be rearranged to better serve Black women giving birth. One way of doing this is having more Black people take roles in the maternal health care profession. It was expressed in this study the need to pick a Black provider and how midwives helped with the birthing experience. It is recommended that more black people start to enter the medical field more. There is a need for more nurses, lab technicians, physician assistants and other healthcare positions. Black people want to black providers so that they can provide more culturally responsive care.

Black people are not monoliths and need more than just someone who physically resembles them when it comes to selecting a provider for healthcare. There are many cultural, societal, and socioeconomical factors that influence bias and racism in the healthcare system. It

goes beyond the color of someone's skin because black providers can be biased towards their patients just like any other race.

Research has been presented about how black patients do not get the same recommendations from doctors compared to their white counterparts when it comes to cardiovascular and renal studies. If the data collected can show the difference between the recommendations given to different patients of races, then there need to be a type of review in place that collects data on how individual providers treat similar cases between patients of different races. Hospitals and healthcare facilities can actively work to collect and review data that would reveal any unfair treatment when it comes to diagnosing or treating patients.

Understanding that there is cultural difference between races and that having more black maternal healthcare professionals will make Black patients feel like there are more people treating them that can understand their culture better. A patient's culture can affect their healthcare treatment and decisions. For example, some cultures do not allow blood transfusions. That severely impacts those decisions about treatment if that patient ever needs a blood transfusion. This country has a variety of different races and cultures, and providers need to be more aware of these diverse cultures because they could be treating anybody from anywhere. A portion of the patient's experience involves relationship management and clinician face time. A provider has a responsibility to make their patients feel comfortable with their exchanges and with the level of care provided. That can become difficult when providers do not understand the nuances of certain people's cultures.

Another thing that needs to be changed in the maternal healthcare system is improving black maternal mental health. Due to the racism in the country, there are different traumatic stressors that black people face in this country. There needs to be a focus on healing the racial

trauma that black people face because it can impact their healthcare services. Since post-partum can bring on different mental health issues it is extremely important to provide black women with extra mental health support if needed. The denigration of mental health will lead to creating poor health outcomes for the mother and the baby. From a government and policy standpoint there are methods that are helping alleviate the current maternal mortality issues. The government can address some of the environmental and social factors that are contributing to racism in the healthcare system and in communities all over the country.

The government can implement more policies to help alleviate poverty in America and help get better access to more affordable healthcare. Patients want more options when it comes to choosing the right healthcare provider and they need better access to quality care. The type of insurance and what kind of insurance a patient can afford heavily influence the type of providers a patient can see. The U.S. healthcare system prioritizes profit over everything. Financial status can impact the level of healthcare provided to a person. Focusing on designing a healthcare system that prioritizes the health of patients over profits is more important. In the U.S., a single payer system would help in prioritizing patient needs and giving them access. U.S. has a large number of uninsured Americans, Medicaid for all would help America with their healthcare access issues.

The presence of doulas and midwives was expressed as something needed by mothers getting pre-natal care. Having that kind of support changed that woman's birthing experience and made it an incredibly positive one. By forming this partnership, the hospital was allowed to make healthcare services more accessible through them and the birthing center.

One theme collected from the data was lack of support. There was a lack of support from some family members and spouses. That can be devastating to some patients because they look for that

support from their healthcare providers. If their healthcare providers do not listen to their patients, it can feel as though they are not supporting their patients as well. This leaves women feeling alone with a lack of assistance during such a stressful time. The lack of emotional support can lead to mental health issues. When providers do not give the proper level of support to their patients, and it can make the patients feel disempowered. There are emotional consequences to not addressing patient concerns and supporting them. More maternal support groups are needed for patients. It is suggested that hospitals or health centers form support groups for their patients. This way there is another way for patients to get the support that they need.

A level of distrust is present in the maternal healthcare system. The negative experiences that women encounter during birth is only reinforcing that mistrust. The fact that some of these doctor-patient relationships felt cold and impersonal, especially during the pandemic, did not help foster better relationships. Participants felt as though the interactions, especially during the pandemic, were cold and impersonal. They wanted to see their doctor more. Even under normal circumstances these women expressed they wanted to see their doctor more. They wanted the support of their doctors more than the typical maternal patient schedule. It was a desire to continue a relationship with their doctors. Some seek an experience of partnership and equality with healthcare providers while others believe it important for diverse providers who can operate in a culturally relevant manner. This reflects how important the doctor-patient relationship is. Doctors should see their patients and be required to have a certain number of face-to-face interactions with their patients. One way they can be implemented by requiring doctors to see their patients for one entrance appointment and one exit appointment.

The maternal healthcare system needs to focus on cultivating more authentic connections between providers and patients. The US healthcare system is a money machine that prioritizes

profit over the well-being of patients. People who seek healthcare want to be treated with respect and dignity. Unfortunately, the US historically has not treated black people with the same level of respect and dignity which is given to other races in this country. Providers can improve their relationships with patients by acknowledging the social and cultural factors that influence their patients' decisions. Providers can also listen more to their patients and have an open dialogue with them and give them options that support the patient's lifestyle.

5.3 Implications

Racism is negatively impacting the United States healthcare system. The result is disproportionate negative health outcomes for black people in this county. Identifying and understanding how multiple forms of racial injustice affect patients in the healthcare system. Locating at what levels racial bias and prejudice occur in the healthcare system is important. As MMR committees review maternal deaths and make policy recommendations it is imperative that they can review qualitative data about the maternal patient experience. These committees work along with different federal agencies like the CDC and organizations to help identify potential prevention opportunities. The federal, state, and local governments allocate funds based off the data provided by the collaborating groups.

Collecting data about their maternal healthcare experience will improve understanding of the causes of maternal mortality and pregnancy problems, as well as the accompanying inequities. From that information decision makers will be able to determine which actions will have the most impact on the patient, provider, facility, system, and community levels. The government is currently allocating funds to alleviate this inequity but the gaps between the inequalities are not getting smaller. Black women are still unnecessarily dying because of the

inequity in the healthcare system, so the government has a duty to come up with different ways to solve this issue.

Patient surveys have been a measure of how satisfied patients are with their healthcare services. Using qualitative methods to obtain data about their maternal patient experiences will help change healthcare policy for the better. For example, in this study patients expressed several different sentiments. One of them was having the support of doulas and the other was having more than one post-partum appoint. This is an opportunity for healthcare policy to address these needs of mothers. The Medicaid program can be expanded to cover more post-partum treatment for their insurance carriers and private insurance carriers can start covering more birthing centers for their insurance carriers.

In this area of southeastern Pennsylvania there have been closures of hospitals over the past twenty years that have shaped the maternal healthcare networks. Incorporating the collaboration of health networks and doulas or midwives would advance maternal care in this country. Encouraging patients to seek services from doulas and midwives would increase healthcare access and passing legislation to make sure that more of their services would alleviate some of the health inequities. Healthcare access is becoming increasingly a bigger issue as the Pandemic wreaks havoc on the economy and healthcare system. The monetary impact of the pandemic has caused businesses to close. Hospitals are businesses as well and they were not impervious to the fiscal damage caused by the pandemic. Having more insurance companies cover birthing centers and doulas will make up for the closure of hospitals. The government could have a single payer system that would pay for these services. Another thing that can be done is the government can give insurance companies incentives for covering these services.

Through Medicare, the government can start covering midwives and doulas for low-income families. It will give patients more access to diverse types of maternal healthcare services.

This study revealed a need to be educated about the healthcare process. Participants expressed confusion and feeling as though they had to make a rushed decision or ill-informed decision as it pertains to their healthcare. Healthcare policy needs to be expanded to increase patient education so that patients can gain the ability to collect, analyze, and comprehend fundamental health knowledge and information required to make sound health decisions. Strengthening patient education will give patients more autonomy and confidence when navigating through the healthcare system. Limited health knowledge imposes a significant financial burden on government healthcare systems and raises the risk of medication, patient compliance, and treatment mistakes. When patients have adequate information to make informed decisions it gives them a sense of power. It also weakens their fears of the unknown and it helps alleviate certain doubts.

5.4 Suggestions for Future Research

This research should be expanded to include a statewide study. The experience of women giving birth in this state should be examined more. Pennsylvania has a large rural population, and it is a state that expanded Medicaid through the Affordable Care Act. This study contained of women who were living in a more metropolitan area. Collecting the experiences of Pennsylvania rural women giving birth will give insight to what women are going through throughout the state. It can reveal the financial implication and lack of access women in rural areas face. Being able to compare the experiences of women in rural areas vs. metropolitan areas would be beneficial to improving the patient experience.

Through expanding the study, medical professionals can get the opportunity to learn about how patients are feeling or experiencing regionally. It can give doctors a better understanding of how to interact with their patients. Knowing the difference between the needs of patients in different areas will be beneficial to improving the quality of services provided. Not all patients are the same and they face different environmental factors and social factors, and medical professionals need to address those differences properly.

The number of the sample should be expanded to gain more data on the experience of women who give birth. Maternal mortality is a nationwide problem. Each state tackles their own issues with maternal mortality. In rural areas they face the challenge of having enough healthcare facilities so that patients do not have to travel long distances to seek care. In urban populations that have a lot of Medicaid recipients they face different challenges with patients being underinsured or not insured at all. If a patient does not have Medicaid, then they have private insurance or not insurance at all which is a problem in areas of lower socioeconomic status. Each state needs to conduct their own qualitative study to understand what women are going through when they give birth in a specific region. Collecting data from such a small sample is not representative of larger populations. Gathering data from a larger sample pool will help further research understand what is going on during maternal care. It will help the country address this problem on a national level. A larger and more diverse sample will truly represent the whole US better because maternal mortality is a national issue not just a Southeastern PA issue.

The next study performed should be done after the Covid-19 pandemic is over. The pandemic really put a strain on the healthcare system, and it created negative consequences when it came to patient care and outcome. The pandemic has had negative socioeconomic and social implications that will affect any research done during that period. The lasting impact of

pandemic will be around for a long time, so it is important that a new “normal” be established. There is an exceedingly small chance that society will return exactly the way it did before the pandemic, so it is important to be aware of the new normal that people face and how the healthcare system will be affected. Conducting a new study outside the parameters of the pandemic, interrelationships within the healthcare system can be further explored free from the restrictions of the pandemic.

This study was focused on the southeastern Pennsylvania and the sample covered counties, Philadelphia, Delaware, and Montgomery County. There are two other counties in the Southeastern PA area. The next study should focus on expanding to those two last counties. The questions asked to the participants should be expanded. One of the questions asked was “What are your impressions about maternal health care in America and racism in the healthcare system?” This was purposely asked to gauge the participants impressions about bias and racism in the healthcare system.

To further expand on that question, the next study should build on that question and attempt to uncover the participant's experience with racism or biases. Attempting to discover the participants own personal anecdotes of racism or bias specifically within the maternal healthcare system. When participants were asked the original question some of them ventured off about racism in America overall. To learn more about the racism in the maternal healthcare system the questions should be more specific to the exchanges patients endure during maternal care. Unintentionally the study revealed the urge to build stronger and more authentic relationships with providers. That is added content that needs to be expanded on. This study focused on the experience and the interactions that patients had with their provider not on how to improve strained and distance patient-doctor relationships. Further research can focus on the impact of

these strained relationships and what patients experience when they have strained relationships with their providers. As it pertains to maternal health, the research should incorporate how those strained relationships are impacting the patient's outcomes. How patients interact when they are navigating through this healthcare system should be further researched. Patient engagement is key to increasing the quality of care provided but research needs to reflect how authentic and meaningful these relationships are. Instead of focusing on how satisfied as patient is with their healthcare facility, practitioners should reflect upon how their interactions with their patients are affecting the patient's healthcare decision. More focus groups and interviews about patient experience should be included in more research.

5.5 Conclusion

A proper, clear, and precise understanding of the patient experience will benefit the health-care industry and society in a variety of ways, including tailoring and personalizing clinical bedside care, providing clear guidance for future research, stimulating consistent and sustainable improvements in medical care quality, and guiding health-care policy. The findings of this study, which aims to highlight the significance of the patient's human experience along the quality of care, is simply the start of a more comprehensive understanding of this multidimensional, complex idea. The data produced by patient experience measuring instruments has not been fully utilized by the health-care business.

Given the potential influence on health-care quality, safety, and cost, research should be conducted to not only provide a uniform definition of the patient experience but also to define its many components. To determine the best ways to incorporate patient experience data into general health-care reform initiatives, present measuring and reporting methodologies should be enhanced. The study reflected negative and positive experiences from patients seeking maternal

care in Southeastern PA. It revealed that there is some underlying racist comments and behaviors still be exhibited in front of patients.

Providing patients with a healthcare system that is free of racism is the ultimate goal that should be focused on. It has been revealed that people experience negative interactions during their healthcare experiences and some of those negative experiences were racially charged. For the women that faced negative experiences they also faced detrimental health incidents. Understanding the underlying issues that are causing racial disparities in the maternal healthcare system is imperative in solving the maternal public health crisis in this country. Interpreting how interactions can be racially charged and it negatively impacts the patient's healthcare will improve the healthcare system.

Understanding the patient experience will help all patients but it will especially help the patients from diverse backgrounds. There appears to be a disconnect between providers and their patients who come from different backgrounds. Within this study there were participants searching for black providers because of the need for more representation in the medical field. Symptoms can present themselves differently in the different races in America, having more doctors of color can help patients of various backgrounds feel at ease about being able to relate to their provider. Improving the patient experience means improving communication channels between the provider and patient.

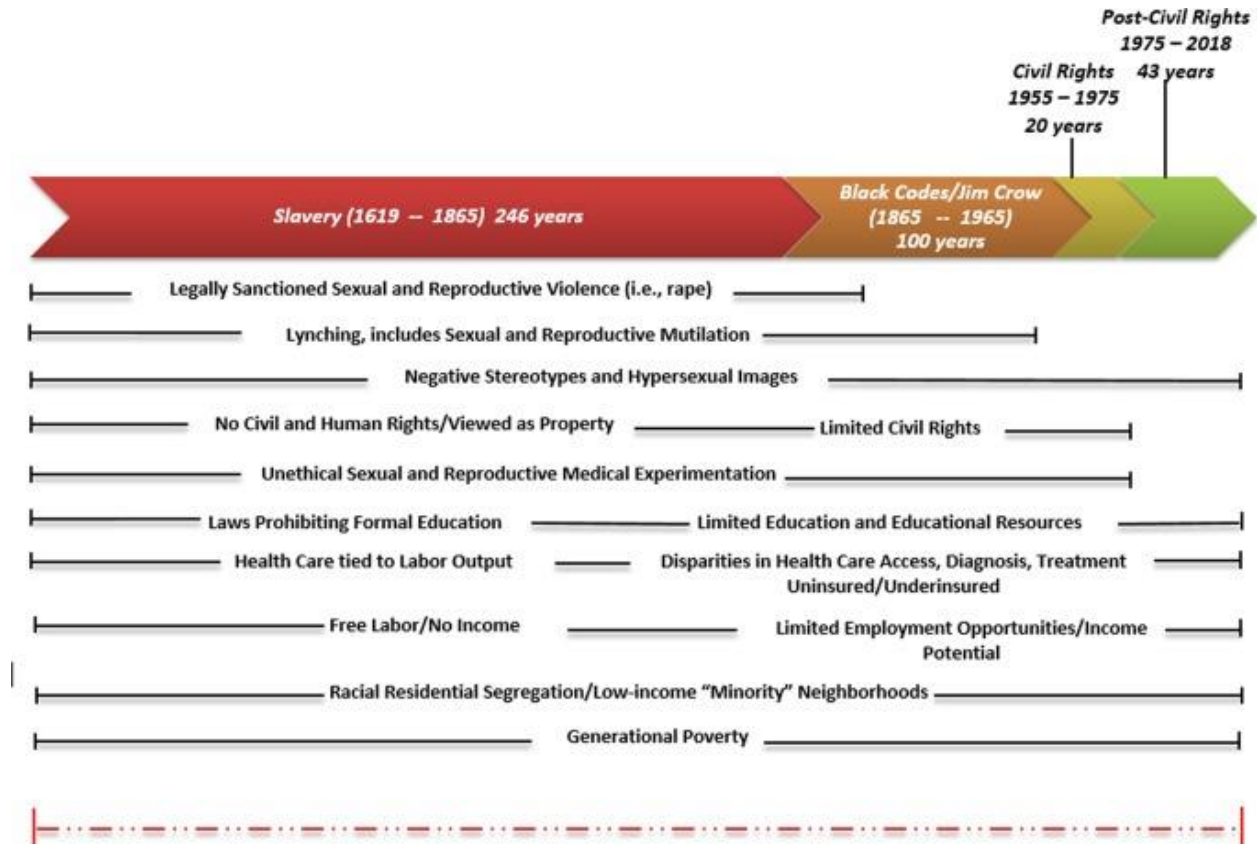
Studying the provider-patient relationships is imperative to addressing some of the racial disparities seen throughout the healthcare system. Research needs to be redirected into analyzing the relationships formed within the healthcare system and how racially charged some of these interactions within these relationships affect patient care. It is time to stop allowing racism to kill patients in the healthcare system. Practitioners need to become more aware of their biases and

expanded research can expose personal biases. Black people deserve a racism free healthcare system.

Appendices

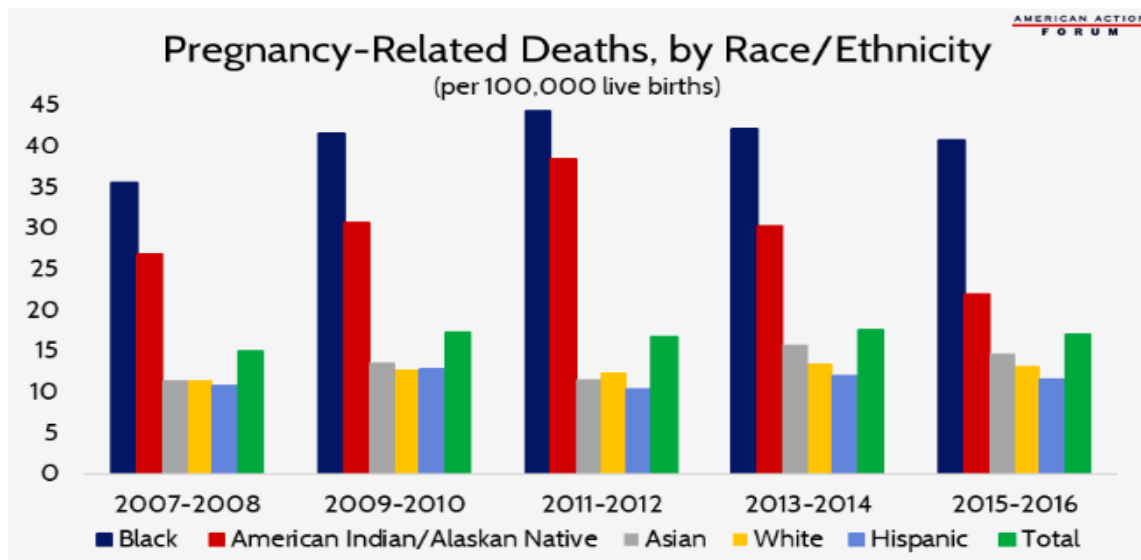
Appendix A

Figure 1



(Prather et. al, 2018)

Figure 2



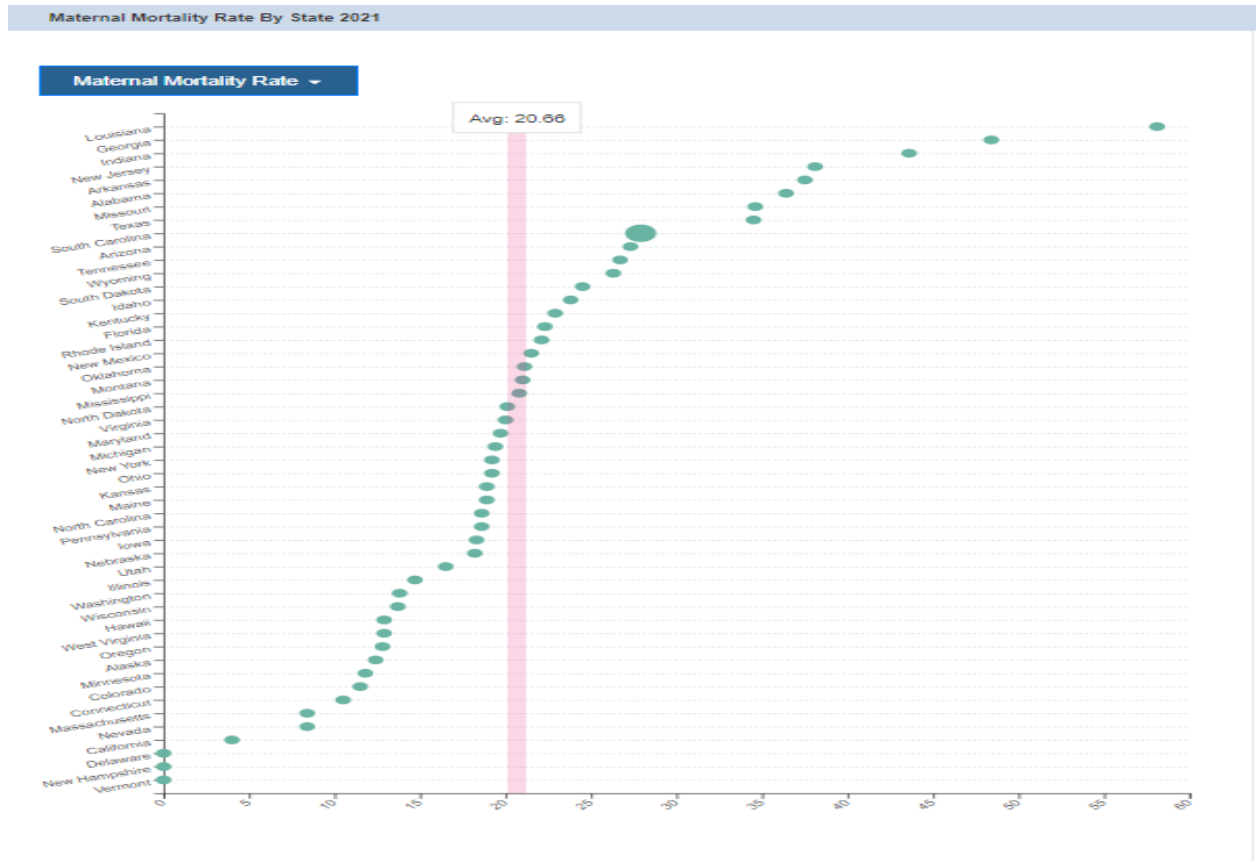
(Hayes et. Al, 2019)

Figure 3



(Hayes et. al, 2019)

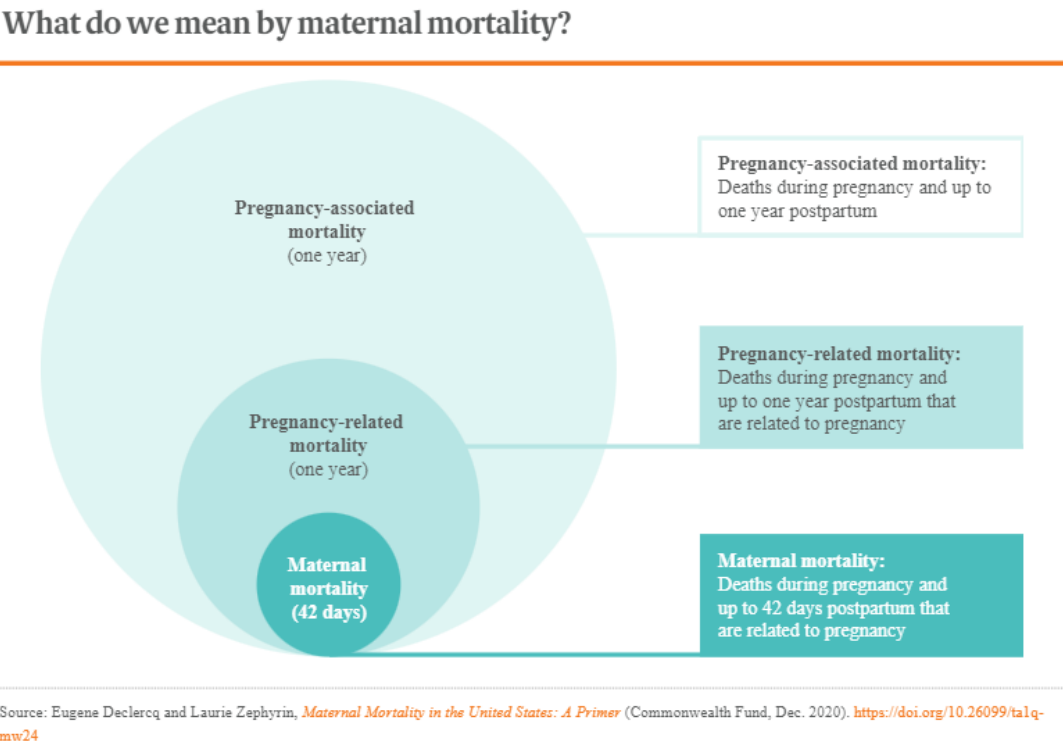
Figure 4



(Maternal mortality rate by state, 2021)

Appendix B

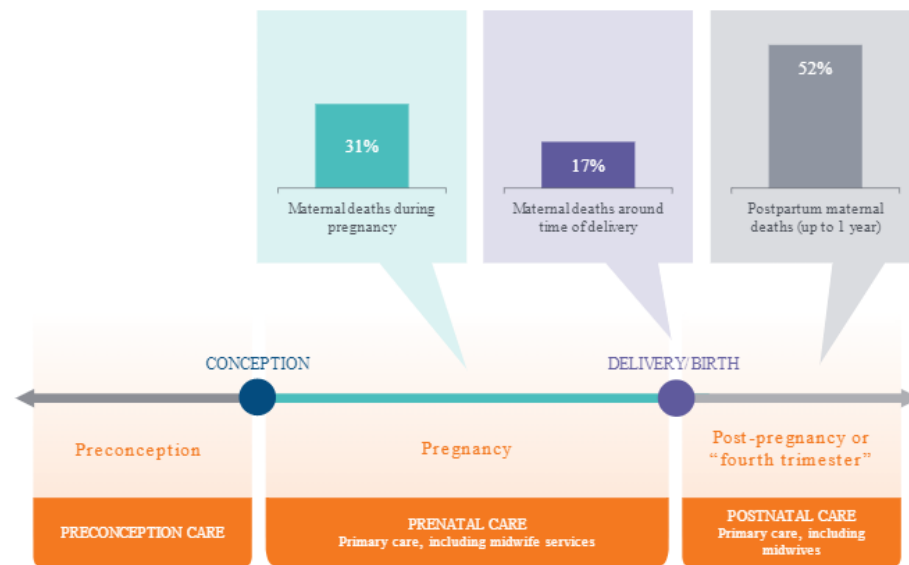
Figure 1



(Maternal Mortality in the United States: A Primer, 2022)

Figure 2

Half of pregnancy-related deaths occur after the day of birth.



Source: Eugene Declercq and Laurie Zephyrin, *Maternal Mortality in the United States: A Primer* (Commonwealth Fund, Dec. 2020). <https://doi.org/10.26099/talq-mw24>

(Maternal Mortality in the United States: A Primer, 2022)

Appendix C

Online Advertisements:

“The Lived Experience: Collective Realities of Black Maternal Healthcare” is a thesis project currently looking for participants for the research study aspect of the project. Anybody interested in contributing their input through answering questions in an in-depth interview can respond to this message. Questions will be about maternal care and the study is open to anybody over the age of 18 that is currently pregnant or has given birth in the past five years that lives in Southeastern PA. Anyone that wants to partake in the study will be pre-screened to see if they

qualify. Internet access is imperative to participating in this study. Please respond to this message if you are interested or have any questions.”

Emails and Messages:

“Thank you for expressing your interest in participating in this study. Before you begin, a consent form must be filled out. For those taking part in the in-depth interview have one week to fill out the consent form and pre-screening and return it by email. Participants will have one more additional week to sign up and complete the interview after being selected. Thank you for your cooperation. Feel free to reach out with any concerns”

Appendix D

Quotation 1	“You know, my biggest anxiety like kind of what keeps me up is like, I don't want to die. Like, it's really not about like morning sickness or, you know, the baby sleeping is really just like, I want to survive this pregnancy. I want to survive the hospital.”
Quotation 2	“I was I was part of me, was very regretful that I didn't take more time to maybe find like a doula or like a black provider like I know I did take the time I searched far and wide for a black provider. But the pandemic was hitting. Everyone was backed up with appointments. There was nowhere for me to go really to get that the care that I would have wanted.”
Quotation 3	“My impression of the maternal health care is I think there's a difference between like the OBs and the midwives. I personally would rather have a midwife than a regular OB doctor because that's what my son had. He had a midwife. I think for black people, it's hard for them to kind of like deal with pregnancy, especially pregnancy in women, because you see a lot of women

	are dying from pregnant, from pregnancy. So with those differences, I think like midwives care more than doctors do.”
Quotation 4	“The only thing I will say to the doctors as far as black women and maternal health is, once we say that we don't feel good or something isn't right, they should listen to us because nine times out of 10 or 10 times out of 10. It's something wrong, and don't brush it away.”
Quotation 5	“Yeah, so it was actually it was it was normalized to have poor care where I am in Philadelphia, which is very, very, very black. I'm black, is very black and where I'm from D.C., Maryland area. That's very diverse and very there's a lot of middle class areas. It was not normal to have poor care like this.”
Quotation 6	“So I definitely think that it does exist within all health care just because you can kind of tell based off of, I guess, the physician and sometimes their staff can treat us, African-American people a little bit different than they would Caucasian people who are of their patients. And just the care that you get and just the customer service, you can tell that there's a little bit of racism. And you know, it's unfortunate, but it's definitely there.”
Quotation 7	“So it's actually harder for a lot of black women when they're having kids. I know that for a fact, there's just a lot of things that go on that people don't tell us or even even just while giving birth, there's just a we're just at a higher risk than most of the other races. And people like to skim over that. A lot of times.”
Quotation 8	“You know, majority of when you give birth, it's on your back. But I was like, I want to try different positions because, you know, I've done this. I had done a little bit of research on what kind of positions are better equipped for you to give birth. And she was very open to all of that. When I went there, I said that I wanted like an epidural to be like the last resort, and she was very open to that. So it was nothing that I considered and brought to her attention that she didn't also that she didn't.”
Quotation 9	“But it's like, I don't know why I'm here. I mean, I know why I'm here, but I don't know what's really exactly wrong. Is it normal? Is it not normal? But I felt like she wasn't really paying too much attention to. Or just caring about what happened, because she just asked me a few questions wrote down and she just said, OK, and then she left and I never saw her again. So. But other than that, I will say, other than her, which is that one person, that one experience that I had everyone else and with a part of the team were great.

Quotation 10	<p>“Yes, I definitely chose a black one and a black female. So it was like, you don't really see a lot of them in that position, especially in maternity. So or OB-GYNs. But that's that's something I chose because that's something I feel comfortable with. I'm not sure about a lot of people, but it's very rare that you kind of see one in the OBGYN section.”</p>


Appendix E

IRB Approval Letter

11/29/22, 4:34 PM Mail - Parham, Rhonda - Outlook

IRB-FY2021-189 - Initial: Initial - Expedited

do-not-reply@cayuse.com <do-not-reply@cayuse.com>
 Mon 6/14/2021 8:54 AM
 To: Wade, Michelle L. <MWade@wcupa.edu>; Parham, Rhonda <RP778485@wcupa.edu>


 Office of Research and Sponsored Programs | West Chester University | Ehinger Annex
 West Chester, PA 19383 | 610-436-3557 | www.wcupa.edu

Jun 14, 2021 8:53:58 AM EDT

To: Rhonda Parham
 Public Policy and Administra.

Re: Expedited Review - Initial - IRB-FY2021-189 The Lived Experience: Collective Realities of Black Maternal Healthcare

Dear Rhonda Parham:

Thank you for your submitted application to the WCUPA Institutional Review Board. Since it was deemed expedited, it was required that two reviewers evaluated the submission. We have had the opportunity to review your application and have rendered the decision below for The Lived Experience: Collective Realities of Black Maternal Healthcare.

Decision: Approved

Selected Category: 7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Sincerely,
 WCUPA Institutional Review Board

IORG#: IORG0004242
 IRB#: IRB00005030
 FWA#: FWA00014155

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