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Negotiating Patient-Provider Power Dynamics in Distinct Childbirth Settings: Insights from Black American Mothers

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Abstract: Several studies have examined women’s perceptions and experiences of out-of-hospital births, that is, births that take place at home or in birthing centers overseen by midwives. However, White women have primarily been the subject of these investigations. Black women are underrepresented among mothers who have out-of-hospital births, yet they provide an intriguing case for this birthing practice, given their elevated maternal mortality rates and the general rise in home and birth-center births since 2005. This study utilizes a split-sample design to compare the experiences of Black American women who gave birth in out-of-hospital and within-hospital settings in San Antonio, Texas. San Antonio is an excellent site for such an inquiry, as Black women are a decided racial minority in this Latino-dominated city, and often face healthcare access challenges. Drawing on insights from theories of intersectionality and power, this study uses in-depth interviews to explore how patient-provider power asymmetries emerge and are negotiated by Black American mothers who have out-of-hospital births, in contrast to their hospital-birthing peers. Narratives reveal that patient-provider power relations and asymmetries exist both within and outside of hospital settings, but are distinctly manifested in each setting. Out-of-hospital births are more mother-centered, but power machinations are more covert in such settings. Participants employ various forms of resistance to negotiate asymmetrical relationships with providers.

Keywords: childbirth; childbearing; intersectionality; maternal health; midwifery; out-of-hospital birth; power; race-ethnicity

1. Introduction

Pregnancy and childbirth are often portrayed as times of immense joy for families. Yet, childbearing in the United States continues to introduce risk into many women’s lives. Despite the advancement of medical technology and a growing knowledge base, the United States has the highest rate of maternal deaths in the developed world [1]. Maternal mortality, defined as the death of a woman related to pregnancy or childbirth up to one year postpartum, is not the only concern. The crises of infant mortality and maternal morbidity are closely intertwined.

Maternal and infant mortality and morbidity are especially daunting for Black American women. Black women are three to four times more likely to die from pregnancy-related complications than their White peers, and Black American infants are more than twice as likely to die than White infants [2]. While disparities vary from state to state, Texas exhibits among the highest maternal mortality rates in the United States. A report released in early 2018 revealed that Black women in Texas have a maternal death rate of 27.8 per 100,000 live births [3]. The elevated maternal mortality rate among Black women in Texas is more than double the national maternal mortality rate of White women, and is disturbingly

similar to the national maternal mortality rate of women age 35 and older, a group which is typically deemed high-risk.

Although it has been speculated that education and socioeconomic status fuel these health disparities, evidence shows that increased maternal and infant mortality rates among Black Americans exist across educational and socioeconomic thresholds [4–6]. According to a recent article in the *New York Times* (2018), “a Black woman with an advanced degree is more likely to lose her baby than a White woman with less than an eighth-grade education” [7]. Therefore, risks related to maternal and infant mortality and morbidity are widely prevalent among Black American women and infants.

While there has been much debate surrounding the cause of increased morbidity and mortality among Black women and infants, many in the medical community have begun attributing the increased risk to the “weathering” of Black American mothers [8]. Scholars and medical professionals propose that “the inescapable atmosphere of societal and systematic racism” has created “a kind of toxic physiological stress, resulting in conditions—including hypertension and preeclampsia—that lead directly to higher rates of infant and maternal death” [7].

In addition to the effect that weathering may have on the birth outcomes of Black American women, the way that many healthcare professionals treat and engage with these mothers is profoundly influential. Black American women are more than forty percent more likely to have a cesarean section than their White counterparts, and are also less likely to receive adequate pain management [2,9]. Results from a study conducted in 2012 and 2013 [10] revealed that one in five women of color report poor treatment from hospital staff based on their cultural background, language, race, and ethnicity. Furthermore, research has revealed a pronounced racial bias in a wide range of healthcare settings and institutions [11–13]. In addition to healthcare providers offering unequal treatment to minority patients, “structural factors, such as policies and practices of health care systems, as well as how health care is financed and delivered in the United States” impact health disparities [13].

Given the rise in maternal mortality and morbidity among Black American mothers and infants, many families now explore various birthing options regarding location and support. Out-of-hospital births have been on the rise since 2005 and offer a means for mothers to experience a midwifery model of care, characterized by more nurturing, hands-on support and trust in the natural labor process [14]. Despite the recent rise in out-of-hospital births, data from 2016 indicate that while roughly 1.5% of births to White women take place at home, only 0.4% of births to Black women take place in home-birth settings [2].

While previous research has shed light on the role of race within conventional healthcare settings, there is limited insight into the specific impact of race on patient-provider relationships during childbirth. Our study redresses significant gaps in scholarly research on a group of women—namely, Black Americans—who face elevated risks in the bearing of children. The qualitative approach complements outcome-based quantitative studies by analyzing narrative accounts of social encounters that may contribute to race-based health disparities for childbearing Black women.

2. Empirical and Theoretical Background

Patient-provider relations evolve throughout the childbearing period. Healthcare providers can be a unique source of stress for pregnant and laboring mothers, due to implicit and explicit racist beliefs and practices that have been documented in much previous research [7,15–19]. During pregnancy, many care providers were seen to be unresponsive to their patient’s needs, with some exhibiting stereotypical beliefs, dismissing concerns, and adopting a condescending demeanor toward patients [15,16]. Some have argued that racism within healthcare may be based on “negative stereotypes of Black women as hypersexual and welfare-dependent” [19]. These patterns can affect Black American women’s navigation of the healthcare system and may make them less likely to acquire medical help, thus leading to poorer health and birth outcomes [19,20].

During the prenatal period, Black women make a series of important decisions and plans regarding their upcoming birth experience and location [16,17]. Some Black American women choose to give

birth at home or in a birthing center. The desire for an out-of-hospital birth is often driven by the appeal of being in control, a desire to avoid medical pain relief, and dissatisfaction with the care received in medical settings [16]. Black American women may also select care providers and support people who share a similar identity, as “it is likely that pregnant Black women experience a heightened power asymmetry with obstetricians, particularly when the physician is not of their same gender and/or race, as is common” [18].

Black American women may also acquire the support of a birth doula, a professional labor support person, to assist them during the pregnancy, labor, and immediate postpartum experience [17]. Doulas can attend births within and outside of hospital settings. For Black American women, doulas play a unique role by helping women to “overcome barriers to quality care and by enhancing their personal agency” [17].

During labor and childbirth within hospital settings, many Black women attest to feeling powerless and out of control. It is suggested that “typical obstetric procedures assign physicians to dominating roles in the birthing process, have women deliver while lying on their backs, encourage the use of epidurals, forceps, and episiotomies, and increase the likelihood of non-medically necessary surgical (cesarean) deliveries” [18]. In an effort to avoid typical obstetric procedures and maintain control during childbirth, some women choose to give birth in out-of-hospital settings [21–24]. Women often describe feeling in control of their bodies during their home birth experiences, and also mention possessing control over their care and their environment [22–24].

The way a woman gives birth, either via cesarean section or vaginally, is shown to impact her perception of the birth experience. While approximately one in three babies is born via cesarean section in the United States, Black American women remain over-represented among women who undergo cesarean deliveries [2]. Both clinical and non-clinical factors may be responsible for these disparities and can include obesity, hypertension, gestational diabetes, chronic illnesses/conditions, patient and provider preferences, hospital-based practices, racial discrimination, legal climates and patient-provider communication [25]. However, “even after adjusting for features known to be risk factors, such as maternal age, socioeconomic status, preexisting chronic disease and obstetric complications such as preeclampsia and macrosomia,” non-White women have a higher risk of cesarean delivery than White women [20].

Several key theoretical considerations can be used to assess patient-provider power relations among Black American women and their healthcare providers with respect to childbearing. First, Black women’s unique standpoint must be considered. Standpoint is governed by the shared knowledge and experiences of Black women as multiply marginalized individuals with intersecting inequalities. The standpoints of women are defined as “the product of a social collectivity with a sufficient history and commonality of circumstance” [26]. These standpoints form their shared knowledge of social relations. Yet, feminist theory recognizes that gender cannot be studied in isolation. To fully understand and account for women’s varying standpoints and experiences related to childbirth, intersectionality requires careful attention. Patricia Hill Collins broadly defines intersectionality as the critical insight that individuals’ experiences of various intertwined social inequalities shape their identities and interpersonal relationships [27]. Thus, intersectionality sparks an analytic shift from observing “multiple independent strands of inequality,” towards a view of inequalities based on their interactions and collective implications [28]. Throughout this research, intersecting dimensions of race, class, and gender are explored.

Black American women hold a unique standpoint as multiply marginalized individuals who reside in a society that has routinely discriminated against them. The collective experience of Black women during childbirth is quite commonly characterized by suffering, abuse, and coercion, as is made evident by prior research and pervasive health disparities. However, although there are similarities in experiences and standpoints, it is not guaranteed that all Black women will share a group consciousness or endure similar challenges, such as those related to childbirth. The reality is that group standpoints

“are situated in, reflect and help shape unjust power relations” which are characterized by the dialectical relationship of oppression and resistance [29].

Post-structuralist theory is also useful in guiding an analysis of women’s birthing experiences. Michel Foucault describes power as a polyvalent (multifaceted and contestable) relationship [30]. He notes that power manifests itself as “an ensemble of actions which induce others and follow from one another” [30]. Thus, Foucault abandons the notion that power is simply positional and a function of consent and argues that power principally exists when it is put into action. In other words, power can best be understood in terms of asymmetrical relations and the interplay of domination and resistance.

Power can manifest itself as direct violence or coercion; however, Foucault argues that violence and coercion “do not constitute the principle or the basic nature of power” [30]. Rather, the basic nature of power includes actions that elicit a range of possible (re)actions. Foucault notes that power “incites, it induces, it seduces, it makes easier or more difficult; in the extreme, it constrains or forbids absolutely; it is nevertheless always a way of acting upon an acting subject or acting subjects by virtue of their acting or being capable of action [30].”

Foucault’s conceptualization of biopower is particularly relevant to this study. Biopower is defined as a “technology of power” that surveils and organizes populations [31]. Biopower includes the subjugation of bodies and involves the control of birth, health, and death [32]. In its most literal definition, biopower means control over bodies. Biopower is observed in the child birthing process where Black mothers find themselves entrenched in asymmetrical power relations.

In attending to the power relations between patients and providers, the institutional authority which obstetricians and midwives hold and exercise warrants examination. Weber takes authority into consideration when he defines power as “the probability that one actor within the social relationship will be in a position to carry out his own will despite resistance” [33]. Institutional authority arises from the elevated position that an individual may hold within an organization or social relationship. Since obstetricians and midwives assume prominent positions within healthcare institutions, they exercise authoritative power and may employ some of the strategies of domination mentioned above.

Power can be exercised overtly and covertly. Overt power is often more visible, and is observed through institutional authoritative relations, coercion, and, at times, the threat or outright use of violence. Overt power may be codified through institutional policies, protocols, and procedures. Denying an individual admittance to an institutional setting (hospital, school, etc.) based on their race or gender, particularly when supported by segregationist laws, is an example of an overt exercise of power. Covert power is often subtle, less visible, and, perhaps, veiled. Covert power is realized through societal norms and structures, ascribed identities, and customs of interaction. Implying that an individual does not belong in a certain social setting (e.g., community, neighborhood, or school) because of their race or gender is an example of a covert exercise of power.

Although power is sometimes misconstrued as exclusively dominating and repressive, it is important to note that power has a creative, productive quality to it. Foucault argues that power “traverses and produces things, it induces pleasure, forms knowledge, produces discourse” [34]. While power can be subtle, Foucault contends that it is everywhere. This conceptualization of power pertains to the childbearing experiences of Black American women because power can motivate and equip women to pursue birth experiences that are desirable to them. Power works to encourage women to employ various strategies and form groups that may benefit them and perhaps elevate their social status.

Individuals cultivate and utilize strategies for negotiating, resisting and, at times, subverting unequal power relations. Strategies may include calculating tactics, enlisting resources, and setting goals to ensure their desires are met. Foucault’s definition of power as relational signifies that it is not best understood as a static structure vested in institutions, but rather that it exists embedded in interactions and is subject to negotiation [30]. Power is the interplay of actions and reactions, or “the relationship between power relations and confrontation strategies” [30].

Collins affirms the dialectical relationship between oppression and resistance, and claims that as long as there is oppression, it will be met with resistance and activism [29]. She even goes so far as to say, “Black American womanhood, as a collective identity, is shaped around the dialectic of oppression and resistance” [35]. Marginalized individuals may create resistance by “doing power,” constituted as repressed individuals altering their actions in anticipation and imitation of the dominant party’s actions and responses [26].

Another form of resistance to biopower and control over the childbearing and birthing process is individual engagement in “counter-conduct” [31,32]. Foucault defines “counter-conduct” as “a matter of conduct done differently, by other leaders (conductors), with other objectives, or procedures/methods” [31,32]. Specific counter-conduct strategies may include modifying one’s actions, withdrawing from society, creating alternative institutions, or sharing subjugated knowledge [32]. Therefore, Black women may pursue such strategies by modifying their bodies or lifestyles, abstaining from the utilization of medical professionals and institutions, employing home-birthing or free-birthing practices or sharing their unique perceptions of birth experiences and power relations.

3. Materials and Methods

In this study, patient-provider power dynamics in distinct childbirth settings are explored through qualitative, in-depth interviews (See Appendix A). Our investigation is governed by standpoint theory and intersectionality, which emphasizes the importance of obtaining information about lived experiences, consciousness, and varying empirical realities. Qualitative, in-depth interviews encourage women to discuss their experiences using their own words. Furthermore, this type of inquiry fosters dialogue and allows for probing when necessary. Qualitative research facilitates in-depth, cross-case comparisons as well, which is important as this study has a comparative dimension.

San Antonio, Texas was chosen as the location for the inquiry because Black American individuals represent such a small percentage of the population, and may even be considered a forgotten minority in this community. Indeed, most public initiatives and programs are aimed towards the predominantly Hispanic-origin population. Within San Antonio, women may give birth at home, in free-standing birth centers, or in hospital settings. At the time of data collection, San Antonio was home to two free-standing birth centers and over a dozen midwives. The midwives in the community include both Certified Professional Midwives (CPM) and Certified Nurse Midwives (CNM). While some local midwifery care providers work independently, others work within OB (obstetric) practices and attend births in hospital settings. It is important to note that while the race of healthcare providers was only discussed if salient to the interviewee, the majority of births occurring at home were attended by a Black American midwife.

This research was inspired by the first author’s occupation as a certified labor and postpartum doula. The experience that she brought to this inquiry was essential, as it helped to make sense of the childbirth processes discussed by participants. Furthermore, her unique background contributed to recruitment efforts, fostered participant comfort during interviews, and helped to facilitate a relaxed and open dialogue. As a woman and experienced doula, the first author had considerable rapport with the interview subjects. Consequently, she was well positioned to analyze their birthing experiences in a respectful manner that resonated with the perspectives of the women sharing them. Like the first author, most women in this study are college-educated. That being said, the first author is White and has not experienced the degree of discrimination commonly faced by Black women in the United States. It is important to consider the points of convergence and divergence between the interviewees and the first author.

Snowball sampling and recruitment via social media (Facebook) mom’s group pages were employed to obtain participants. The online groups ranged in size from roughly one thousand to over five thousand mothers. The first author was a member of these online groups and created a recruitment post asking interested individuals to message her privately to preserve anonymity. Local midwives and doulas were also made aware of the study and supported recruitment efforts.

The authors sought to recruit women who self-identified as Black American and were between the ages of eighteen and forty when they gave birth in San Antonio, Texas. Additionally, participants must have given birth within the past five years to ensure their memory was vivid. Originally, this study aimed to utilize an equivalent split-sample design to compare the experiences of ten women who had given birth within hospital settings to the experiences of ten women who had given birth in out-of-hospital settings in San Antonio, Texas. However, due to issues with accessibility, this study drew on the experiences of seven women who gave birth outside a hospital setting and thirteen women who gave birth within a hospital setting. Trouble accessing Black American women who had given birth in out-of-hospital settings is reflective of suspected obstacles in pursuing out-of-hospital births. These obstacles may include financial considerations and familial pressures.

Demographic information describing the participants' self-reported race, relationship status, educational attainment, household income, number of children, birth location, mode of delivery, and denominational affiliation was obtained in a pre-interview survey and is included in the table below. This information further describes the sample and offers context for specific responses (see Table 1). The average age of participants sampled was 31.4 and the average age of participants at delivery was 27.4. In total, the twenty participants reported on thirty-five birth experiences. The percentage of babies delivered vaginally was 87.5%, while only 14.3% were delivered via cesarean.

Table 1. Demographic Characteristics and Related Attributes of Respondents.

Name ¹	Race-Ethnicity	Relationship Status	Educational Level	Household Income	# of Children	Birth Location	Mode of Delivery
Roberta	Black, White	Married	High school	\$30–40,000	2	Home	Vaginal
Lila	Black	Married	Master's	>\$100,000	3	Hospital	Vaginal
Giselle	Black, Haitian	Married	Master's	\$40–60,000	4	Military Hospital, Home (Unintentional)	Vaginal
Jessica	Black	Widowed	Associate's	\$60–80,000	1	Military Hospital	Vaginal
Amber	Black	Married	Master's	\$60–80,000	1	Hospital	Vaginal
Sam	Black	Divorced	Master's	\$40–60,000	2	Military Hospital, Home	Vaginal
Kelly	Black	Married	Master's	>\$100,000	3	2 Hospital, 1 Home	Vaginal
Alex	Black, Hispanic	Married	Bachelor's	n/s	1	Hospital	Vaginal
Catrina	Black, White	Married	Bachelor's	>\$100,000	2	Hospital	Vaginal
Sydney	Black	Married	Bachelor's	\$30–40,000	2	Hospital	Cesarean-Twins
Tara	Black	Married	Master's	\$40–60,000	2	BC, Home	Vaginal
Ariana	Black	Married	Master's	\$60–80,000	2	BC, Home	Vaginal
Brooke	Black	Married	Associate's	\$40–60,000	1	Home	Vaginal
Debra	Black	Married	Master's	>\$100,000	1	Hospital	Vaginal
Lindsey	Black	Married	Associate's	>\$100,000	4	Hospital	1 Vaginal, 3 Cesareans
Ashley	Black	Cohabiting	Bachelor's	\$80–100,000	2	Hospital	Vaginal
Kim	Black, White	Married	Associate's	\$30–40,000	2	Hospital	Vaginal
Megan	Black	Married	Associate's	\$20–30,000	1	Hospital	Cesarean
Trina	Black	Married	Master's	\$60–80,000	2	Hospital	Vaginal
Jackie	Black	Married	Bachelor's	\$80–100,000	2	Hospital	Vaginal

¹ To preserve anonymity, participant names were changed.

Of the thirty-five births represented in the sample, 25.7% occurred outside of a hospital setting and 74.3% within a hospital setting. Within the sample, 20% of participants gave birth strictly in out-of-hospital settings, 70% in hospital settings only, and 10% both within and outside of hospital settings. All of the women who gave birth within and outside of hospital settings had a hospital birth first, and then proceeded to explore out-of-hospital birthing options.

The average number of years of formal education was 16.35, indicating attainment of a bachelor's degree. The most frequent number of years of formal education reported was eighteen, indicating a master's degree. In regard to average household income per year, 20% of the sample made more than \$100,000, 10% made \$81,000–100,000, 40% made \$41,000–80,000, and 30% made \$20,000–40,000. The high socioeconomic status of many participants indicates a degree of educational and economic privilege within the sample. While this limitation is addressed in the discussion section, it is also beneficial, as it helped to facilitate comparisons in birthing experiences by location and is optimal

for evaluating resistance strategies that could be employed by people with financial and educational resources (high SES).

The interviews were conducted in a location set by the participant and lasted an average of forty-five minutes. Before the interview took place, participants provided verbal consent to participate in the research and were given ample opportunity to ask questions before, during, and after the interview. The interviews were audio-recorded and transcribed and although no identifying information was obtained, any identifying information which did emerge was destroyed.

The interview questions drew on the birthing experiences of Black American women that occurred in San Antonio within in the last five years. The questions were designed to elicit empirical findings concerning patient-provider power dynamics. The questions were arranged by experiential chronology. The openness of some questions encouraged participants to draw on the aspects of their childbirth experiences and interactions with care providers which were salient to them.

Once the data were collected, patient-provider power asymmetries among Black American women and their care providers were evaluated through analysis of experiential narratives. Sensitizing concepts were used in an a priori fashion given the theory-governed nature of our study. This approach is consistent with the utilization of sensitizing concepts in qualitative data analysis. After the full range of sensitizing concepts were applied, emergent themes were detected more inductively. Care was taken to ensure that all codes were consistently applied across every interview transcript. Full-sample and subsample analyses were also carefully conducted. For example, discussions of asymmetrical power relations such as lack of control, conflict, tension, negative assessments of care providers, and childbirth experiences were investigated overall and among both subsamples to determine the forms in which such asymmetries manifested themselves. Quotes were woven into the data analysis and are reported to reinforce themes and findings.

Efforts to ensure validity entailed, first, pretesting the instrument with women who were not included in the study. Pretest subjects were interviewed and, thereafter, were asked to comment on the interview questionnaire in an item-by-item review. Slight modifications were incorporated to ensure clarity of phrasing and to remove interpretive ambiguity. Second, strong internal validity was ensured through the use of probes and follow-ups during interviews. Probes and follow-up questions were pursued as needed to ensure that interpretations of interview narratives resonated with subjects' experiences. Among the many virtues of semi-structured interviews are the facts that (1) every interviewee is asked the same set of core questions and (2) probes and follow-ups can be used to ensure that researcher understandings adequately reflect subjects' experiences. Finally, the careful use of theoretical constructs can improve validity because concepts illuminate patterns that would otherwise remain obscure in the data.

Reliability was pursued through various means. First, the careful coding of all transcripts was completed with the same set of codes. Thus, multiple passes through the data were necessary and all transcripts were analyzed with the same interpretive lenses. Second, the first and second author discussed key coding decisions to ensure consistency of interpretation. Disparate interpretations were rare and could be adjudicated through additional consultation of the transcript from which a quote in question had been distilled. Third, reliability was enhanced through the combined detection of common patterns and deviant cases. In qualitative research, deviant cases are not a reliability threat but instead underscore the diverse range of experiences evident in the data.

4. Results

The following findings are organized around two central themes, including: (1) experiential narratives of care and power relations; and (2) resistance strategies confronting asymmetrical power dynamics. It should be noted that the results are organized following the arc of the childbearing process because narratives were originally sequenced this way and we wanted to respect women's accounts while preserving narrative consistency. Moreover, structuring results in this fashion fostered analytical depth and precision.

4.1. Care and Power Asymmetries: Experiential Narratives

Exploring participants' positive and negative experiences during the childbirth process offers keen insight into their perception of care and various power asymmetries in distinct settings. Experiential narratives revealed that asymmetrical power relations are present across both birth settings, but are manifested more overtly in hospitals and more covertly for birth center and home births. When discussing motivations for choosing obstetric care providers and birth locations, financial considerations were routinely mentioned. Participants reflected on insurance coverage, out-of-pocket expenses, and Medicaid. Unfortunately, some families have limited access to out-of-hospital birthing options, as various insurance companies offer little or no coverage for this type of birth. Therefore, if families desiring an out-of-hospital birth lack the financial means necessary to pay out-of-pocket, they are forced to give birth in a hospital setting. This lack of coverage is a clear example of overt power at play within the child birthing process. Through the parameters set forth in the Medicaid program, military institutions, and various insurance agencies, political and economic entities explicitly act upon the actions of families and restrict their options in regard to birth location. Furthermore, for families desiring an out-of-hospital birth as a form of institutional resistance, this lack of coverage may impede resistance efforts.

Lila had a hospital birth despite her desire to give birth in an out-of-hospital setting. Financial considerations and insurance coverage governed this decision.

Originally when I had my first child, I wanted either a home birth or a birthing center that had more of a home-like feel, but insurance was that deciding factor. (Lila, Hospital)

The desire to have a safe birth experience impacted many women's decisions about birth location. For some respondents, giving birth in a hospital seemed safest due to increased access to medical technology.

It does not give me peace to be at home while having a baby, having the complications I had with my first and then the experience with my second . . . I'd rather be at a place where If I'm going to do it natural, great. But if something goes wrong, they're right there. (Giselle, Military Hospital and Unintentional Home)

For other respondents, giving birth outside of a hospital appeared safest, as birth was seen as a normal, non-medical phenomenon. Tara mentioned:

I really think the hospitals are for sick people. And so why go there if you're perfectly healthy? I feel like doctors are trained to handle the worst-case scenario, and I don't know if they really know how to be present and to assist a natural healthy birth. (Tara, Birth Center and Home)

Some participants viewed obstetricians and hospital staff as a threat. Brooke found hospitals to be particularly uninviting for Black women, and was aware of the visible, overt power exercised within hospital settings. She reflected on her perceived threat, based on recent media publications surrounding the increased maternal mortality rates among Black American women.

I had to stop listening to NPR and I had to stop reading books. I'm like, "Nope, they're [obstetricians and hospital staff] going to kill me. I'm not going to hospital." This is why delivering at home is much better. (Brooke, Home)

After making decisions regarding their upcoming birth experience, participants routinely visited with their chosen care provider throughout their pregnancy for prenatal care. During the interviews, it became evident that there is a distinct difference in the prenatal care offered by midwives and obstetricians. Many women who saw midwives reflected on their ability to ask a lot of questions and

get to know their care providers, whereas many women being seen by obstetricians reflected on the rushed nature of their appointments. Interview narratives indicate that the fabric of relationships between healthcare providers and mothers are completely different within hospital and out-of-hospital settings. Brooke was seen by a midwife and had positive perceptions of the care that she received:

She [midwife] honestly felt like an older sister. She spoke with me whenever I needed it. Now, looking back at it without the pregnancy hormones, I'm like, "Oh my gosh! [Laughs.] The amount of time she spent with me!" So, I'm not going to say like she was my counselor in the sense that she was giving me like that type of advice, but she definitely counseled me. She spoke with me . . . She was my midwife for the first pregnancy [miscarriage] and so she's very familiar with that. So, she's very caring. She's very loving. She checked in on me. She let me vent. She assured me of things. She's very reassuring. She was just always there when I needed her. (Brooke, Home)

While it is evident that women who saw midwives reported greater satisfaction with their prenatal care, that does not imply that covert, asymmetrical power relations were absent. The status of Brooke's midwife as an obstetric care provider with ascribed authority is an exercise of power. Moreover, the midwife's ability to counsel, care for, and reassure Brooke is illustrative of the productive dimension of power. In this case, covert power relations had a positive effect and incited satisfaction for Brooke.

Some mothers seen by obstetricians reflected on suboptimal prenatal care experiences. These participants reported that providers avoided establishing relationships with the mothers, and often rushed them during their prenatal appointments. The rushed nature of the appointments lends itself to the discussion of obstetrics and childbirth as merely a business. Within a profit economy, obstetric care providers exercise biopower to control the social (re)production of "outsiders," or individuals who represent difference [26,36]. For the sake of efficiency and profitability, obstetricians may minimize interaction time with mothers, so they can maximize their ability to treat more patients. This is an example of an overt exercise of power.

With a [medical] provider, I feel like a number. I feel like they don't know who I am or what I want for myself, or my baby, or my birth. (Sam, Military Hospital and Home)

During labor and delivery, experiences varied both within and outside of hospital settings. Topics of medical interventions, pain management, birthing positions, control, communication, and provider care initiatives were frequently discussed. Clear examples of domination, subordination, and asymmetrical power relations were evident in the participants' experiences. Mothers more commonly reported experiences of overt domination and subsequent subordination within hospital settings in births attended by obstetricians. Power was exercised more covertly within the home and hospital birth settings attended by midwives.

Overall, it is evident that obstetricians, midwives, and institutions (i.e., hospitals) exercise biopower to control the childbirth process. Domination manifested itself as care providers restricting laboring positions, denying pain management, dismissing concerns, not responding to requests for assistance, performing procedures without proper consent, and aggressively engaging in the physical manipulation of mother's bodies. This domination appeared to be driven by authority, racism, and institutional practices and policies.

Participants were keenly aware of the racism that was embedded in their experiences and the care that they received. Personally mediated racism, manifested as prejudice and discrimination, was exhibited when care providers explicitly treated mothers differently based on their own biases and prejudices.

I just know that for Black moms, you will never be treated like your White friends. Don't expect to get the same treatment. I made that mistake thinking because I am someone educated, and I was informed about the birth process and everything, it wasn't like I

was going into it with no knowledge at all, and this [nonconsensual cesarean section] still happened to me. I know other moms and I've heard their stories or read their stories and it's all the same, it comes down to a provider who just lacks compassion. (Megan, Hospital)

Institutionalized racism is characterized by unequal access to services and opportunities. During the childbirth process, institutionalized racism revealed itself as a lack of equal care and access to pain management or food services. Kelly was a labor and delivery nurse for fourteen years and observed the institutionalized racism and unequal care that women of color experienced.

You can have a woman of color that delivers and a non-woman of color that delivers, but say the woman of color delivered an hour before and she's waiting on her food. Her tray comes up and they'll give it to the other lady first. They just make her keep waiting. And epidurals, it's time for an epidural, this woman of color was ready first then somebody else comes in and they'll give it to her instead. Even though her [woman of color] stuff is ready to go. (Kelly, Hospital and Home)

Many participants discussed medical interventions, and a few participants had their labor induced. While some mothers opted for induction, others were coerced into it. During her pregnancy, Giselle solicited the support of a doula named Jamie who worked closely with a midwife named Stacia. Although Giselle had every intention to deliver at a hospital, she welcomed the support of these two women while experiencing her labor starting and stopping. One day, Jamie and Stacia came over to Giselle's house to work on getting her baby into the optimal birthing position. After attempting to rotate the baby, Stacia checked Giselle's cervix to assess her progress.

And then, when she took her hand out [of the cervix], my water broke. And I thought, did she do that or? And so, I was excited, but I knew inside she did that on purpose, and Jamie's face was like "crap," almost like she had seen this done before. (Giselle, Military Hospital and Unintentional Home birth)

Giselle proceeded to enter active labor quickly after her water was broken, as labor was induced. Although she was never under the care of Stacia and had every intention of delivering in a hospital, this midwife and doula proceeded to overtly force her to deliver at home.

They [midwife and doula] start taking my clothes off and they got me in the tub, and ... that's when my husband got there and he freaked out and was like, "Why is she in the tub? This is not her birth plan. She was very specific about what she wanted this time." And they said, "It's okay. She's too far along. She's crowning. We need to just do it, or she's going to have him in the car." (Giselle, Military Hospital and Unintentional Home birth)

Giselle's story illustrates that asymmetrical power relations exist not only within hospitals but in out-of-hospital settings as well. While respondents were more likely to describe overt physical domination within a hospital setting, Giselle told a different story. It is also clear that covert power was at play. Giselle allowed Stacia to rotate the baby and check her cervix because she perceived Stacia to be nurturing and more natural-minded based on her status as a midwife. In this example, covert power was masked by Stacia's midwifery licensure and identity.

On the topic of medical interventions, Megan experienced a traumatic cesarean birth within a hospital setting attended by midwives. Upon the detection of decelerations in her baby's heart rate, she noted:

They just came in the room like snapping their fingers at me. I had an epidural. Telling me to get up and get on my knees. Nobody helped me. I'm like "I need help, I can't hold myself up," nobody was helping me. Nobody was listening to me at all. They did not try, if they were claiming they tried for ten minutes to stop the decels [decelerations in fetal heart rate] they did not. They were just like, "Oh this is happening" and I'm being wheeled into a cesarean that I did not consent to. (Megan, Hospital)

Megan was keenly aware of her care provider's overt exercise of power and she begged them to avoid the cesarean. Once she came to terms with the procedure, she proceeded to ask for a gentle, family-centered cesarean with a clear drape. However, she was consistently dismissed and eventually subordinated.

Emotionally, I was like just out of it because I'm like saying "I don't want this." Then I was like I better be quiet or they're going to put me under, so I just laid there, and I was just done. I was like, nobody is listening to me. So, if I keep talking and trying to advocate for myself, they're just going to shut me up. So, I didn't say anything else. (Megan, Hospital)

Like Megan, Lindsey had a traumatic birth experience and was routinely ignored. The care provider's unresponsiveness and dismissal of concerns is an example of overt power and put her baby's life in serious jeopardy.

I'm sitting there and I'm telling the doctors like, "Something doesn't feel right" and they're like, "Well, just wait," because I ended up going into birth in their shift change, the nurses' shift change. They're like, "Well, just wait cause the new nurses are going to come be in here for you." I'm like, "No, I'm trying to tell you something is not right, right now." So, literally an hour passed. Nobody's coming and I'm hitting the red button cause I'm like something is not right. Well, I'm hitting the call button and they're just like, "Well, just wait. Your new nurses are clocking in." And so, the nurse who was my nurse for my first son, she was absolutely amazing, comes in and she's like, "Hey! Do you remember me?" And I'm like, "Yeah, I remember you," And she's like, "I saw your name on board and I was wondering was this you?" And she's like, "How're you doing?" I was like, "I'm good. Are you my nurse?" She's like, "No, I'm not. I'm training today, but I just wanted to come say hi. Is everything fine?" I said, "No. Something doesn't feel right." She said, "Well, do you mind if check you? I'm not your nurse, but do you mind?" And I'm like, "No. Please do." So she sticks her hand up there to check and she goes hitting the red button, the emergency button. All these doctors start flying in. They're rushing me straight to the surgery room. She has to keep her hand there the entire time while they're doing the C-section. I think they called it a prolapse cord. And they literally had like told me had she not had gone that my baby could've died, had a whole other hour passed. I was so livid because I was like "I kept telling ya'll something was not right. Something was not right," but then again, they thought I was on Medicaid when I had come into the hospital. It wasn't until I was like "I had did all my paperwork. I'm already registered with you all. I don't understand why you all keep thinking I'm on Medicaid." I think it's just because I'm Black. (Lindsey, Hospital)

Other medical interventions and assessments which were discussed included a placental extraction. Unfortunately, it was a very adverse experience for this new mother. While the intervention described is inherently unfavorable, the lack of compassionate care and communication and the aggressiveness made this experience extremely distressing. Through explicit physical manipulation, the hospital-based care provider exhibited authoritative power.

He just walked in as soon as he was ready to help me with the placental extraction, he walked in and grabbed my cord, wrapped around his hand twice, braced two fingers on my pubic bone, and then pulled, and just pulled my placenta right out. I thought I'm going to die. I just thought right then, I was like he's going to pull my uterus right out like you're not supposed to do this. So, it hurt. There's like nothing, you know, no one could have stopped him anyway. (Roberta, Home)

Roberta's experience during her placental extraction is another clear example of overt biopower and the exploitation and objectification of women's bodies during childbirth. Roberta gave birth at

home and had to transfer to the hospital for a retained placenta. The contrast in the care she received at home and in the hospital setting was evident in her narrative. She reported being respected and in control at home. However, when she was transferred to a hospital environment, her body was physically manipulated without caution. The obstetrician exercised complete physical control over Roberta's body, and "no one could have stopped him" (Roberta, Home).

Roberta's experience illustrates the difference between observable, overt power and veiled, covert power. Although she reported being completely in control at home, it is apparent that the midwife attending her birth exercised some covert power. Although Roberta noted that she made the ultimate decision to transfer to the hospital, it is evident that her decision was covertly impacted by the information and options that her midwife suggested to her. Roberta's experience illustrates that power is more subject to joint deliberation and negotiation in out-of-hospital settings.

Pain management in labor was also consistently mentioned. For the most part, it appeared the participants were able to receive adequate pain management during labor and birth.

They immediately gave me something to take the edge off. They were very tentative, and the nurse let me hold her the whole time [laughter]. She even stayed after her shift to make sure I was okay. (Ashley, Hospital)

However, a few participants alluded to being denied pain medication both during and after birth, or having such medication intentionally withheld for no good reason. The denial of pain management for these mothers may have stemmed from inherently racist and stereotypical beliefs regarding the pain tolerance of Black Americans and is another clear example of the overt power exercised in hospital settings.

When I went in and I asked them, "Can I have something for pain while I wait for the epidural?" They gave me 500 mg of Tylenol, which I'm a nurse, and I'm just like, "Why even give this to me?" So, there is that. I was vomiting from the pain and they wouldn't even give me a tissue to wipe my face or a throw-up bag. They let me labor with no pain medication, no supervision for several hours. I kept asking, you know, for a doctor, for assistance. (Ashley, Hospital)

Aside from medical pain management, some mothers were forbidden from utilizing upright positions, hydrotherapy, and other types of non-medical strategies to manage pain.

With my second, I tried to stand up because they wouldn't give me any pain medicine. So, I was like I do know if I stand up I feel better. You know? And they were like, "No, lay down." They wouldn't let me do anything. Like not even normal pain management, like non-pharmaceutical. (Ashley, Hospital)

Some respondents, like Lila, were so keenly aware of the overt power that hospital-based providers exercised and the asymmetrical power relations that they felt intimidated initiating basic tasks like using the restroom.

I did not feel in control. I felt like I had to kind do what they said, to be quite honest. Even though things got better the second time, I was still intimidated by requesting "Can I get up and go to the bathroom?" "Can I sit in a shower?" I felt intimidated asking those questions. (Lila, Hospital)

Birth attendants such as obstetricians, midwives, nurses, and doulas significantly impacted the birth experiences of many participants. Tara was extremely satisfied with the care she received from her midwives, and her insight illuminates the productive forms of power that out-of-hospital midwives exercise.

I feel like I almost have fallen in love with my midwives. They brought me my babies safely and they make sure to check up on me. They're so encouraging and empowering. You know, after I had my babies, they called me Superwoman and they said that I was amazing to have not torn delivering these babies, and just really made me feel good about myself. (Tara, Birth Center and Home)

As previously noted, power has a productive dimension to it. In this instance, the midwives exercised their power by providing words of encouragement, thereby empowering Tara. They even positively labeled Tara as "Superwoman." Such a label can indeed be seen as a well-intended form of positive reinforcement, one that Tara could proudly proclaim during her interview. At the same time, it is not difficult to imagine a new mother feeling pressure to live up to such a label by seeking to avoid the introduction of any "difficulties" or "problems" for the midwives. Interestingly, Tara's narrative also signals covert asymmetrical power relations when she mentions that the midwives brought her baby to her safely. Despite the fact that the midwives empowered her, she still attributed the success of her birth to her care providers and not her own body or its inherent abilities. Thus, the midwives were seen as the governing force—albeit a form of well-meaning, benevolent governance—in Tara's childbirth experience.

While it is evident that many families were fond of the care offered by midwives, it should be noted that some of the contentment that mothers feel concerning their out-of-hospital midwifery care providers may stem from the fact that mothers can choose which midwife will attend their birth. However, mothers are not always able to choose the obstetricians or hospital-based midwives that will deliver their babies, as these providers typically have a rotating on-call schedule. Increased discontentment with hospital-based midwives may also be a result of the structural and institutional constraints and pressures dictating their care practices. Moreover, hospital-based midwives may practice differently based on the education, licensure, and certification that they are required to hold. Megan describes her opinion of a group of hospital-based midwives:

I'm really trying to get out there that these particular midwives are not . . . they're "medwives." They're not natural-minded at all. They didn't trust the birth process, they didn't make me feel emotionally safe with them or anything and when I looked at my medical records, it looks like they gave me medication without my consent before the cesarean, so there's that too. (Megan, Hospital)

Midwives operating in a hospital setting are likely to exercise both overt and covert power. Many mothers seek the support of a hospital-based midwife because of insurance restrictions and/or the desire for a midwifery model of care in a clinical setting. Hiring a midwife may give some women a sense of peace that their provider will encourage the natural progress of labor unless it becomes medically necessary to deviate from the birth plan. The trust that mothers have in their midwives allows these obstetric care providers to exercise covert power. For example, hospital-based midwives who are bound to structural and institutional policies may suggest augmenting a labor that is stalling. Mothers may consent because they have a perceived notion that midwives only intervene if medically necessary. Thus, hospital-based midwives have used their covert power to exercise overt domination.

The covert power that midwives exercise in various childbirth settings is illustrated by both Megan and Trina:

The midwife that was on call before the shift change had told me that my cervix was swollen and to take a Benadryl because that would help. I didn't question that because she's a midwife. I was like well, you know, the midwife is telling me to do this, so I guess I should do it because they're a midwife and they're not an OB [obstetrician]. Not that all OBs are bad, but you kind of believe the midwives more over an OB. That was another mistake on my behalf there. (Megan, Hospital)

I went with midwives because they tend to be more lenient when it comes to natural birth and not having interventions. I had an entire birthing plan that I wrote out and it included no interventions . . . I didn't really consider artificially breaking my water as an intervention, but I see now how even that even when you're in labor can be detrimental to the natural birthing process. I honestly think that she just thought that she could be done quicker with me if she broke my water. (Trina, Hospital)

During the interviews, mothers also elaborated on their postpartum experiences. While some were exceptional, others left a lot to be desired. The postpartum period is a time of immense transition for new families. There is much to be said for continuity of care and both physical and emotional nurturing. While Tara received remarkable care during the postnatal period, the care that Kim received was lacking.

They were great on my follow-up care, to the point where I paid for six weeks of care, but they had me scheduled for an informal visit just so that I can come back and meet with my main midwife who was actually my doula with my daughter. She was on vacation at my last visit and they really wanted continuity of care. (Tara, Birth Center and Home)

After the baby was born she's [obstetrician] like, "Oh, okay. Bye. Congrats," and we didn't see her again. (Kim, Hospital)

4.2. Resistance: Power Contested and (Sometimes) Subverted

Throughout the birthing narratives shared by participants, it was evident that there were both positive and negative experiences of care in both hospital and out-of-hospital settings. Clear examples of biopower and unequal power relations were apparent. Characterized by both overt and covert domination, exploitation, subordination, and resistance, these instances significantly altered experiences of care and outcomes during the childbearing process in both positive and negative ways, as power can both restrain and mobilize.

As previously mentioned, power exists as an interplay of domination and resistance. During the interviews, participants mentioned engaging in several resistance strategies to counter, mitigate, and evade biopower and domination. Resistance obstacles typically involved monetary limitations. However, some participants were able to overcome those obstacles. Resistance strategies included: (1) doing power as resistance; (2) counter-conduct and cultures as resistance; (3) social support as resistance; and (4) escape as resistance.

The actions that some participants took to prepare for their upcoming birth experiences could be seen as "doing power." Previously defined, "doing power" occurs when oppressed individuals alter their actions in anticipation and, at times, imitation of the dominant person's actions and responses. Before Kim even went into labor, she made her preferences clear to her provider, as she anticipated his potential overt dominating actions.

I told him I didn't want any blood. I told him I didn't want to be induced. I told him I didn't want any Pitocin, and I gave a whole "this is what I did not want" speech and he was like, "okay, okay, okay." (Kim, Hospital)

Participants also resisted by engaging in counter-conduct and occupying resistance cultures [31,32]. Counter-conduct is defined as "a matter of conducts done differently, by other leaders (conductors), with other objectives, or procedures/methods" [31,32]. Specific counter-conduct strategies may include modifying oneself, withdrawing from society, creating alternative institutions, employing unconventional tactics, and/or sharing subjugated knowledge [32]. Resistance cultures are often formed in response to the exercise of biopower and involve individuals engaging in "alternative and self-governed practices" [32].

When Amber was being coerced into an unwarranted medical induction, she utilized two resistance strategies. First, she incited confrontation and aimed to reverse power by explicitly denying the induction. Second, she revealed her intention to use counter-conduct strategies such as natural labor encouragers. Amber's quotation illuminates her position within a resistance culture.

She [the obstetrician] told me, "If you're not dilated by Friday, then I'm going to induce you." And I said, "No, you're not going to induce me." She's like, "I'm going to have to." I'm like "Why? I'm not even 40 weeks by then." So, it wasn't even my due date yet, and she said, "If you're not dilated by this date, I'm going to induce you." And I said "No, it's not happening. You're not going to induce me, I don't care what you say. You're not going to induce me." And so, I said, "I'm going to find any natural labor inducing things that I can do." Pineapple juice and all those things, walking around. Whatever, sex. I was like let me try anything that I can, because I'm not going to get induced. I don't want that. (Amber, Hospital)

The act of giving birth outside a hospital setting can be considered a counter-conduct strategy, as it takes place outside of a medical institution. Despite the fact that many mothers alluded to financial obstacles in mobilizing this type of resistance, some overcame them. For Roberta, nothing was getting in the way of her having a home birth. Although finances were tight and insurance would not cover her home birth, she prevailed.

Because of income disparities, home birth is less of an option for a lot of, especially, Black women. To me, I don't view money as something that I will allow to control my outcome. To me, I would rather go into debt to be safe on something, especially something as big as birth and have the birth that I want. It's important to be in a place where I'm comfortable and feel okay doing this. This is a big deal. This isn't just go wake up and go buy [a] car from somewhere. This isn't go to Walmart and pick up some food. This is a big deal. Women die. If your kid fell from three stories high and was alive, but you didn't have the money and you needed care for them, you wouldn't mess around about that. You'd put it on every credit card you have, and tell the hospital to bill me later, whatever, fix my kid. I think it [birth] should be the same. (Roberta, Home)

Soliciting the support from family members and doulas is another way in which women employed resistance strategies. Domination within structural and disciplinary domains of power includes rules and regulations present within hospital settings (medical institutions). Examples of these rules include those on fetal monitoring, labor and delivery positions, and eating during labor. Since doulas are actively aware of the childbearing rights of women and provide informational support to families, their presence increases resistance efforts. Again, fourteen of twenty participants solicited the support of a doula.

My husband and my doula were very . . . kind of like at my beck and call almost. If I was like, "Okay, I need to get on the floor." They rushed to get me on the floor. If I needed to walk around, they were the ones advocating, "No. You said she could have a wireless monitor. She needs this wireless monitor." All that kind of stuff. Even when they put me on Pitocin, you have to be on a monitor all the time. They [husband and doula] were like, "That's fine, but it needs to be wireless, though." I think that they really helped me, and whatever I wanted, for the most part, was able to be done. (Debra, Hospital)

As previously mentioned, some participants were so disappointed with the suboptimal care which they received that they decided to switch providers. Lila's decision to seek a new care provider and birth location was a form of resistance to the institutional and authoritative domination unique to some military facilities. The domination described is reflective of military culture. She noted:

That was one of the final reasons why I decided I will not deliver there, because I was not satisfied with the care that doctors were giving me. They told me, when I go into labor, “Yes, a student will deliver you. No, you do not have the choice to the midwives or to request the doctor on staff. You have to have a student” or a resident I should say. That was my deciding factor. I should have a choice. As a medical provider myself, I’m all for learning. I’m all for having residents there, and being involved and giving them a chance, but I also have to be accountable for my own experience, and my own health care, and if I did not feel comfortable with the teachers, there was no way I could feel comfortable with the residents and because they said I didn’t have a choice, I said, “Well, I won’t be coming here.” (Lila, Hospital)

In summary, it is evident that many participants engaged in resistance strategies and attempted to negotiate power asymmetries. However, it should be noted that the majority of resistance strategies exist in response to overt exercises of power within hospital settings, as this demonstration of power is more anticipated and visible. Resistance efforts in response to overt exercises of power may also be more feasible and abundant. For example, mothers may have a larger number of obstetric care providers who operate in hospital settings from which to choose, if they decide to abandon their current care provider. Additionally, one large hospital in San Antonio offers free, contracted doula care to all mothers upon admittance. As mentioned previously, the social support that doulas offer functions as a resistance strategy.

Covert power manifests itself in less structured relationships that are at once welcome but also potentially more insidious due to their invisibility and limited resistance efforts. Megan noted that her resistance efforts were lacking due to an absence of awareness of asymmetrical power relations among mothers and midwives.

Nobody told me that there are bad doulas and midwives. Nobody talks about that in the birth community and I realize that in Texas, at least the area I was in, the birth community is very hush-hush about the bad doulas and providers as far as OBs and midwives. I’m not saying, “trash them online,” but at least put the information out there like “I had a bad experience with so and so.” There are so many things that other moms who aren’t minorities are never going to experience in their lives. Ever. (Megan, Hospital)

While covert power may appear less starkly oppressive, its lack of visibility may make it less prone to subversion. In other words, counter-conduct and outright resistance to covert power may be more difficult to pursue and achieve given its invisibility. Thus, despite the emancipatory potential of out-of-hospital births (which are less hierarchical and more negotiable), they may not fully deliver on that potential for Black American women.

5. Discussion

This research drew on Black American women’s lived experiences and perceptions of care during the childbirth process. Through experiential narratives, comparisons were made regarding the birth experiences of women who had given birth within hospitals and women who had given birth outside hospitals. Insight was obtained into the ways in which mothers employed various birth attendants and strategies to mediate asymmetrical power relations and their risk of mortality and morbidity. The key finding is that patient-provider power relations exist both within and outside of hospital settings. As previously mentioned, participants made important decisions regarding their upcoming birth experience during the prenatal period. Motivations for selecting care providers and birth locations included financial considerations, familial support, desire for safety, accessibility, characteristics of care providers, desire for control, birthing environment preferences, and previous suboptimal care experiences

Although several participants reflected on their decision to employ midwifery care providers who offered out-of-hospital births to evade unequal power relations, it is vital to recognize that there is

no escaping power. Power relations exist everywhere but may manifest themselves more overtly or covertly. Expressions of power depend on the social setting. For the most part, overt domination and subordination were more evident within hospital settings. Truthfully, the only clear example of overt domination and subordination outside of the hospital occurred when Giselle's water was forcefully broken by a midwife who was not even acting as her care provider. In out-of-hospital settings, power manifested itself more covertly through customs of interaction.

Within hospital settings, examples of overt domination and subordination were plentiful. Mothers were restricted to various positions, denied pain management, dismissed, and given procedures and medications without consent. Many mothers alluded to experiences with explicit racism. While one may infer that employing a hospital-based midwife may reduce the domination experienced during childbirth, Megan noted otherwise. She claimed that these "medwives" who operate in a hospital setting are no different than obstetricians. It is likely that institutional policies that the midwives are bound to within a hospital setting govern their practices.

Within out-of-hospital settings, examples of covert power were at times evident. The majority of women who gave birth in out-of-hospital settings praised their midwives. One interviewee, Roberta, even went so far as to identify herself as an "evangelist" for her midwife, Ava [pseudonym]. Covert power was made evident through dialogue which reinforced the significant role of the midwives in "bringing" babies into the extrauterine world, in empowering and encouraging women, and in guiding decision-making during labor and delivery. Covert power also played a role in shaping respondents' perceptions of their birth experiences, as midwives possess ascribed authority which enhances their ability to be perceived as nurturing and reliable. Covert exercises of power in out-of-hospital settings had primarily positive effects and often incited satisfaction.

It is important to return to the fact that the majority of births within our sample that took place at home were attended by a Black American midwife. Black women may "focus on common identities as a way to reduce intergroup bias" and level power relations [19]. It is proposed that "Black women view each other as 'double' ingroup members and view White women as 'partial' ingroup members" [19]. When care providers are of the same racial-ethnic background, mothers feel they participate more and hold more decision-making authority [19]. Therefore, the home birth midwife's racial identity may have contributed to less visible exercises of covert power.

Resistance efforts exercised by mothers were abundant. As noted, power quite commonly spurs resistance. Aside from the diminished ability to secure an out-of-hospital birth, resistance strategies did not appear to differ significantly based on socioeconomic status. To resist, some participants made it explicitly clear to their care provider what they would and would not tolerate during childbirth. These declarations are clear examples of participants "doing power." Other participants engaged in counter conduct. Examples of counter conduct included employing a midwife, using non-medical induction techniques, and pursuing an out-of-hospital birth. Some mothers formed resistance cultures that offered a way for them to share knowledge and solicit support. Doulas and prenatal education also increased resistance efforts through empowering mothers with information and support. Some mothers simply abandoned their obstetric care provider as a form of resistance. This abandonment allowed them to secure a provider who shared similar care philosophies.

Again, the majority of the described resistance strategies operated in response to exercises of power within hospital settings. The demonstration of power is more overt and visible in these institutional settings and, thus, more likely to face resistance. Covert power manifests itself in less structured relationships that are often more invisible. Therefore, limited resistance efforts were discussed in response to covert power.

Turning finally to the limitations in this study, the greatest limitation is also one of its most significant strengths. The sample is disproportionately split, as the majority of respondents had higher socioeconomic statuses. This sampling attribute is limiting, as it did not illuminate the experiences of different types of Black American women. However, the interviewees are an optimal sample for examining resistance strategies among Black American women who enjoy significant stocks of human

capital. The sample was also not evenly split in terms of birth settings. It was especially difficult to recruit Black, out-of-hospital birthing mothers. This difficulty is indicative of issues in accessing out-of-hospital birthing options for women of color. Thus, this limitation was not surmountable given the limited geographical setting

Future research may be undertaken to overcome these limitations by sampling Black women who occupy several socioeconomic statuses to provide more in-depth insight into variations in experiences of domination and subordination based on income, class, and education levels. Additionally, new resistance obstacles may emerge, which will help evaluate ways to improve access to resistance strategies for all Black American women. Future research should also aim to include women of different racial-ethnic minority backgrounds who have given birth within hospital settings and out-of-hospital settings to facilitate increased comparisons of experiences.

Similar data could also be collected in different regions of the United States to determine if experiences vary based on geographic location. Finally, future research could address policies and protocols evident across birth settings to determine if variations in experiences could be attributed to differing organizational policies, protocols, and practices.

6. Conclusions

This study set out to examine patient-provider power dynamics for Black American women who had babies in distinct childbirth settings, namely, within and outside hospitals. Medical providers are the unambiguous experts and women are often subject to the childbirth decisions of such providers. Outside of hospitals, we found that power relations are, on balance, more negotiable because expertise is defined as shared between the midwife and the childbearing woman. However, we nevertheless found that domination can emerge in such settings, but is often exercised in a more covert—that is, subtle and sometimes insidious—fashion.

The insights generated from this research are significant to scholars, practitioners and policymakers alike. For scholars, this research has shed new light on the intersections of race, socioeconomic status, and gender across distinct healthcare settings. While similar research has been conducted in other healthcare settings, this study illuminates how patient-provider power asymmetries are uniquely negotiated during childbirth, with special attention to the diverse forms of resistance manifested in the interview narratives of childbearing women. This study reveals women to be agents who actively manage their childbirth experiences, albeit while facing sometimes severe social constraints given the privileged position of healthcare providers (whether physicians or midwives).

Practitioners could utilize the results reported here to modify and improve their care strategies and patient interactions. They may contemplate and utilize various strategies to level power relations, such as spending more time with mothers, listening to and acknowledging concerns, and engaging mothers in decision-making processes. Policymakers could draw on the findings reported here to set guidelines, recommendations, and goals towards improving the birth experiences and outcomes of Black American women. Moreover, policymakers may work with the government and insurance agencies to increase access to and coverage of out-of-hospital birthing options. Initiatives could also be put into place to increase the number of racially diverse midwifery care providers in the United States.

This study has demonstrated that asymmetrical power relations related to childbirth exist in both hospital and out-of-hospital settings. Black mothers employ various strategies of resistance in response to these forces. This study is the first of its kind to focus solely on Black American women, and offers unique insights into the ways in which scholars, practitioners, and policymakers can work together to improve birth experiences and outcomes for Black American women.

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Appendix A. Interview Guide

1. (a) To begin, can you generally tell me about your birthing experience(s)? [Most memorable aspects.]

Pregnancy and Prenatal Care

2. (a) During your most recent pregnancy, how did you feel physically? (b) And how did you feel emotionally? (c) What actions, if any, did you take to prepare for the birth?
3. (a) What influenced your decision to give birth at [location]? (b) Influence of financial considerations?
4. (a) How did you choose your midwife or obstetrician? (b) How would you describe your relationship with your obstetrician/midwife before becoming pregnant? (c) How did your relationship with your midwife/obstetrician differ from relationships you have with other healthcare professionals you've encountered? (d) What have others said about your care provider, if you're aware of others' views?
5. (a) How was the quality of your prenatal appointments (information, duration, etc.)? [Typical visit.]
6. (a) Before you gave birth, what did you feel was most important during your labor and birth experience? (b) In what sort of environment did you want to give birth and why? (c) Did you want a certain type of delivery (vaginal or cesarean)? Why? (d) Who did you want to be present at your most recent delivery, and why? (e) What kind of comfort measures, if any, did you plan to use during your delivery (e.g., bath tub, squat bar, medical pain management, rocking chair)?

Labor and Birth

7. (a) Describe your labor support team. (b) What forms of support did you receive during childbirth, and how did that work out for you (positive, negative, mixed experiences of support)?
8. (a) Will you recount in detail your most recent birth experience? (b) Some women describe their actual birth experience as being much different than what they wanted or planned. How did this work out for you? [Probe for environment, comfort measures, support team, mode of delivery.]
9. (a) Was your care provider present during labor and delivery? (b) Did you feel like you could ask them questions? (c) How would you assess your care provider (positives, negatives)?
10. (a) Describe your participation during your labor and delivery experience. (b) What decisions did you make during your labor and delivery experience? (c) Describe ways that you felt (1) in control and (2) not in control during your birth experience? (e) Overall, were your wishes and intentions honored?
11. (a) What happened as soon as baby was born? (b) What was your initial reaction after giving birth?
12. (a) Reflecting on your childbirth experience, what were you happy with and what would you change?

Postpartum

13. (a) What role did your care provider play in your postpartum experience? (b) How was your follow-up visit with them? (c) Do/did you plan to keep in touch with your care provider? (d) If you have another baby, will you have them as your care provider? Why or why not?
14. (a) Would you recommend [location/provider] to your friends? Why or why not? (b) What advice would you offer expectant mothers in relation to their upcoming birth experience and care provider?

Follow-Up

15. (a) Do you think that it's dangerous or risky to give birth? (b) If so, what are the dangers and risks?

16. (a) What do you think about maternal healthcare in your community? (b) What are the main problems/challenges that women face? (c) What could be done to improve the situation?
17. (a) What have you heard, if anything, about maternal mortality risks in Texas? (b) From what sources have you learned of this information? (c) Are you aware of any racial disparities regarding maternal mortality rates in Texas? If so, please describe them. (d) What actions, if any, have you taken in light of information you've heard about maternal mortality risks of women in Texas?
18. Looking back on your most recent birth experience, were there any conflicts, tensions, or disagreements between you and your care provider? If so, please describe them and their resolution.
19. Do you have any final thoughts or comments you'd like to share regarding your birth experience or your interactions with your care providers?

References

1. Martin, N.; Montaigne, R. U.S. Has the Worst Rate of Maternal Deaths in the Developed World. 2017. Available online: <https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world> (accessed on 3 June 2019).
2. Center for Disease Control and Prevention. Reproductive Health. U.S. Department of Health & Human Services. 2018. Available online: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm> (accessed on 3 June 2019).
3. Price, S. Does Texas Still Have a Maternal Health Crisis? You Bet It Does. 2018. Available online: <https://www.texmed.org/TexasMedicineDetail.aspx?id=47295> (accessed on 3 June 2019).
4. Braveman, P.; Heck, K.; Egarter, S.; Dominguez, T.P.; Rinki, C.; Marchi, K.S.; Curtis, M. Worry about Racial Discrimination: A Missing Piece of the Puzzle of Black-White Disparities in Preterm Birth? *PLoS ONE* **2017**, *12*, 1–17. [[CrossRef](#)] [[PubMed](#)]
5. Colen, C.G.; Geronimus, A.T.; Bound, J.; James, S.A. Maternal Upward Socioeconomic Mobility and Black–White Disparities in Infant Birthweight. *Am. J. Public Health* **2006**, *11*, 2032–2039. [[CrossRef](#)] [[PubMed](#)]
6. Kothari, C.L.; Paul, R.; Dormitorio, B.; Ospina, F.; James, A.; Lenz, D.; Baker, K.; Curtis, A.; Wiley, J. The Interplay of Race, Socioeconomic Status and Neighborhood Residence Upon Birth Outcomes in a High Black Infant Mortality Community. *Popul. Health* **2016**, *2*, 859–867. [[CrossRef](#)] [[PubMed](#)]
7. Villarosa, L. The Hidden Toll: Why America's Black Mothers and Babies Are in a Life-or-Death Crisis. *New York Times*, 11 April 2018, pp. 30–51.
8. Geronimus, A.T.; Hicken, M.; Keene, D.; Bound, J. Weathering and Age Patterns of Allostatic Load Scores among Blacks and Whites in the United States. *Am. J. Public Health* **2006**, *96*, 826–833. [[CrossRef](#)] [[PubMed](#)]
9. Hoffman, K.M.; Trawalter, S.; Axt, J.R.; Oliver, M.N. Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences Between Blacks and Whites. *Proc. Natl. Acad. Sci. USA* **2016**, *113*, 4296–4301. [[CrossRef](#)] [[PubMed](#)]
10. Declercq, E.R.; Sakala, C.; Corry, M.P.; Applebaum, S.; Herrlich, A. *Listening to Mothers III: Pregnancy and Birth*; Childbirth Connection: Washington, DC, USA, 2013.
11. Cooper, L.A.; Roter, D.L.; Carson, K.A.; Beach, M.C.; Sabin, J.A.; Greenwald, A.G.; Inui, T.S. The Associations of Clinicians' Implicit Attitudes About Race With Medical Visit Communication and Patient Ratings of Interpersonal Care. *Am. J. Public Health* **2012**, *102*, 979–987. [[CrossRef](#)] [[PubMed](#)]
12. Sabin, J.A.; Greenwald, A.G. The Influence of Implicit Bias on Treatment Recommendations for 4 Common Pediatric Conditions: Pain, Urinary Tract Infection, Attention Deficit Hyperactivity Disorder, and Asthma. *Am. J. Public Health* **2012**, *2*, 988–995. [[CrossRef](#)]
13. Smedley, B. The Lived Experience of Race and Its Health Consequences. *Am. J. Public Health* **2012**, *102*, 933–935. [[CrossRef](#)]
14. Morgan, L. Conceptualizing Woman-Centered Care in Midwifery. *Can. J. Midwifery Pract.* **2015**, *14*, 8–15.
15. Abbyad, C.; Robertson, T.R. African American Women's Preparation for Childbirth From the Perspective of African American Health-Care Providers. *J. Perinat. Educ.* **2011**, *20*, 45–53. [[CrossRef](#)]

16. Farrish, J.; Robertson, R.V. A Qualitative Examination of Factors That Influence Birthing Options for African American Women. *Crit. Sociol.* **2012**, *40*, 271–283. [[CrossRef](#)]
17. Adams, C.; Thomas, S.P. Alternative Prenatal Care Interventions to Alleviate Black–White Maternal/Infant Health Disparities. *Sociol. Compass* **2017**, *12*, 1–13. [[CrossRef](#)]
18. Rosenthal, L.; Lobel, M. Explaining Racial Disparities in Adverse Birth Outcomes: Unique Sources of Stress for Black American Women. *Soc. Sci. Med.* **2011**, *72*, 977–983. [[CrossRef](#)] [[PubMed](#)]
19. Remedios, J.D.; Snyder, S.H. How Women of Color Detect and Respond to Multiple Forms of Prejudice. *Sex Roles* **2015**, *73*, 371–383. [[CrossRef](#)]
20. Bryant, A.S.; Worjolah, A.; Caughey, A.B.; Washington, A.E. Racial/Ethnic Disparities in Obstetric Outcomes and Care: Prevalence and Determinants. *Am. J. Obstet. Gynecol.* **2010**, *202*, 335–343. [[CrossRef](#)] [[PubMed](#)]
21. Annandale, E.C. Dimensions of Patient Control in a Free-Standing Birth Center. *Soc. Sci. Med.* **1987**, *25*, 1235–1248. [[CrossRef](#)]
22. Jouhki, M.R.; Suominen, T.; Åstedt-Kurki, P. Giving Birth on Our Own Terms—Women’s Experience of Childbirth at Home. *Midwifery* **2017**, *53*, 35–41. [[CrossRef](#)]
23. Moore, S. Reclaiming the Body, Birthing at Home: Knowledge, Power, and Control in Childbirth. *Humanit. Soc.* **2011**, *35*, 376–389. [[CrossRef](#)]
24. Viisainen, K. Negotiating control and meaning: Home birth as a self-constructed choice in Finland. *Soc. Sci. Med.* **2001**, *52*, 1109–1121. [[CrossRef](#)]
25. Washington, S.; Caughey, A.B.; Cheng, Y.W.; Bryant, A.S. Racial and Ethnic Differences in Indication for Primary Cesarean Delivery at Term: Experience at One U.S. Institution. *Birth* **2012**, *39*, 128–134. [[CrossRef](#)]
26. Ritzer, G.; Stepnisky, J. *Modern Sociological Theory*, 8th ed.; Sage: Thousand Oaks, CA, USA, 2018; pp. 315–326.
27. Collins, P.H. Intersectionality’s Definitional Dilemmas. *Annu. Rev. Sociol.* **2015**, *41*, 1–20. [[CrossRef](#)]
28. Choo, H.Y.; Ferree, M.M. Practicing Intersectionality in Sociological Research: A Critical Analysis of Inclusions, Interactions, and Institutions in the Study of Inequalities. *Sociol. Theory* **2010**, *28*, 129–149. [[CrossRef](#)]
29. Collins, P.H. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*, 2nd ed.; Routledge: New York, NY, USA, 2000; p. 28.
30. Foucault, M. *The Subject and Power: Afterword*; The University of Chicago Press: Chicago, IL, USA, 1982.
31. Foucault, M. *Security, Territory, Population: Lectures at the Collège De France 1977–1978*; Picador Pan Macmillan: London, UK, 2009.
32. Lilja, M.; Vinthagen, S. Sovereign Power, Disciplinary Power and Biopower: Resisting What Power with What Resistance? *J. Political Power* **2014**, *7*, 107–126. [[CrossRef](#)]
33. Szelenyi, I. Weber’s Theory of Domination and Post-Communist Capitalisms. *Theory Soc.* **2016**, *45*, 1–24. [[CrossRef](#)]
34. Foucault, M.; Colin, G. *Power/Knowledge: Selected Interviews and Other Writings 1972–1977*; Vintage Books: New York, NY, USA, 1980.
35. Alinia, M. On Black Feminist Thought: Thinking Oppression and Resistance through Intersectional Paradigm. *Ethn. Racial Stud.* **2015**, *38*, 2334–2340. [[CrossRef](#)]
36. Lorde, A. *Sister Outsider: Essays and Speeches*; Crossing Press: Berkeley, CA, USA, 1984; p. 115.

