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ORIGINAL ARTICLE

BIRTH ISSUES IN PERINATAL CARE WILEY

Do Black birthing persons prefer a Black health care provider during birth? Race concordance in birth

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Abstract

Background: For many years in the United States, there has been an active discussion about whether race concordance between care providers and patients contributes to better health outcomes. Although beneficial provider–patient communication effects have been associated with concordance, there is minimal evidence for concordance benefits to health outcomes.

Methods: A cross-sectional survey was conducted including 200 Black mothers who had given birth within the last 2 years asking about the perceived racial identity of their birth health provider, whether they preferred to have Black women providers, and the intersection between race and gender concordance on birth outcomes. In addition to race and gender concordance, other variables were tested for their impact on birth satisfaction including respect, trust for the care provider, perceived competence, care provider empathy, and inclusive communication.

Results: Forty-one percent of the mothers in this study were assisted in birth by a Black woman provider. Although patient–provider concordance did not result in measurable health outcomes, it is clear that compared to other studies of birth satisfaction among Black birthing persons, this study showed relatively higher levels of satisfaction, perceived trust, empathy, perceived provider competence, inclusive communication, and equal respect for both concordant and discordant care providers.

Conclusions: Although many participants showed a preference for race concordance, participants equally valued respect, competence, and trust with their care providers. Further community-based research needs to be conducted to examine whether race, gender, and cultural concordance results in other beneficial health outcomes.

Keywords: Black mothers and providers,Black OB/GYNs,concordance and-health outcomes,health outcomesrace concordance in birth

1 | BACKGROUND

There has been ongoing discussion whether race concordance, defined as patient and provider sharing the same perceived race, contributes to improved health outcomes.[1,2] Finding a care provider who shares some relevant aspects of one's identity can result in enhanced trust, improved understanding of care recommendations, and adherence to treatment.[3–8] Although many studies of concordance are atheoretical, we situate this investigation in intersectionality theory[9] and the Reproductive Justice Framework.[10] Intersectionality considers how convergent identities such as race, gender, and class contribute to a person's experience of their lifeworld. Wilson et al[11] observed: "An essential principle of intersectionality is that axes of disadvantage cannot simply be added together, but coalesce to create their own unique forms of disadvantage" (p. 10). Care providers might determine treatment based on stereotypes about race, class, or gender which could then interfere with accurate diagnosis.[12] Perceptions of intersectional identity are both individual and structural and need to be reframed to obtain better health outcomes.[13]

The Reproductive Justice Framework articulated four principles of bodily autonomy including the right to decide if and when to get pregnant, prevent or end a pregnancy, being able to parent children in a safe and sustainable way, and differentiating sex from reproduction.[10] Reproductive injustices toward Black birthing persons are manifested in numerous ways including disrespect, humiliation, verbal abuse during childbirth, coercing mothers to have unwanted procedures, inadequate pain medication, violating privacy, and negligence.[14–18] The CDC reported that per 1000 births in 2019, 10.8 Black infants died compared to 4.6 White infants.[19] Compared to other racial groups, Black women have the highest rate of cesarean births; planned and emergency cesarean births can result in complications for the mother and/or the infant.[20] For Black women over 30, the rate of maternal death is even higher than for younger mothers. Such data reflect profound reproductive injustices. Health inequities contribute to Black women's risk for disproportionate birth complications.[21]

1.1 | Previous concordance studies

It is important to examine whether concordance yields health benefits. Alsan and colleagues (2018) found that race concordance for Black men resulted in more screening adherence including with invasive procedures. They suggested that if Black men had Black cardiologists, the Black–White gap in cardiovascular mortality might be reduced by 19%.[1] Greenwood and colleagues (2020) found when Black physicians cared for Black infants, there was reduced infant mortality.[22] Moreover, hospitals that regularly assisted in the birth of Black infants showed lower mortality rates compared to hospitals that rarely served Black infants. They also examined the effect of race concordance on parturient mothers finding that although Black birthing persons experienced twice the rate of mortality compared to White, there was no effect for race concordance. [22] The likelihood of a Black woman in the United States giving birth assisted by a Black provider is low. In 2019, only 11.1% of all OB/GYNs were Black women and 7.8% were Black men.[23] Current trends indicate that fewer Black doctors are entering OB/GYN residencies.[24,25] About 6% of hospital births by Black birthing persons in the United States during 2020 were assisted by a certified nurse midwife. *Only 12.7% of all midwives are Black*.[26]

The Reproductive Justice Framework suggests that care provider respect, empathy, perspective taking, inclusion of the mother, birthing person trust in the care provider, and birthing satisfaction are important dimensions of the birthing experience. [10] We connect Intersectionality and Reproductive Justice with the medical concordance literature which assesses whether race–gender concordance results in improved quality and compassion of care. Thus, we investigate the following hypotheses and research questions.

H1: Race and gender concordance, respect, trust, competence, empathy, and inclusive communication are likely to be positively associated with birth satisfaction.

RQ1: Do factors such as respect, trust, competence, empathy, and communication mediate the relationship between race/gender concordance and birth satisfaction?

Intersectionality considers how convergent identities such as race, gender, and social class contribute to a person's experience of their lifeworld. Therefore, to examine whether the interaction among these variables affect outcomes, we ask:

RQ2: Is there an interaction effect between race and gender and for race and gender with type of care provider on outcome variables?

H2: Black birthing persons assisted in birth by Black providers are likely to show perception of (1) greater respect, (2) greater trust for the provider, (3) provider competence, (4) provider empathy, (5) more inclusive communication, and (6) greater birth satisfaction than birthing persons assisted by White providers.

H3: Black birthing persons assisted in birth by women providers are likely to show perception of (1) greater respect, (2) trust, (3) provider competence, (4) provider empathy, (5) inclusive communication, and (6) greater birth satisfaction than birthing persons assisted by providers who were men.

2 | METHODS

2.1 | Participants and procedures

Two hundred Black birthing persons who gave birth during the last 2 years participated in an online cross-sectional survey. Participants ranged in age from 18 to 35 (mean age of 27.6, *SD* = 6.3). Filtering questions selected participants who met age, race, and birthing inclusion criteria. The sample was recruited by Qualtrics Research Suite^{XM} (QRS), a social marketing firm that assembles research panels. QRS maintains a large standing pool of Black participants. A QRS manager assigned to our project sent a study solicitation email to Black mothers in their standing pool and to childbirth sites. A preliminary "soft launch" was conducted to provide an opportunity to identify problems in the survey. Responses revealing no variance or which were completed in a short timeframe were deleted from the final sample. IRB approval was obtained from the corresponding author's institution and informed consent was obtained from each participant in the opening frame of the survey. Two hundred and nine participants started the survey with a 95% completion rate of 200 surveys. Participants received $20 deposited in their QRS account in compensation for completing the study. The research was funded by a competitive internal grant. Eighty participants (40%) came from seven states in the south (Alabama, Arkansas, Florida, Georgia, Louisiana Mississippi, and Texas). Other demographic and birth information is included in Table 1.

We acknowledge this relatively high percentage of Black providers is not representative of the experience of Black birthing persons. Table 2 details the race and gender of perinatal providers. Eighty-five participants (42.7%) showed preference for a Black woman provider, 8 participants (4.1%) for a Black man provider, 54 participants (26.9%) for a White woman provider, 28 (13.9%) for a White man provider, and 25 participants (12.4%) preference for other providers.*

TABLE 1 Demographic characteristics of the sample

	Number of participants	Percent
Education		
Completed high school	66	33%
Some college	38	19%
4-year college degree	40	20%
Advanced degree	30	15%
Income		
10 to 39 K	109	54.5%
40 to 70 K	36	18%
More than 70 K	56	28%
Marital Status		
Married	98	49%
Never married	59	30%
Cohabiting	32	16%
Number of children		
1 child		93
46.5%		
2 children	65	32.5%
3 or more children	40	20%
Place of birth		
Hospital	181	90.5%
Birthing center/clinic	14	7%
Home birth	7	2.5%
Primary Caregiver during birth		
Ob-Gyn	108	54%
Certified nurse-midwife (hospital)	60	32%
Certified nurse-midwife (birthing center)	6	3%
Midwife home birth	7	3%
Nurse	14	7%
State of Residence at time of birth		
Georgia	20	10%
Texas	17	8.5%
Florida	16	8.0%
New York	13	6.5%
California	11	5.5%
Alabama	10	5%
Louisiana * Mississippi	8 each	8%

2.2 | Measures

The survey consisted of 67 items plus demographic questions. All measures used 7-point Likert scales (1 = *Strongly Disagree* to 7 = *Strongly Agree*). Confirmatory factor analyses (*Lavaan* package in *R*) assessed internal validity prior to calculating composite scores. Table 3 reported descriptive statistics and reliabilities for focal variables. Validity information can be requested from the corresponding author.

Preference for race concordance was measured with six items created by the authors. Sample items included: (a) If it were possible, I would prefer to have a Black physician; (b) I would prefer to have a Black midwife; and (c) I would like to have a health care provider who was the same race as me.

Preference for gender concordance was measured with six items created by the authors. Sample items included:

TABLE 2 Type of obstetric provider by race and gender

	Ob-Gyns	Certified midwife	Homebirth midwife	Birth Center
Black Female	34	46	3	3
Black Male	8	1	0	0
White Female	24	23	2	2
White Male	28	1	0	1
Native American Female	2	1	0	0
Native American Male	1	0	0	0
Asian American Female	3	3	1	1
Arab American Female	4	1	0	0
Unspecified	7	0	0	0
Totals	111	76	6	7

(a) If it were possible, I would prefer to have a Black woman physician; (b) If it were possible, I would prefer to have a Black woman midwife; and (c) I would prefer to have a woman nurse.

Provider respect was measured with 10 items from the Mothers on Respect (MOR) Index.[27] Sample items included the following: (a) My health care provider was open to seeing labor and birth from my perspective; (b) My health care provider really listened to me; and (c) My health care provider saw me as a partner in giving birth.

Trust for the health care provider was measured with three items from the Trust in Physicians Scale.[28] These included the following: (a) My health care provider is highly ethical; (b) I have great trust in my health care provider; and (c) I trust my life and my baby's life to my health care provider.

Perception of care provider competence was measured with three items [28] including (a) My health care provider for labor and birth has a high degree of medical competence; (b) My health care provider for labor and birth is up to speed on all the latest medical developments in birth; and (c) My health care provider for labor and birth has excellent medical training.

Inclusive communication was measured with 10 items for Patient-Centered interaction.[29,30] Sample items included: (a) I think that an important role of my health care provider was to give assurance to me during the birth of my baby; (b) I liked that my provider asked me rather than told me what to do; and (c) My health care provider told me we were a birthing team.

Empathic traits of the health care provider. We measured eight care provider traits associated with compassionate care.[31] These included kindness, empathy, expertise, listens, humility, inclusive, considerate, and open-minded.

Birth satisfaction was measured with 13 items from the Birth Satisfaction Scale.[32] Sample items included: (a) I came through birth without much difficulty; (b) I felt very well supported during labor and birth; and some reverse coded items (c) I felt very anxious during labor and birth.

The first hypothesis was tested with OLS (Ordinary Least Squares) regression. We conducted bivariate correlations between demographic variables with birth satisfaction showing no significant correlations. Hence, these variables were not included in the regression analysis. Empathy, trust, inclusive communication, respect, and perception of provider competence were centered to control for multicollinearity. The four conditions of race–gender concordance were dummy coded and entered into the regression with Black women providers as the reference group (n = 85) compared to Black men providers (n = 8), White women providers (n = 54), and White men providers (n = 28). Mediation was tested using PROCESS.[33]

3 | RESULTS

The first hypothesis predicted that gender and race concordance plus the other variables would contribute to birth satisfaction. OLS regression results showed that the entire model was significant, $F(7, 189) = 74.81$, $P < 0.001$, $Adj\ R^2 = 0.73$. Results showed that neither race nor gender concordance were significant contributors to birth satisfaction, $\beta = -0.03$, $P = 0.40$, 95% CI [−0.32, 0.13] and $\beta = 0.02$, $P = 0.61$, 95% CI [−0.20, 0.34], respectively. However, perception of provider competence and respect for the patient were significant predictors of birth satisfaction, $\beta = 0.38$, $P = 0.004$, 95% CI [0.13, 0.66] and $\beta = 0.49$, $P < 0.001$, 95% CI [0.35, 0.59], respectively.

Research question 1 asked about mediation. Even though regression analysis showed that neither race nor gender concordance had any effects on birth satisfaction, in the case where X does not predict Y, if there is theoretical reason to believe predictor variables have an impact on potential mediators, then mediation analysis

TABLE 3 Descriptive statistics, reliability, validity, and zero-order correlations of focal variables

variable	1	2	3	4	5	6	7	8	α
1. Race concordance	5.23 (1.81)								0.90
2. Gender concordance	0.79**	4.27 (1.16)							0.87
3. Respect	−0.04	0.07	5.03 (1.42)						0.90
4. Trust	0.02	0.14*	0.77**	5.22 (1.41)					0.86
5. Perceived competence	0.06	0.17*	0.78**	0.54**	5.24 (1.13)				0.82
6. Patient-centered Comm.	0.13	0.21**	0.53**	0.58**	0.61**	5.21 (1.28)			0.80
7. Empathic traits	0.20**	0.13	0.41**	0.40**	0.50**	0.45**	4.04 (0.80)		0.85
8. Birth satisfaction	−0.01	0.07	0.82**	0.77**	0.79**	0.54**	0.39**	5.02(1.36)	0.86

Note: Mean scores (standard deviations) are presented in the diagonal line. Alpha reliabilities are presented in the last column .

Abbreviation: Comm., Communication.

*$p < 0.05$; **$p < 0.001$.

is warranted.[34] Perceived competence and respect were significant predictors in the regression and thus were tested as possible mediators. Results showed that neither perceived competence nor respect mediated the relationship between race concordance and birth satisfaction, the indirect effect for competence was [−0.03, 0.07] and for respect [−0.08, 0.07]. Both confidence intervals included zero showing no mediation effects. The same nonsignificant results were obtained for gender concordance, competence [−0.02, 0.12] and respect [−0.07, 0.08].

Research question 2 was examined using ANOVA with race and gender as well as race, gender and type of provider as interaction terms showing no significant two- or three-way interactions with any of the dependent variables. We report results for the 3-way interactions for each of the six dependent variables: satisfaction, F (1, 170) = 2.5, p = 0.12 NS; perceived competence of care provider, F (1, 170) = 0.47, P = 0.59 NS; perceived provider empathy, $F(1, 170) = 0.13$, $P = 0.72$ NS; respect, $F(1, 170) = 0.46$, $p = 0.50$ NS; trust, $F(1, 170) = 0.07$, $P = 0.78$ NS; and perceived provider inclusion of the patient, F (1, 170) = 0.41, P = 0.52 NS.

The second hypothesis predicted that race concordance would increase perception of provider competence, empathy, respect, inclusion, satisfaction, and patient trust. The mean scores for White and Black providers are presented in Table 4. Three variables showed significant differences between Black and White providers.

Contrary to what was predicted, White providers were seen as having more perceived competence compared to Black providers, $t(174) = 2.41$, $P = 0.02$. Participants attributed greater empathy to White providers, $t(174) = 4.21$, $P < 0.001$ and White providers were seen as using more inclusive communication, $t(174) = 2.03$, $P = 0.04$.

The third hypothesis asked whether gender concordance affected perception of provider competence, empathy, respect, inclusion, satisfaction, and trust. Independent-samples t-tests were conducted to test the hypothesis. As shown in Table 4, participants with providers who were men ($M = 4.28$, $SD = 0.63$) reported significantly stronger emphasis on empathy than participants who had women providers ($M = 3.98$, $SD = 0.83$), $t(198) = 2.64$, $P = 0.03$. There were no other significant differences yielded.

As shown in Table 5, we again measured race–gender provider type with a one-way ANOVA comparing 8 race–gender provider categories with the 6 outcome variables.

Empathy was the only variable which showed a significant result, F (9, 171) = 2.09, P = 0.03, $\eta^2 = 0.02$. Unexpectedly, the mean scores show that Black women Ob-Gyns, Black women midwives, Black women nurses, and Black male midwives were perceived to have less empathy compared to other providers.

TABLE 4 Independent-samples T-test results of Providers' Race and Gender

	White HCP (n = 81)	Black HCP (n = 94)	*t* (*P*-value)
Perceived competence	5.51 (1.19)	5.03 (1.39)	2.41 (<0.05)*
Empathy	4.28 (0.65)	3.81 (0.84)	4.11 (<0.001)***
Respect	5.18 (1.48)	4.89 (1.41)	1.23 (0.20)
Inclusion	5.36 (1.30)	4.97 (1.27)	2.03 (<0.05)*
Birth satisfaction	5.13 (1.39)	4.87 (1.33)	1.23 (0.22)
Trust	5.41 (1.44)	5.04 (1.27)	1.70 (0.09)
	Female HCP (*n* = 153)	**Male HCP (*n* = 40)**	***t* (p-value)**
Perceived competence	5.18 (1.35)	5.49 (1.16)	1.34 (0.18)
Empathy	3.98 (0.83)	4.28 (0.63)	2.14 (<0.05)*
Respect	5.02 (1.46)	5.07 (1.26)	0.18 (0.86)
Inclusion	5.23 (1.30)	5.10 (1.19)	−0.59 (0.56)
Birth satisfaction	5.01 (1.39)	5.05 (1.27)	0.16 (0.87)
Trust	5.17 (1.44)	5.39 (1.27)	0.88 (0.38)

Note: All scales were 7-point Likert measures.

Abbreviation: HCP, Health care provider.

*Significantly different at $p < 0.05$, ***$p < 0.001$.

Although most participants in this study were satisfied with the birthing care that they received, 50 participants (25%) indicated some degree of dissatisfaction. Twenty-eight of these women were treated by an Ob-Gyn (14 Black Ob-Gyns, 12 White, and 2 other race), 18 were treated by a midwife (11 Black midwives, 4 White, and 3 other race) and 4 were assisted in birth by a Black nurse. Six of these providers were men and the rest were women. In this group, mean scores for perceived competence ($M = 3.81$, $SD = 0.87$), empathy ($M = 3.63$, $SD = 0.93$), respect ($M = 3.43$, $SD = 1.09$), and trust ($M = 3.77$, $SD = 1.11$) were all below the midpoint of the scale suggesting these women believed the treatment they received from their perinatal care provider was wanting.

4 | DISCUSSION AND IMPLICATIONS

This study tested whether concordance was associated with greater birth satisfaction showing that 75% of participants had relatively high birth satisfaction compared to results from other studies.[37] There were no interaction effects for race and gender or for race–gender and type of provider. Consistent with other concordance studies, nearly half of the participants showed a preference for Black women care providers. Both Black and White care providers were seen as competent, positive, and inclusive. To identify some mechanisms explaining how concordant medical interactions contribute to perceptions of respect and inclusion, future studies might assess patient perceptions of language, culture, and class shared with the provider. Although many sources describe "shared cultural identity," this concept is ambiguous. Karbeah et al[3] asked what this meant. One midwife explained: "When I am working with a Black woman, I begin by saying I don't want to stereotype you based on what some book told me. I want to ask you what do you need? What can I offer you?" (p. 594). Is the fact of race concordance sufficient to assume shared cultural identity? Can providers in discordant cultural dyads prioritize compassion and respect to ensure the patient is able to feel safe expressing their unique needs?

Many concepts related to intersectionality need further elaboration. Hagiwara et al[35] questioned the meaning of patient-centered communication in discordant patient–provider dyads. What interpersonal approaches for providers might effectively establish a perception of patient-centeredness in both discordant and concordant clinical encounters? How might care provider communication shape patients' feeling of inclusion? More work needs to be done to understand how provider-patient interaction triggers patient perceptions of exclusion/inclusion, and how care provider indifference/empathy in medical contexts affect health outcomes.

There are workforce implications to concordance. Kelly-Blake et al[36] concluded that targeted recruiting of under-represented minority medical students to serve the needs of vulnerable populations potentially limits the full scope of their clinical practice. It is unrealistic to attempt integration of strategies that would intentionally "race-concordantly" match patient-to-provider. Moreover,

although it is laudable to expand diversity of the care provider workforce, the suggestion that such an expansion would then lead to patient–provider race matching is untenable. Further evidence of health outcomes from concordance is needed.

4.1 | Limitations

Although the study investigated satisfaction with care providers during labor and birth, we did not ask about the postpartum period. This was a missed opportunity with this sample who had already given birth within the last 2 years. This would have given us critical information, even if anecdotal, about health outcomes. Since our survey was already long, we also were not able to ask questions about women's prenatal care. A measure of education and income was taken, but we did not ask whether participants were born in the United States. We asked about the state where they resided but not the city.

Several previous studies have revealed racial disparities in birth satisfaction showing reduced satisfaction for Black birthing persons compared to other groups.[37] So, high birth satisfaction in this study may be linked to a concordant care provider. As we did not anticipate a high number of concordant care providers, we did not probe this outcome in our survey. Did these birthing persons go out of their way to find a concordant provider or a midwife to help in childbirth? Were they blocked from other perinatal care because of health disparities? Did they choose a midwife because of their own or friends' bad experiences? Were there intergenerational influences for concordance? Future concordance studies need to investigate these questions.

We did not include patient perceptions of shared language, culture, and class. We could have included items about perception of the patient sharing similar language with the provider and patients' belief that care providers understood their personal situation and background. These factors might have provided insight for greater understanding of the mechanisms explaining preference for concordance.

4.2 | Conclusions

This study collected precious data from a sample of Black birthing persons with a high percentage of concordant care providers. Although patient–provider concordance did not result in measurable health outcomes, it is clear that compared to other studies of birth satisfaction among Black birthing persons, this study showed relatively higher levels of satisfaction,

TABLE 5 Comparison of mean scores for race and gender by type of provider

	WWOB (n = 25)	WMOB (n = 24)	BWOB (n = 41)	BMOB (n = 3)	WWM (n = 24)	BWM (n = 34)	WWN (n = 3)	BWN (n = 9)	WMM (n = 4)	BMM (n = 5)	*P* significant
Satisfaction	5.1 (1.5)	5.1 (1.4)	4.7 (1.4)	5.6 (0.5)	5.4 (1.5)	5.2 (1.3)	5.3 (1.2)	4.5 (1.6)	4.5 (1.2)	4.8 (1.0)	No
Competence	5.5 (1.3)	5.7 (1.1)	5.0 (1.4)	6.0 (1.0)	5.5 (1.3)	5.2 (1.4)	6.1 (0.8)	4.7 (1.8)	4.8 (1.0)	4.5 (1.0)	No[a]
Empathy	4.1 (0.7)	4.4 (0.5)	**3.8** (0.92)	4.4 (0.51)	4.3 (0.71)	**3.8** (0.81)	4.3 (0.50)	**3.8** (0.75)	4.1 (0.89)	**3.7** (0.85)	Yes[b]
Respect	5.1 (1.7)	5.0 (1.4)	4.8 (1.4)	5.5 (0.5)	5.4 (1.4)	5.1 (1.4)	5.6 (0.4)	4.4 (1.9)	5.5 (1.1)	4.4 (1.0)	No
Inclusion	5.4 (1.4)	5.2 (1.3)	5.1 (0.9)	5.5 (1.3)	5.3 (1.4)	5.0 (1.3)	6.3 (0.3)	4.2 (1.9)	5.0 (0.9)	4.2 (0.9)	No[a]
Trust	5.3 (1.4)	5.5 (1.3)	5.0 (1.4)	6.0 (1.0)	5.5 (1.2)	5.2 (1.5)	6.0 (0.9)	5.0 (1.9)	4.7 (0.7)	4.3 (1.3)	No[a]

Abbreviations: BMM, Black man midwife; BMOB, Black man Ob-Gyn; BWM, Black woman midwife; BWN, Black woman nurse; BWOB, Black woman Ob-Gyn; WMM, White man midwife; WMOB, White man Ob-Gyn; WWM, White woman midwife; WWN, White woman nurse; WWOB, White woman Ob-Gyn.

[a]The cell size of this mean score (3 White woman nurses) is too small to yield significance. The *p* values were .20 or higher.

[b]$F(9, 171) = 2.09$, $p = 0.03$, $\eta^2 = 0.02$, bolded mean scores significantly lower than other mean scores.

The p values are p = .27, p = .23, and p = .25, respectively using two-tailed t-tests. All are not significantly different likely because of the small number of nurses.

perceived trust, empathy, perceived provider competence, inclusive communication, and respect for both concordant and discordant care providers. Given lower birth satisfaction in a parallel body of research, it is possible that the presence of concordant care providers amplified overall positive effects found in this study. The basic premise of Reproductive Justice is that it demands an end to racist medical oppression with Black birthing families receiving equitable and respectful perinatal care. Persons giving birth should not have to fight for their human rights. Further community-based research needs to be conducted to examine whether race and cultural concordance results in beneficial health outcomes. The best way forward is to build enhanced communication skills in the medical/midwifery workforce that reflect optimal inclusive, patient-centered care for Black birthing families and that effectively address obstetric racism.[38] Concordant providers and inclusive communication practices contributed to more equitable perinatal care for Black birthing families in this study.

ACKNOWLEDGMENTS

Thank you to the 200 Black mothers who agreed to participate in this study.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICAL APPROVAL

The study received approval from the first author's Institutional Research Review Board (Study #00006187, granted exempt review April 27, 2021).

CONSENT TO PARTICIPATE

Consent to participate was obtained from all participants before they could enter the online research portal. The consent form used was approved by the IRB as part of the review process.

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ENDNOTE

* We were not able to document the gender identities of the providers that participants identified on their own. Asians, and Arab and Native American providers were excluded from further analysis as they were such a small number. We used the more inclusive term man/men and woman/women rather than male or female.

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