Walden University

College of Health Sciences and Public Policy

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Valerie C. Robinson

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Walden University
2023

Abstract

Opportunities for Improving Communication Between Maryland Nurses and Black Maternal Health Patients

by

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MPhil, Walden University, 2023

MHA, University of Phoenix, 2007

MBA, University of Phoenix, 2007

BS, University of Maryland Eastern Shore, 2002

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

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Abstract

This qualitative, hermeneutic, phenomenological study was conducted to better understand how maternal health nurses in Maryland and Black women patients communicate. The study's secondary objectives were to understand the communication procedures and leadership responsibilities within the state's health services organizations (HSOs) and the nurses' experiences with these topics. The patient-centered care conceptual framework was applied in this study to explore the high maternal mortality and morbidity health crisis affecting U.S. Black maternal health patients to discern the processes involved and determine whether potential communication as well as a lack of leadership roles and support could be contributing factors. The participants were 11 nurses from public hospitals and clinics throughout Maryland that have provided maternal health care in the state for at least 3 years. Interpretive coding was used to manually classify and organize the data for analysis. Iterative data analysis revealed five overall themes: (a) maternal health nurses experienced burnout, (b) maternal health nurses were challenged with cultural and health literacy barriers, (c) maternal health nurses fostered patient-centeredness, (d) maternal health nurses were key patient safety advocates, and (e) the need for more consistent HSO interdepartmental partnerships in delayed communication, interventions, and baseline care plan conformity. The findings of this study may lead to positive social change by providing a basis for understanding and addressing specific factors, such as access and delivery coordination, that may contribute to poor maternal health care outcomes and communication experiences between nurses, patients, and HSOs, improving Black maternal health outcomes.

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Dedication

This research is dedicated to the incredible individuals in my life who have been there for me every step of the way while I worked on my dissertation. Thank you, God, first and foremost. You consistently made ways for me, and nothing here would exist without You. Dear JR, my husband: Thank you for being *my soft place to land*, and my biggest supporter. I love you. I dedicate my aspirations to my wonderful children, Zoie, Tyler, and Weston: You mean the world to me. Because of you, I returned to this purpose-driven adventure to show that our family tree is rich in inherited strengths and that we can do everything we set our minds to. I cannot wait to keep cheering you on in all your future undertakings as we embrace generational blessings. To my nieces and nephews: Be audacious in pursuit of your goals. The world needs your light. My deepest love goes out to my siblings and my beautiful parents: You deserve just as much credit as I do for this. We own it. Mommy, I appreciate the solid groundwork you have set for me. I miss you, Daddy, and I wish you could have seen me become the first doctoral degree in our family. Thank you for stressing to me the importance of education; I know you are beaming with pride from above. To my high school math teacher who, with a straight face, referred to me as "Dr." daily, despite my failing his class with flying colors: Thank you for believing in me before I could see it for myself. Finally, I acknowledge and value the vital roles of our maternity care nurses, and I provide space and compassion, particularly to pregnant Black mothers. Just know that you are seen and heard. We will figure this out. More assistance is on its way.

Acknowledgments

I would like to thank my Chair, Dr. Sally Marie Willis; Second Committee Member, Dr. Suzanne M. Richins; and my University Research Reviewer (URR), Dr. Kristin L. Wiginton; for their advice, support, and attentive care throughout this journey. I feel like I have struck the committee lottery! Dr. S., you are one-of-a-kind. You have poured into me in such a way that has kept me focused and motivated, even on the difficult days. Dr. Morris Bidjerano, your methodology office hours and incredible tech-savvy have been invaluable. I would also like to thank the participants in this research, who are indeed the glue of our health care system. This study would not have been possible without your willingness to outwardly share your experiences. I also express gratitude to my friends, colleagues, and fellow scholars who have held me accountable and been a constant source of inspiration and sanctuary of hope. May this research contribute to betterment within the health services field and beyond. Lastly, but certainly not least, I pay tribute to the women who have died during and postchildbirth; you deserved better.

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Chapter 1: Foundation of the Study

According to Oribhabor et al. (2020), racial and ethnic disparities in obstetric treatment continue to persist despite the significant advances that have been made in medicine. Every year, the health care system lets down many women, particularly women of color, since the risk of death during pregnancy is much greater for Black and American Indian/Alaska Native women (Oribhabor et al., 2020). As Heavey (2022) stated, the United States is the only industrialized country that continues to see growing maternal mortality rates. In fact, non-Hispanic, Black women in the United States have up to 4 times the risk of dying from problems connected to pregnancy compared to non-Hispanic, White women in the same demographic group. A significant number of maternal fatalities and complications are avoidable in their entirety (Heavey, 2022). In addition, according to Heavey (2022), 1,205 women passed away in the United States due to complications associated with pregnancy and childbirth in 2021, compared to 861 in 2020 and 751 in 2019. In 2021, the maternal mortality rate among Black women was 2.6 times higher than that among White women (26.6 deaths per 100,000 live births; Hoyert, 2023; Oribhabor et al., 2020). According to Heavey (2022), the discrepancy between the two groups becomes even more pronounced with age. Provider communication and, particularly, nursing advocacy may have a significant effect on the experiences of Black maternity patients and their possible health outcomes (Vedam et al., 2019).

It may be helpful to have a more in-depth understanding of respectful maternal care and communication to investigate how health service organizations (HSOs) that manage Black maternal health patients can advance to higher quality pregnancy-related

experiences and outcomes through early intervention (Heavey, 2022). Patients of African descent who are expecting children should have access to patient-centered health care that is respectful, of a high level, culturally sensitive, and free from bias; however, Creanga et al. (2014) and Hoyert (2023) have shown that Black women are more likely to get biased treatment than their peers.

Communication is one of the most critical roles perinatal and neonatal nurses perform to effectively address the disproportionate incidence of poor pregnancy outcomes reported among Black childbearing women. In addition, the degree of leadership support in HSOs is essential in determining the success of a coordinated care environment when treating maternal health patients. It is necessary to have a more in-depth knowledge of and strategy for addressing the upstream disparities in maternal health to realize equity and improve outcomes. In this chapter, I present the background of the study, problem statement, purpose of the study, research questions, conceptual framework, nature of the study, key term definitions, assumptions, scope and delimitations, study's limitations, significance, and implications for positive social change.

Background

Several studies have illuminated upon research that non-Hispanic, Black women are up to 4 times more likely to die from pregnancy-related complications as their Non-Hispanic, White counterparts (Hoyert, 2023). Although there is a vast array of available literature on the high rates of maternal mortality and morbidity in non-Hispanic, Black women and Black maternal health experiences (Oribhabor et al., 2020; Qian et al., 2023),

there is an evident lack of literature on provider communication and HSO leadership support during maternal health experiences where the women do not feel listened to and/or that their concerns are taken seriously (Byrd et al., 2022; Janevic et al., 2020). The literature does not explicitly address nurses' perceptions and lived communication experiences with Black maternal health patients, which justifies the importance of and need for the current study. As a window into their roles in the maternal health patient communication experiences of not feeling heard in health care settings, it is critical to understand how nurses interact with maternal health patients as well as existing communication processes and encounters with organizational leadership regarding roles and support (Altman et al., 2020; Byrd et al., 2022; Vedam et al., 2019).

In this study, I focused on the state of Maryland. Maryland's 5-year maternal mortality rate is 12% lower than the national average (Maryland Department of Health, 2021). While the national maternal mortality rate rose, Maryland's rate fell somewhat; however, both rates remain higher than the Healthy People 2020 target of 11.4 deaths per 100,000 live births, and racial disparities in maternal mortality continue (National Center for Health Statistics, 2021). The Maryland Maternal Mortality Review Committee (Maryland Department of Health, 2021) advocated for developing tools, guidelines, and ongoing education on systemic racism in health care and its influence on the access to and use of care systems by hospital-based and private doctors and staff. Another suggestion presented, and relevant to the bigger picture of this study, is to investigate ways to empower physicians, patients, and their families to demand better continuity of care from the health care system, create and maintain safe spaces for pregnant or

parenting women in distress, and improve their health using internal and external resources, including community-based ones (Maryland Department of Health, 2021).

Problem Statement

The research problem under study was the potential disconnect in maternal health nurses' communication and processes in caring for Black women maternal patients, which may hinder positive patient-provider relationships and communication experiences. In this qualitative, hermeneutic, phenomenological study, I aimed to understand the lived experiences or shared phenomenon of Maryland nurses in communicating with Black maternal health patients as well as nurses' experiences with organizational leadership roles and support and existing communication processes within the state's HSOs. Many studies have been conducted on this topic from the patient's vantage point (e.g., Njoku et al., 2023; Wolfson et al., 2022). Despite the prevalence of research on the social problem of maternal morbidity and mortality among Black women, the topic has not been investigated in a way that explores the significant and original gap based on the literature search regarding communication between HSOs, its leadership support, and patient relationships.

Early identification and management prevent 66% of pregnancy-related fatalities, and HSO-patient postpartum follow-up and return-to-work contact is poorly documented (Heavey, 2022). Heavey (2022) recommended future research on maternal health patient perceptions of the lack of listening and communication. Communication and maternal health outcomes among Black mothers are still unstudied. In addition to leadership roles and support, Maryland regional public hospitals and clinics need greater data on staff

communication procedures and checkpoints. In this study, I focused on nurses who work with maternal health patients to gain insight into their communication processes, which may offer guidance on how they may be best prepared and supported.

Purpose of the Study

The purpose of this qualitative, hermeneutic, phenomenological study was to explore the communication between maternal health nurses working at public Maryland hospitals and clinics and Black women maternal patients. An additional goal of this study was to understand nurses' experiences with organizational leadership roles and support and existing communications processes within the state's HSOs. The patient-centered care (PCC) conceptual framework was employed to increase understanding of the communication processes and determine if there is a potential communication disconnect and lack of leadership roles and support that may drive the high maternal mortality and morbidity health crisis plaguing U.S. Black maternal health patients. The findings of this study have the potential to influence positive social change and serve as a building block to gain more profound knowledge of access and the coordination of delivery, which may contribute to poor maternal health outcomes and experiences. This research may also have future implications for researchers to explore further expanded population segments of the U.S. public HSOs' communications approaches outside of Maryland (see Alexander & Clary-Muronda, 2022; Alio et al., 2022; Vedam et al., 2019).

Research Questions

RQ1: What are the lived experiences of Maryland nurses concerning communication in caring for Black maternal health patients?

RQ2: What communication supports have been implemented among leadership for Maryland nurses that may reduce communication lapses with Black maternal health patients?

Conceptual Framework

This study's conceptual framework was based on the hermeneutic phenomenology method, which Martin Heidegger (1962) proposed in the early 1900s. This exploratory framework was based on existing consciousness (i.e., Dasein) and lived experiences (i.e., foresight and fore conception) and is used when seeking to comprehend human interaction in its total context (i.e., the Hermeneutic circle), undergoing constant revision as new knowledge and understanding emerge through verbally shared experiences stemming from open-ended questions. The hermeneutic method lent itself to this study because it allowed for a more thorough extraction of nurses' experiences and perspectives regarding their interactions with Black maternal health patients through semistructured interviews.

In giving historical background, Heidegger's (1962) method was anchored in Edmund Husserl's transcendental phenomenology, the original framework from the father of phenomenology. Husserl's technique varies from Heidegger's in that transcendental phenomenology does not allow for a conceptual framework and requires suspending prejudices or bracketing (i.e., epoché) via "innocent" eyes and ears, as though encountering a thing for the first time. Heidegger's phenomenology, on the other hand, involves utilizing one's experiences to improve understanding via prepared knowledge or

foresight, making it impossible to bracket or put aside one's prejudices and experiences (while making them known; Sloan & Bowe, 2013).

Sundler et al.'s (2019) qualitative phenomenological approach to nursing experiences in delivering maternity and newborn care is one of the logical linkages between the theoretical framework offered and the research methodology using thematic analysis (Chang & Wang, 2021). Heidegger's approach entails the interpretation of data (Saldana, 2016), which reveals the implicit or silent meanings embodied or concealed in lived experiences and is related to the thematizing meaning in hermeneutic phenomenological traditions, whereas Husserl focused on descriptive phenomenology with a focus on natural reactions and intentionality, as demonstrated in Sundler et al.'s study.

I employed thematic analysis to look for recurring patterns in the data, which aided in instrumentation development and addressing the specific research questions. When it comes to the real experiences of maternal health nurses, I determined that the interpretive approach would be more thorough than the descriptive one because it considers what the researcher already knows and has experienced with the phenomenon. In contrast, the descriptive approach leaves them out or ignores them through the bracketing technique. A more thorough and detailed explanation of the conceptual approaches will be presented in Chapter 2.

Nature of the Study

To answer the research questions posed in this qualitative study, I used a Heideggerian hermeneutic phenomenological method. Additionally, the data were

analyzed by adhering to Saldana's (2021) thematic analysis of interpretation (Saldana, 2021) to identify reoccurring patterns or themes (see Esan et al., 2022). The purpose of this study was to investigate and learn more about the lived experiences of nurses working in maternal health care in Maryland concerning how they interact with maternal health patients as well as leadership positions and support that are available to help them carry out their responsibilities (see Creswell & Creswell, 2017). I gathered the data by conducting semistructured interviews with the participants, consisting of open-ended questions followed by more in-depth inquiries. The data were transcribed and analyzed using codes and emergent themes to support the inquiry into understanding the communication experiences of nurses.

Definitions of Key Terms

Compassion fatigue: A state of tiredness and dysfunction (i.e., biologically, physiologically, and socially) due to long-term exposure to compassion stress, characterizing the distress brought on by work-related pressures (Cross, 2019; Figley, 1995).

Dasein: Being there (Peoples, 2020).

Foresight or fore-conception: A preconceived notion regarding a phenomenon (Peoples, 2020).

Health communication: Health education for better understanding and application of data (Office of Disease Prevention and Health Promotion, n.d.).

HSOs: A social system planned and constructed to facilitate the delivery of health care services by trained professionals to specific clientele in one or more geographic areas (Heaton & Tadi, 2023).

Hermeneutic circle: Understanding as revision, not a process (Peoples, 2020).

Intersectionality: The junction of gender, race, ethnicity, professional group, and other socially constructed categories (e.g., culture; Aspinall et al., 2022).

Maternal death: A woman's death during pregnancy or within the first 42 days postpartum due to the pregnancy or how it was cared for, not because of an accident or unrelated incident (Hoyert & Miniño, 2020).

Maternal health: A woman's well-being before, during, and after childbirth (World Health Organization, 2019).

Patient-centered care: Quality, patient-centered treatment, and collaboration to include patients (and their families), physicians, and health systems (Epstein et al., 2010).

Racial and ethnic disparities: Racial and ethnic differences in health care quality that cannot be explained by access or clinical factors, preferences, or the suitability of intervention (Stith & Nelson, 2002).

Social determinants: The circumstances in which individuals are born, develop, live, work, and age that significantly influence disease risk and susceptibility throughout clinical care and public health systems (Crear-Perry et al., 2021).

Weathering: This hypothesis suggests that Black Americans' health may start to decline in early adulthood due to persistent social and economic disadvantage (Geronimus, 1992).

Assumptions

I made two assumptions related to this hermeneutic, phenomenological study where researcher biases could not be bracketed or set aside and were, therefore, acknowledged. These highlighted assumptions underwent revision as new information emerged throughout the study. I believe these assumptions to be correct, but they were difficult to verify. The first assumption was that all participants fully understood the study parameters, were well-versed in the subject matter, and were educated and presently working in the nursing field with a concentration in maternal health. I also assumed that the participants would be willing to respond to the interview questions openly, honestly, and accurately. Nurses may fear that discussing possible communication lapses may reflect poorly on their managers' performances; therefore, participant interviews were conducted privately and individually to help alleviate any outside pressures and influences on recoil or inflated responses. Furthermore, I assured participants that the data collected via audio-recorded interviews were de-identified and that their identities were to remain confidential.

Scope and Delimitations

This study addressed the research questions on how maternal health nurses communicate with Black patients and how HSO leadership support influences maternal health nurses' communication with Black pregnant patients in Maryland. Maryland maternal health nurses, each with at least 3 years of experience, participated in semistructured interviews for this study. This study excluded non-Maryland nurses with less than 3 years of experience and no maternal health specialty. Maryland was the

targeted state because it fell into the moderate-to-high-risk scale for maternal mortality rates by U.S. states (National Center for Health Statistics, 2021). However, the total transferability of the results may be limited due to these boundaries. I used purposive sampling to recruit volunteers to offer specific information on this research study (see Ravitch & Carl, 2021). The findings of this study will help maternal health nurses and HSO leadership bridge communication barriers with Black pregnant patients to potentially reduce maternal mortality and morbidity.

Limitations

The following caveats should be considered when interpreting the study's findings. Because the research characteristics were tailored to maternal health nurses in Maryland, it is possible that the results cannot be extrapolated to a national level due to the limited sample size of participants (N = 11). Concerns about difficulties in arranging interviews had been raised considering the already busy workloads of health care practitioners. Additionally, I also acknowledged participants' concerns about ability that surfaced throughout the interview process as a potential source of bias or limited validity in the final findings. Future researchers trying to replicate the study may be concerned about the study's transferability because the results are conditional. However, the study findings may be replicable because data were collected from a focused sample of registered nurses in Maryland.

My experience, knowledge base, and requirements to reach predetermined goals were also constraints. The study's data will be kept for 5 years before being destroyed (i.e., USB drives deleted and paper documentation shredded). I also considered technical

difficulties as possible limitations. For instance, slip-ups or mistakes in recording might have occurred on mobile devices and computers. Additionally, it could have been difficult or impossible for a financially constrained researcher such as me to get financing for a licensed Zoom account and coding software, such as MAXQDA.

Significance

This study is significant in that studies have widely proven that in the United States, Black women are 4 times more likely to die from pregnancy-related complications than their White counterparts compared to other countries across North America and Western Europe (Hoyert, 2023). Although maternal mortality rates have trended downward globally in recent years from up to 6 times as likely, the United States continues to own the highest rates (Flanders-Stepans, 2000). Such life-threatening pregnancy and postpartum complications of new and expectant mothers are preventable (Hoyert, 2023). Maternal mortality and morbidity are not only due to socioeconomic factors but also the stresses and racism at individual and systemic levels, which may lead to biases in health care settings.

There may be ways to improve the unacceptably high rates of maternal death in the United States if efforts are made to find women of reproductive age with preexisting conditions that increase their risk of maternal death, if risk factors for significant adverse pregnancy outcomes are managed before conception, and if primary care visits happen within the first year after delivery (Wang et al., 2023). The communication processes and experiences of nurses with maternal health patients is an emerging and urgent health care gap by which Walden University's (2015b) Ph.D. of Health Services program vision

aligns in this research study that identifies the experiences, challenges the status quo, and activates social and systemic changes. Identifying the common themes and barriers to care and communication may offer insight into Black maternal health outcomes and serve as a window to the future of positive change in the overall communications structure for maternal patients by mobilizing both human and institutional resources.

Implications for Positive Social Change

The findings of this study can be used to enact positive social change by empowering the health services community to adequately assess patient communications needs and concerns, which will, in turn, assist in changing the trajectory of maternal health patient-provider relationships in Maryland HSOs through early intervention and prevention. In addition to bridging the communication gap for generations of Maryland maternal health patients and providers, the study outcomes hold implications for best serving maternal patients on a larger scale, past the bounds of this study, through the potential for an informed and engaged HSO communication environment, leadership policy updates, and internal support to reduce the overall stress of nursing staff. Enhancing existing operational processes can also shift practices and span larger maternal health staff populations beyond just nurses in Maryland through advancing policy, procedures, and research in health services.

Summary

While there is a wealth of research on the disproportionately high rates of maternal mortality and morbidity among non-Hispanic, Black women and Black maternal health experiences, there is a striking lack of investigation into provider-patient

communications in which women do not feel heard or have their concerns addressed. There is a gap in the research about nurses' perspectives and actual communication experiences with Black maternity health patients. To understand the experiences of maternal health patients who feel unheard in health care settings, it is crucial to examine various factors, including the interactions between nurses and patients, the existing communication processes, and the nurses' encounters with organizational leadership regarding roles and support. These elements collectively provide valuable insights into the dynamics of patient communication in the context of maternal health. Nurses are in a prime position to be reliable caretakers for pregnant Black women, especially those facing perinatal loss (Fenstermacher & Hupcey, 2019).

The goal of this qualitative, hermeneutic, phenomenological study was to learn more about the ways in which Maryland maternal health nurses interact with their Black women patients as well as the processes involved in caring for pregnant Black women to determine whether a lack of leadership roles and/or effective communication is to blame for the current health crisis of high maternal mortality and morbidity rates. The findings of this study have the potential to affect positive social change by providing a foundation for learning more about the complex factors, such as access and the coordination of delivery, that may impact adverse maternal health outcomes and experiences.

In the first chapter, I established the fundamental significance of this study by emphasizing that beyond the state of Maryland, the findings of this study could have significant implications for researchers to explore broader demographic segments of the communication strategies employed by HSOs in the United States. In Chapter 2, I will

comprehensively analyze the previous literature on the historical background of Black maternal care as well as the communication gap and recurring themes in the literature relevant to maternal mortality and morbidity rates.

Chapter 2: Literature Review

This study centered on the social problem that non-Hispanic, Black women are up to 4 times more likely to die from pregnancy-related complications than their Non-Hispanic, White counterparts (see Hoyert, 2023). For the literature review of this study, guided by the Heideggerian hermeneutic phenomenological method and PCC conceptual framework, I explored previous studies on maternal health nursing communication and HSO leadership roles and support from the provider standpoint. Additionally, Chapter 2 includes a discussion of previous research referencing the historical context of the social determinants concerning maternal mortality and morbidity, PCC, and the current statistics of Maryland. In this chapter, I also expand on the thematic focus areas of women's maternal health communication experiences, leadership support systems, nurse training, and interventions.

Literature Search Strategy

Library Databases

To locate sources for this literature review, I searched electronic research databases and search engines accessible through the Walden University Library, including EBSCO Host, APA PsycInfo (formerly PsycInfo), CINAHL Plus & MEDLINE with Full-text, CINAHL Plus with Full Text, MEDLINE with Full Text, ProQuest Health & Medical Collection, Pubmed, TRIP Database, EMBASE, and Google Scholar.

Search Terms

The following main keyword and Boolean operators were used to find relevant literature on the study topic: *African American, Black women perinatal, perinatal*

experiences, nurse, labor and delivery, postpartum return to work, provider, perinatal care, maternal health, maternal care, maternal health experiences, compassion fatigue, nurse's attitudes, nurse's biases, racial barriers, maternal mortality, maternal morbidity, maternal deaths, pregnancy-related deaths, maternal near-miss experiences, communication, relationships, health services, nursing communication, perinatal communication, maternal health communication, provider communication, listening to women, doula services, obstetric racism, and *healthcare leadership support*.

Search Process

I primarily focused on peer-reviewed, scholarly journals ranging in publication dates from 2019 to 2023 in this literature review. Original and older references were utilized as references in this study when referring to the historical context in Black maternal health. Additionally, I scanned the reference lists within each article reviewed for any additional relevant studies that may not have been captured in the literature search spanning the specified publication date range and to further confirm the research gap.

Conceptual Foundation

The conceptual framework for this study comprised PCC. Carl Rogers, an U.S. psychologist, coined the term, PCC, in the 1950s to describe building trust between a therapist and a patient so that the latter can reach their full potential in life (Latimer et al., 2017). The history of this term is crucial because it focuses on the original intent of PCC and its possibility for clinicians, patients, and their advocates or support networks to collaborate and positively improve health care relationships and health outcomes. In the last 30 years, according to Latimer et al. (2017), there have been many pieces of literature

that support a patient-centered approach to medicine. However, despite its widespread acceptance, there needs to be more agreement on what this idea means.

As defined by Balint (1969) and Byrne and Long (1976), patient-centered medicine is a consultation approach in which the doctor relies on the patient's knowledge and experience to direct the engagement. To add additional historical context, Mcwhinney (1989) stated that physicians aim to penetrate the world of their patients to experience illness through the eyes while using a patient-centered approach. Patient education and participation in treatment planning have also been emphasized as part of PCC.

In every phase of a patient's treatment, PCC places the patient's needs, desires, and priorities at the forefront (Latimer et al., 2017). This entails transitioning from a conventional health care paradigm, in which the health care professional makes choices on behalf of the patient, to a collaborative model in which patients are empowered to engage in their treatment actively. I used the PCC conceptual framework to examine maternal health nurses' key experiences, views, obstacles, leadership, and procedures (see Ahmed et al., 2019). In the PCC framework, it is suggested that physicians and patients would enhance health outcomes linked to experiences, productivity, contentment, and morale via the collaboration (Latimer et al., 2017). Use of the Heideggerian hermeneutic phenomenological approach and the PCC conceptual framework helped me to concentrate on the research topic and thematically code the collected data on nursing-maternal patient communication and interactions. As referenced by Ahmed et al. (2019) and Sundler et al. (2019), viewing maternal care connections, along with available

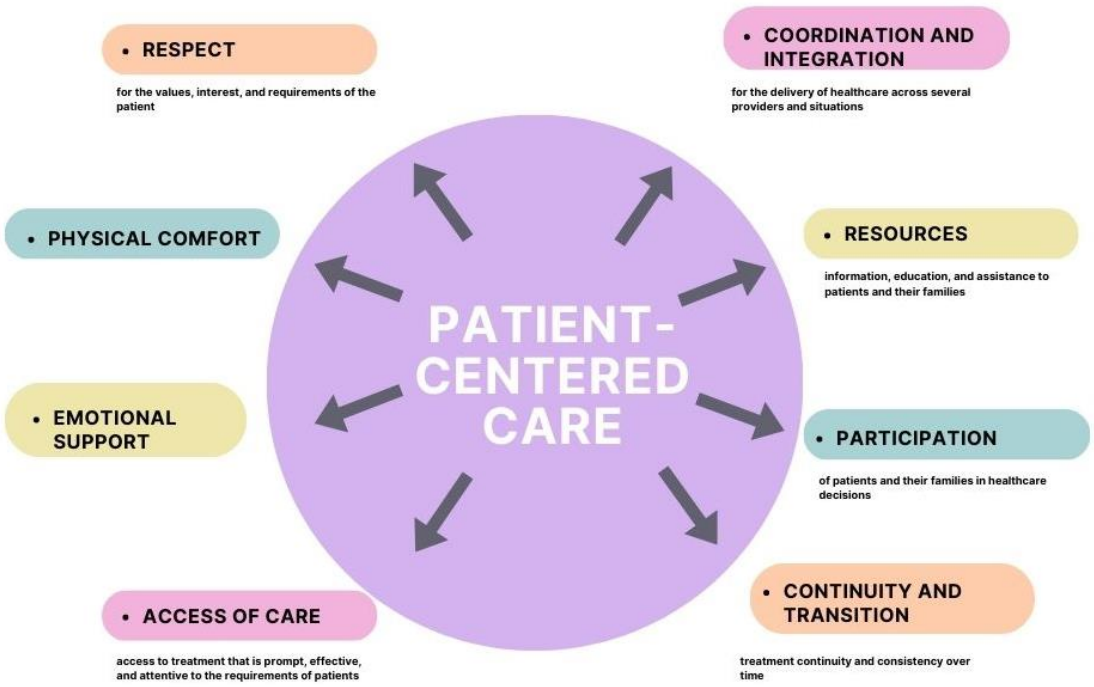
leadership roles and support, at the most frequent contact phases will allow for early interventions or prevention, health literacy considerations, and systematic improvements beyond surviving to thriving.

Verbiest et al. (2018) presented recommendations for improving patient-centered postpartum assistance because the health of the mother and child and the family unit's stability depends on the first few months following delivery. The fourth trimester, or the first 12 weeks after giving birth, is a critical phase of the process from pregnancy through recovery and family transition. Although millions of women in the United States experience this annually, it remains a relatively unexplored area of women's health care. Their conceptualization of PCC entails some fundamental tenets (see Figure 1) that include, but are not limited to:

- respect for patient values, interests, and needs,
- coordination and integration of health care across providers and circumstances,
- patient and family education and support,
- patient-family involvement in health care choices,
- treatment continuity and consistency, and
- quick and effective patient-focused care.

Figure 1

Fundamental Tenets of Patient-Centered Care



Note. Original figure with source data on PCC. From "Elevating Mothers' Voices: Recommendations for Improved Patient-Centered Postpartum," by S. Verbiest, K. Tully, M. Simpson, and A. Stuebe, 2018, *Journal of Behavioral Medicine*, *41*(5), pp. 577–590.

PCC may be applied in HSOs in various ways, including by educating health care professionals on how to interact effectively with patients, including patients in quality improvement, and utilizing patient feedback to inform organizational choices (Latimer et al., 2017). It may also entail revamping care procedures to better fit the needs and preferences of patients, for example, by enabling flexible scheduling or learning resources in many languages. PCC was developed to try to improve the quality of care

and patient outcomes by putting the patient at the center of the process (Latimer et al., 2017).

In more recent accounts, Ahmed et al. (2019) affirmed that PCC provides collaboration and benefits to patients, providers, and the health care delivery systems by addressing important aspects of care centering on patient needs and provider experiences while accounting for access and health care costs. The primary criticism of the model amongst users of the framework has been that, although it has a guiding principle of placing the burden on patients to disclose their encounters with HSOs and support, many of the concerns fall onto deaf ears and result in little to no changes on the HSO-level (Eide & Feng, 2020). PCC, even in developed health care systems, is considered equally as vital as in health care delivery for HSOs and should be incorporated by providers, in practices, and within pieces of training in health care environments where the assessments should be heavily focused inwardly towards HSOs in providing comprehensive and collaborative care to patients (Chappell et al., 2021).

Researchers such as Afulani et al. (2021) and Ahmed et al. (2019) have applied, refined, and articulated the PCC framework by performing semistructured interviews with clinician-scientists and experts to extract patient-centered quality improvement perspectives through descriptive thematic analysis (Sundler et al., 2019) for the appropriate measurement of PCC quality indicators. Some emerging themes included PCC measurability and guidance on implementing measurement, policy, and practice recommendations. Their participants also considered potential barriers and future recommendations to refine PCC domains, including incorporating the feedback of

patients, families, and their advocates (e.g., doulas). More evidence that the PCC framework might be used successfully to targeted groups was provided by Afulani et al. who used community-based participatory approaches in low-resource areas to generate a patient-centered scale for maternity care to reflect the quality of experiences and care for women of color prenatal patients. However, PCC has also drawn criticism from some researchers on potentially being perceived as consumer driven, in the health care setting (O'Dwyer, 2013) and compromising focus on other key areas, such as the key social determinants of health (Manzer & Bell, 2022).

PCC may also present some limitations. Manzer and Bell (2022) noted the limits of PCC in relation to women's contraceptive withdrawal, namely that physicians often encourage patients to continue contraception for a little longer against the patient's wishes, whereas Miyauchi et al. (2022) highlighted the significance of polite relationships and intrapersonal encounters. Positive relationships between women and health care practitioners result from robust systems and settings. In future research, cultural and economic differences in how women are cared for and treated with respect during birth must be considered.

Likewise, Filler et al. (2020) conducted a qualitative inductive analysis and mapped themes to a six-domain PCC conceptual framework when interviewing family doctors, cardiologists, cardiac surgeons, obstetricians/gynecologists, psychiatrists, nurses, and social workers who treat women of all ages for depression and heart disease and provide counseling about birth control. Clinicians said women might only sometimes notify physicians about their health issues, and doctors sometimes do not engage or

investigate further. Women require different PCC; therefore, the clinician participants tailored PCC for women (PCCW) in six areas: establishing a healing connection, communicating information, dealing with emotional responses, dealing with uncertainty, making choices, and giving women the power to manage themselves. They found that PCCW was able to help more people because it offered privacy, female clinicians, facilities for children, and flexible appointment formats and schedules. Clinicians in their study offered seven methods to remove PCCW obstacles at the patient level (i.e., online appointments, transport to health services, use of patient partners to plan and deliver services), clinician level (i.e., medical training and ongoing professional development in PCC and women's health), and system level (i.e., online appointments, transport to health services, funding models for longer appointment times, and multidisciplinary teamwork to address all PCC domains).

PCC may help address the gender gap in health care quality; however, PCCW is an emerging area that has yet to undergo in-depth study. The need for a unified PCC definition has slowed theoretical and practical progress. For large-scale adoption to happen, more research needs to be done on how these methods affect essential things, like how women feel about PCC and their health (Filler et al., 2020).

The PCC conceptual framework was meaningful to this study because it directly applied to maternal health nurses being able to identify communication, leadership roles, and support within HSOs. PCC can be used to help guide health care systems by improving collaborative decision making between patients and providers, thereby

increasing personalized care for maternity patients as well as improving information or data sharing based on experiences and procedures.

Literature Review

Despite medical advances, racial and ethnic disparities in obstetric treatment persist (Oribhabor et al., 2020). Yearly, the medical system fails many women, particularly women of color, since pregnancy-related mortality among Black and American Indian/Alaska Native women remain much higher.

Historical Context

Many Black Americans resided in the South throughout the Civil Rights Movement (Bulletin of the Tuskegee School of Nurse-Midwifery, 1945). Black Americans" health care, housing, education, and employment were separated. Hospital and doctor shortages impeded Black Americans' access to healthcare, and Black Americans had higher rates of tuberculosis, syphilis, gonorrhea, infectious illness, and maternal problems (Craven & Glatzel, 2010). Even then, Black women had greater maternal and newborn death rates than Whites, and rural residents also have trouble getting health care due to poor transportation and affordability (Bulletin of the Tuskegee School of Nurse-Midwifery, 1945). Black mothers in the 1940s seldom received obstetric treatment owing to prejudice and poverty (Grünebaum et al., 2023).

Before 1619, grandmother midwives were vital because Black women would have had no obstetric treatment without grandmother midwives who attended two thirds of births in Mississippi, South Carolina, Arkansas, Georgia, Florida, Alabama, and Louisiana (Bulletin of the Tuskegee School of Nurse-Midwifery, 1945). Doctors, nurse-

midwives, and nurses considered grandmothers a significant health risk to mothers and infants due to their advanced age, low education, unsanitary habits, and superstitious beliefs (Berry & Boyle, 1996; Dawley, 2000). Consequently, many grandmother midwives participated in state and municipal midwife education programs (Almanza et al., 2019; Bell, 1993). Grandmother midwives were self-taught through family and community ties (Bulletin of the Tuskegee School of Nurse-Midwifery, 1945).

Medical racism has shaped Black patient care. White laypeople, medical students, and residents have historically believed that Blacks and Whites are biologically "different" (Bulletin of the Tuskegee School of Nurse-Midwifery, 1945). For example, Hoffman et al. (2016) discussed the 19th-century enslaver Dr. Thomas Hamilton's myth that Black skin is "thicker," has fewer nerve endings, and is less sensitive. Hoffman et al. further debunked the myth that Black individuals can tolerate more pain than Whites.

These beliefs reflect racial prejudice in pain perception and treatment recommendations. Black Americans get less pain relief than Whites. "Black people's skin is thicker than White people's" and "Black people do not feel as much pain" contribute to this racial prejudice. Even among medical professionals, misconceptions regarding biological distinctions between Blacks and Whites exist and may affect medical choices. Racial differences in pain assessment and treatment have resulted. Black individuals get fewer pain medications than White patients (Meghani et al., 2012). Todd et al. (2000) found that, despite identical self-reports of pain, Black patients were less likely to get analgesics for extremities fractures in the emergency department (57% vs. 74%). Worse, it was even falsified that young Black children react to pain differently.

Medical studies used Black Americans as "guinea pigs" (Durant et al., 2011; Ferrera et al., 2015; Mays et al., 2007). The Tuskegee Syphilis Study, Henrietta Lacks, and other research misconduct have reduced Black American health research participation. Black Americans are underrepresented in research because they fear damage from researchers (Ferrera et al., 2015; Lang et al., 2013). Black Americans also fear being given drugs without instructions (Swanson et al., 2021). Black Americans have shared the sentiment that HSOs ignored their warnings about unsafe surroundings and drugs because they were Black (Ferrera et al., 2015). For generations, structural inequities have harmed Black Americans' health and livelihoods (Ferrera et al., 2015; Lang et al., 2013).

Reproductive justice-based research on women of color helps us understand maternal health inequities and how to remedy them (Crear-Perry et al., 2021). Reproductive justice is the right to birth and raise children safely and sustainably. This worldview promotes policies that eliminate human value hierarchies. When we recognize that surroundings impact health, we blame systems, not individuals. Governance, policy, and cultural or societal norms and values that define health-promoting resources and opportunities are difficult to regulate. This framework is not part of this study but should be explored for future research.

Njoku et al. (2023) discovered that racism had a detrimental influence on Black people's health in several overlapping ways when other contributing variables to healthcare inequality were considered. This claim is supported by many academic systems, notably the "weathering" paradigm. The foundations of this framework in

maternal health, disease, and mortality directly question the historical and societal narratives of teenage pregnancy, fertility peaks, and birth timing for Black women. The theory by Geronimus (1992) is that racism in our society causes "premature biological aging," or "weathering," in Black women, which has a direct influence on maternal and infant mortality and morbidity, as well as birth outcomes in general. Because of this aging, racism at all levels in the United States adds to "general health vulnerability."

Black women who delayed fertility until their late teens had lower pregnancy and birth outcomes than White women. Health is a human right, and health inequities result from failing to address these factors. In the United States, race, ethnicity, education, and insurance (including prenatal care) create and sustain pregnancy-related mortality and severe maternal morbidity risk (Dagher & Linares, 2022; Nelson et al., 2018; Wang et al., 2020).

In the United States, the elevated maternal mortality rate among Black women has remained a significant issue for decades. Access to perinatal health care is limited because it is not universally available (Stanley & Wallace, 2022). There are numerous "maternity care deserts" in the United States, where women have limited or no access to obstetricians. HSOs can utilize telemedicine to ensure that pregnant women receive the necessary care, regardless of their proximity to a facility that provides it.

To link quality of care to patient-provider interactions, care processes that affect outcomes may be identified and assessed (Donabedian, 1966, 1988). Care procedures include providing and receiving care. Previous research has compiled the types of communication and interaction that Black pregnant women perceive as biased or

stigmatizing (Wishart et al., 2021). However, there has been no systematic review of interventions, including communications research, to reduce the adverse effects of poor patient-provider relationships or change these exchanges. Modern telehealth allows physicians and nurses to speak with people who cannot attend a clinic or hospital (Wishart et al., 2021). Telehealth services should be standardized and discussed in prenatal care to prevent maternal and neonatal mortality.

Trends in Maternal Mortality and Morbidity

The Hoyert (2023) study adds data about the deaths of mothers in 2018 and 2019. In the United States, 861 women died of pregnancy-related reasons in 2020, up from 754 in 2019. In 2020, 23.8 mothers died for every 100,000 live births. In 2019, that number was only 20.1. According to Grünebaum et al. (2023), there were 55.3 maternal deaths per 100,000 live births in 2020 among non-Hispanic Black women, 2.9 times the rate among White women (19.1). The numbers for Black women were much higher than those for White and Hispanic women. From 2019 to 2020, the number for non-Hispanic Black and Hispanic women grew significantly. The rise in non-Hispanic White women from 2019 to 2020 was insignificant. The Hoyert study from 2023 also showed that the mother's age raised the rates. In 2020, 13.8 women under 25 died for every 100,000 live births, 22.8 women between 25 and 39, and 107.9 women over 40. The rate was 7.8 times higher for women over 40 than those under 25. Rates were very different for each age group. In 2019 and 2020, the death rates of mothers aged 25–39 and women aged 40 and older increased significantly. According to recent statistics (Gunja et al., 2022), the U.S. maternal mortality rate remains higher than that of other high-income nations (see Table

1). The United States had a far higher maternal mortality rate than other high-income nations in 2020, with 24 fatalities for every 100,000 births. Pregnancy-related deaths were infrequent in the Netherlands. Black women in the United States have a far higher incidence of maternal death than White women—more than twice as high as the national average and almost three to four times as high the rate for White women.

Table 1

Maternal Mortality Around the World: How Does the United States Compare?

Country	Maternal mortality rate (deaths per 100,000 live births)
Netherlands	1.2
Australia	2
Japan	2.7
Germany	3.6
Norway	3.7
United Kingdom	6.6
Sweden	7
Switzerland	7
France	7.6
Canada	8.4
Korea	11.8
New Zealand	13.6
United States - Hispanic	18.2
United States - Caucasian	19.1
United States – Black	55.3
United States	23.8

Note. Original table from source data on maternal mortality rates. From "The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison, To the Point" [blog], by Gunja, Munira Z., Gumas, Evan D., and Williams II, Reginald D., 2022, Commonwealth Fund.

Chen et al. (2021) stated that many women have significant problems after they leave the hospital. One in 7 cases of severe maternal morbidity (SMM) starts after a

woman leaves the hospital. This is true for women with private insurance. One in 6 cases of SMM in Medicaid-eligible women starts after the baby is born. Almost three quarters of SMM cases were found in the first 2 weeks after the baby was born, and all were found in the first 42 days or 6 weeks. Typical reasons for SMM after birth release are blood transfusions, lung edema, sudden heart failure, sepsis, adult respiratory distress syndrome, air and thrombotic embolism, eclampsia, acute kidney failure, and puerperal brain vasculature disease. There are differences in SMM after a mother gives birth based on race. For babies covered by Medicaid, the chance of SMM was 1.7 times higher for Black women than for White women. If the focus of SMM is changed to include people discovered after birth and SMM tracking continues, the cost and effects of SMM may be better known, and new ways to improve maternity and postpartum care may be found.

Katz et al. (2022) performed a secondary analysis of a large observational cohort study to examine ethnic variations in postpartum blood loss and postpartum hemorrhage (PPH), mainly when blood loss was assessed. The authors compared Black American and Hispanic PPH and postpartum blood loss to others. Visual blood loss (EBL) estimations showed similar blood loss across Black and African ethnicities for all deliveries. Africans and Black Americans lost more blood utilizing quantitative EBL (QBL). Black Americans accounted for most PPH patients (EBL, p0.023; QBL, p0.001). Provider cognitive bias, socioeconomic level, language hurdles, communication concerns, and other variables may have produced these discrepancies.

Black and White women have distinct risks (Henry et al., 2021). The prenatal risk factors of 315 stillbirths were compared between Black and White mothers using *t* tests

and chi-square testing (National Center for Health Statistics, 2021). Black women were more obese (44.5%) and less educated (12.94% vs. 28.49%). In this multivariate study that considered relationships, Black women were different from White women younger than 20 who had less education, were overweight before getting pregnant, had chronic and pregnancy-related high blood pressure, had never given birth before a stillbirth, and went into labor sooner. Multilevel interventions should target less formal education, obesity, under 20, hypertension (chronic and pregnancy-related), never giving birth, and an earlier gestational age to diminish racial inequalities in stillbirth. If they listened to and valued pregnant women's concerns, nurses and other health care staff might assist in promoting equitable health outcomes (Henry et al., 2021).

Implementation of effective and safe interventions require a strong safety culture, interprofessional integration, excellent communication skills, cultural humility, and checklists. Providers must listen to and evaluate women to meet minimal levels of care. Women dread pregnancy and childbirth uncertainty. Substandard delivery care includes abuse and contempt (Morton et al., 2018). Labor and delivery nurses and birth doulas in the United States and Canada reported disrespectful conduct. The Maternity Support Survey (2,781 respondents) assessed six types of disrespectful behavior by doulas and nurses. The multivariate analysis examined demographics, practice aspects, geographic location, and hospital policy regarding disrespectful treatment.

Over two thirds of respondents reported seeing healthcare providers treat women without giving them adequate time to refuse (Morton et al., 2018). One in 5 doulas and nurses reported seeing physicians or other nurses go against the patient's preferences.

Doulas and nurses who intended to resign after 3 years often reported seeing patients treated disrespectfully. Doulas and nurses often witness verbal abuse, including threats to the baby's life, if the mother does not agree to a procedure and lacks informed consent. Maternity support workers who saw disrespectful birthing care resigned within 3 years, which affects nurse availability, doula health, and maternity care.

Obstetric racism worsens birth outcomes (Nelson et al., 2018). Midwives and doulas have the unique positionality to mediate obstetric racism and reproductive layering. Identifying and preventing pregnancy-related mortality disparities may diminish them (Oribhabor et al., 2020). There is not enough data to establish where women gave birth and their rates of mortality and severe sickness (Grünebaum et al., 2023). Episiotomies, epidural anesthesia, surgery, and cesarean sections are less common in home births. Emergency cesarean sections save lives, but they are risky. Even when risk variables were addressed, out-of-hospital deliveries had a greater prevalence of preventable perinatal outcomes. Electromyography, crucial for its therapeutic promotion and application, may one day lead to more accurate assessments of oxytocin treatments and more effective interventions to prevent prolonged labor, according to Qian et al. (2023).

Communities, health care providers, patients, families, physicians, and health care systems must collaborate to achieve these goals. Improvements in underrepresented women's access to high-quality preconception, maternity, and postpartum care, multiethnic education for physicians and healthcare providers to eliminate implicit biases,

adequate funding, and improvements to underrepresented health care facilities, and education of health care providers on pregnancy-related deaths are all ways to help.

Patterns in Women's' Experiences

Byrd et al. (2022) used phenomenology to analyze hospitalized Black women with near maternal misses. 12 Black women were questioned qualitatively about emergency medical treatment. Maternal near misses predict fatalities. Black mothers die more. We can learn from patients and their relatives about what caused these near misses. Researchers recommend that hospitals and OB-GYN clinics improve care around racial structures and procedures, examine their prejudices, put patients first, explore historical near-misses, and revisit hospital delivery near-misses. Black women are more likely than other women to have their pain complaints neglected, independent of wealth or education (Collins et al., 2021; Liese et al., 2021; McLemore et al., 2018; Witt et al., 2022). Black women have also complained of doctors mistreating, neglecting, and disrespecting them.

Kwezi et al. (2021) set out to investigate communication's role in the quality-of-care women receive with a "maternal near-miss event," defined as a nearly fatal hemorrhage or pre-eclampsia complication during pregnancy, childbirth, or within 42 days postpartum. Women in southern Tanzania who have experienced a maternal near miss were interviewed for this descriptive, phenomenological, and qualitative research. Women who had resided in the research region for at least a year and experienced a maternal near-miss incident were eligible for participation. After identifying 16 women, researchers visited their homes 4 weeks following their discharge to conduct in-depth interviews. They did a thematic analysis to uncover three overarching ideas that surfaced:

1. Being open to inquiry
2. Actively participating in one's care and engagement.
3. Not being in the dark about what is going on.

The research results emphasized the need to maintain open lines of communication with patients to make them feel appreciated, respected, and cared for. Women who were unconscious during care often did not find out what had occurred to them until much later. This triggered some unfavorable emotions and nervousness. This research emphasizes the value of open dialogue and understanding the context of events. A good result that should stimulate the development of consistent ways to strengthen healthcare providers' communication skills is that trust among women may be cultivated via empathic communication, including an adequate explanation of what occurred and why.

Wolfson et al. (2022) used Maryland's SMM monitoring and review program to assess SMM levels, causes, and prevention methods. This cross-sectional research included women admitted to one of Maryland's six maternity centers between 2020 and 2021 who were pregnant or had given birth within 42 days—hospital SMM monitoring using medical data analysis. The key outcomes were intensive care unit admission, at least 4 U of red blood cell transfusion, and a COVID-19 infection necessitating hospitalization. SMM was 50% more common in non-Hispanic Black patients (119.9 vs. 65.7 per 10,000 births). Sixty one (31.8%) SMM results may have been avoided. Prenatal interventions and clinician-level factors frequently affect SMM results. Good practices primarily concern hospitals' readiness and speed to handle pregnant patients. This cross-

sectional research, which employed hospital based SMM monitoring and assessment instead of administrative data, may enhance quality and minimize SMM. Most treatment improvements include identifying and resolving issues immediately. Maryland's SMM reduction strategy should start with the most prevalent causes and circumstances that hospitals can avoid.

Provider Training, Leadership Support, and Interventions

Regarding acute hospital treatment, labor and delivery (L&D) units provide service to specific demographics that are of national and global priority (Lake et al., 2020). First responders during childbirth are nurses. Nurses' working conditions and care gaps may affect maternal morbidity and mortality. This study employed a cross-sectional design to analyze data from a nurse survey conducted in 2005-2008 across four states, with 1,313 L&D staff nurses representing 247 facilities. There were currently 1.25 tasks that required remaining nurses to complete them correctly because half of the nursing staff at several hospitals had left. Patient education and counseling mostly fell below expectations. It was discovered that specific nursing responsibilities were habitually ignored by L&D staff. Most laboring women's emotional, comfort, and education needs are hindered, which may affect the quality and outcomes. Nurses need to talk about care gaps with their colleagues and higher-ups. L&D nurses' working environments may influence missed care. Improved working environments for nurses led to fewer patient care delays. Managers should talk to their nurses about care gaps and evaluate the nursing workplace to identify problems that may be fixed.

Explaining the relationship between health inequities and socioeconomic variables that aggravate them may cut healthcare system expenditures and enhance treatment quality for everyone (Njoku et al., 2023). The curriculum should foster interprofessional collaboration to address health inequalities. Patient education, healthcare staff training, community health organizations, and academic researchers may uncover racial disparities in maternal and child health outcomes. Strengthening maternal-fetal medicine training and treatment is essential to eliminating racial disparities in maternal mortality and severe morbidity. Expanding and diversifying the perinatal workforce—including doulas, licensed and lay midwives, and perinatal social workers—could lower maternal and infant morbidity and mortality (Alexander & Clary-Muronda, 2022).

Chang et al. (2018) investigated (a) whether interventions to increase communication between maternity care staff and healthy women in labor with a term pregnancy may improve delivery outcomes and experiences of care and, (b) the feasibility and resources of such treatments. Obstetricians, anesthesiologists, doctors, family physicians, pediatricians, midwives, nurses, and other delivery professionals were assessed. Home health delivery was also covered. The analysis found no interventions to improve L&D staff to healthy woman communication. Maternity care worker communication training needs more significant proof. More specifically, maternity care communication techniques need substantial investigation. Organizations must create, manage, and maintain programs to enhance communication by incorporating women's aspirations, local culture, and labor and birth care environments.

Some healthcare personnel have associated Black patients with being less cooperative, compliant, and responsible in hospitals (Patel & In Psychology, 2020). This assumption has led to poor patient-centeredness, contextual awareness, and provider-patient communication for Black patients. Sampson et al. (2022) revealed that mothers of all races and ethnicities, including 57% of Black women, desired more significant control over their lives and more opportunities to speak up for their children. Self-advocacy has several uses, including in maternal health research. Empowered healthcare lets patients voice their preferences, meet their requirements, and feel in control. The participants wanted their perspectives acknowledged by case managers and health care experts when creating treatment programs.

Frederick and Lee (2019) examined primary care providers' contacts with low-income Black patients in two urban clinics. Empowerment and community development were used to examine health care providers' contact with low-income Black patients. The authors performed 12 in-depth interviews and examined the findings to find recurring patterns within the qualitative data. According to their reports, health care workers applied all the researchers' patient-centered/collaborative methods to be equal partners in their patients' health care, with these adjustments of providing accommodating, collaborative, and patient-centered techniques to assist low-income Black patients.

Patients may enhance their safety by reporting health and safety concerns (Rance et al., 2013). This study revealed that disregarding personnel reduced patient complaints, as patients were less confident in raising concerns. When personnel ignored them, many women had to "speak up" or communicate forcibly to raise safety concerns. Friends and

relatives acting as liaisons tended to make speaking out easier. Several women continued to complain about the staff not listening to them. Women are speaking up, but organizational staff responsiveness needs improvement. Patient toolkits, patient-activated fast-response calls, and real-time patient feedback warrant additional investigation.

Priority was placed on the ability to express thoughts, concerns, and values by women seeking medical treatment. They desired to have faith in those who provided medical and social services but were hesitant to do so. Numerous mothers desired allies who would "be in their corner" and teach them to advocate for themselves. Users recommended that HSOs' communication materials indicate whether the software can facilitate interactions with medical professionals. Future research investigating maternal health communication should include the perspectives of womens' partners, as family health research has begun to argue for the necessity of paternal engagement (Hans et al., 2022; Sampson et al., 2022).

To improve the health care system, there needs to be firm guidance and management. Tomblin Murphy et al. (2022) conducted additional research to improve the health of mothers and babies at basic health facilities in Morogoro, Tanzania, from a leadership and management point of view. In this study, there were three ways to measure leadership: team environment, role clarity/conflict, and job happiness. During the three years of the project, the study found that happiness, job satisfaction, and understanding of roles all increased at every site. In small groups, people had discussed how this success is linked to enhanced leadership, management skills, and better communication between the health facility, the council, and the regional health

management teams. Overall, teamwork, job satisfaction, productivity, and services for mothers and babies improved. Leaders and managers trained well are necessary for effective and efficient healthcare service.

Barriers to Provider-Patient Relationships

Due to poor health care access, maternal mortality and morbidity remain high. Maternal health care providers' attitudes and behaviors affect health care-seeking and quality. Five electronic databases were utilized for research from January 1990 to December 2014 (Mannava et al., 2015), including research describing maternal healthcare providers' client attitudes and behaviors or their causes. Studies on traditional birth attendants and HIV-related attitudes and behaviors were omitted. The review found that several unfavorable maternal health care providers' attitudes and behaviors influence patient well-being, treatment satisfaction, and care-seeking. Patient encounters were primarily unfavorable. Strengthening health systems and workforce development, particularly communication and counseling skills, is vital due to the variables that impact health professionals' attitudes and behaviors. For women and health care professionals, improving maternal health requires more attention to maternal health care providers' attitudes and behaviors.

Neonatal nurses face severe workplace stress (Walden et al., 2020). Nurses may worry after prolonged ethically unpleasant patient care and other health care difficulties. Nurses and advanced practice registered nurses may lose job satisfaction if they worry too much. Meaningful work may improve nurses' satisfaction, engagement, productivity, and burnout. The term "compassion fatigue" was coined by psychologist Figley (1995) to

describe the negative psychological symptoms that caregivers experience after prolonged exposure to either primary trauma (experienced directly) or secondary trauma (caring for those experiencing trauma). "Compassion fatigue" refers to a state of mental deterioration.

Chronic, repetitive exposure to stressful situations rather than a single traumatic event is more frequently the cause of compassion fatigue. Maintaining an equilibrium between personal and professional stresses is difficult for nurses (Cross, 2019). Nursing is challenging because it requires constant interaction with people who are often in pain and distress. The stress nurses experience from working with these patients for extended periods may reduce their ability to provide compassionate care. When nurses experience compassion fatigue, it may harm their work satisfaction, patient care, and retention rates, all contributing to the nursing shortage.

Walden et al. (2020) used a convenience sample of neonatal nurses to determine their top professional satisfiers and professional fears and concerns. Twenty-nine neonatal nurses had complete data. Caring for newborns and families, making a difference, seeing resiliency, the intellectual challenge of specialization, great working connections with colleagues, and educating parents and families were top professional satisfiers. Staffing, missed care, workload, mistakes, and failure to rescue were top professional concerns. The authors determined that interventions to improve neonatal nurses' job happiness and stress management require more study. Today's complicated healthcare environment demands occupational stress management solutions from healthcare and professional organizations. Identifying professional concerns may help

nurses handle difficult circumstances. Understanding nurses' professional satisfiers may also improve workplace health and resilience (Walden et al., 2020).

Maternal Health and the Impact of COVID-19

Examining the intersecting experiences of perinatal women of color during the COVID-19 pandemic is one way to combat racial health inequalities throughout pregnancy and the first year after giving birth. Participants in a study by Hoang et al. (2022) were asked about their experiences with perinatal healthcare, including whether they had been affected by COVID-19, any difficulties they had encountered, how they had overcome those difficulties, and any suggestions they had for improving the quality of perinatal care. Eight groups of perinatal women of color participated in online focus groups led by the study's authors. Interviews were recorded and transcribed verbatim; a semi-structured interview approach was utilized. The information was evaluated using a method called reflexive thematic analysis. Reflexive thematic analysis yielded three overarching themes common in women of color's perinatal healthcare experiences during the COVID-19 pandemic:

1. An overwhelming lack of support from providers
2. Experiences of blame and shame
3. Difficulties navigating institutional policies that were unclear or ever-changing.

Participants requested more compassion from providers as they navigated the exciting and busy time, including more empathic communication from providers in the face of uncertainty during COVID-19 and more access to information and guidance for

caring for themselves and their babies (Gomez-Roas et al., 2022). Using logistic regression models, Clark and Lake (2020) conducted a secondary cross-sectional analysis of the prevalence of work dissatisfaction (including compassion fatigue) and burnout among maternity nurses and the potential link between these factors and missing care. It can mitigate the adverse effects of nurse burnout and work discontent on patient safety and care quality. More data must be collected on the correlation between maternity nurse work discontent and burnout and service gaps in maternity units. Twenty-five percent of nurses were deemed positive for burnout, and over 20% were unhappy. Missed care was indicated by 72.6% of nurses who were dissatisfied with their jobs and 84.50% of those who were burned out (p = .001). Increased rates of missed maternal care have been linked to work discontent and burnout, both controllable states, suggesting that treating job dissatisfaction and burnout may enhance care quality.

Women undergo significant physical, emotional, and social changes in the weeks and months after delivery. Black and Hispanic women were already at a higher risk of delaying or skipping prenatal care before the COVID-19 pandemic, which has been linked to increased emergency room visits, complications during childbirth, postpartum depression, and unmet postnatal care needs (Mi et al., 2022). The number of cancellations of postpartum treatment was highest during the COVID-19 epidemic, while the incidence of cancellations was lowest for Black women compared to White women. Pregnancy-related and postpartum-related anxiety has been more common among Black women during the current COVID-19 epidemic.

Role of Maternal Health Communication at HSOs

The doctor-patient relationship relies heavily on open lines of communication. High-quality provider-patient communication in healthcare interactions is most successful when it is two-way, patient-centered, and characterized by active listening to engage patients and understand their viewpoints (Adebayo et al., 2020). Overall health outcomes, adherence to the health care professionals' recommendations, and faith in the health care system are all impacted by patients' experiences with communication. However, the Black community's experiences receiving health care services in the U.S. have been characterized by difficulties such as a lack of interpersonal contact, restricted information disclosure regarding ailments, and language hurdles.

The healthcare problems of Black Americans have been the subject of several studies, most of which have lumped them in with other persons of color in the United States People of the same race may have similar healthcare issues, but their experiences may vary. Policies based on systemic racism have created and maintained racial gaps in Black educational success and literacy rates. Literacy rates among Black Americans have been negatively impacted for years due to historical practices such as the prohibition of books and writing among enslaved people, segregation of housing, and the consequent underinvestment in urban areas (Cohen et al., 2012). Low health literacy, which in turn influences health outcomes, is a direct result of and contributor to inadequate schooling.

Lack of faith in the health care system measures how little people trust their providers to deliver safe, effective treatment. Health care consumers should believe that their physicians are seeking their best interests. It is widely established that Black people

have low confidence in the medical community and its practitioners (Cuevas et al., 2016; Durant et al., 2011). Due to such research, Black Americans have more reason to doubt the authenticity of their healthcare providers than their actual skills.

Black women's health care is limited by racism and other oppressions. Using critical race theory, Adebayo et al. (2022) examined the United States health care system's structural impediments to pregnant and new mothers' care. Thirty-one Black women described their pregnancies. Race and class uneven health insurance, institutionalized care's biological approach, and race as a social notion reject pain concerns as a "strong Black woman" motif. "Standard" healthcare communication practices significantly marginalize Black women. This research suggested that health care practitioners embrace and incorporate Black women in communication.

Chronic stress is connected to preterm birth, although health care encounters may increase or decrease stress. McLemore et al. (2018) examined 54 pregnant women of color with social and medical risk factors for preterm birth who received medical care. Five themes emerged through transcript thematic analysis. Focus groups addressed racism, prejudice, stressful interactions with healthcare professionals, unresolved issues, and a lack of social support. Participants proposed strengthening birth planning, healthcare professional communication, and patient listening. Most research participants felt mistreated and stressed throughout prenatal care. These findings support the idea that healthcare practitioners discriminate against women of color, particularly those seeking treatment for themselves or their children.

Prenatal interactions between Black women and healthcare providers are troublesome. Renbarger et al. (2023) assembled qualitative research to show how healthcare providers restrict prenatal therapeutic interactions with Black women. Thematic synthesis of 12 systematic-searched qualitative research is offered. Seven minor concepts described two primary ideas. Discrimination, shows of prejudice, failing to show empathy, limiting patient alternatives, offering inadequate health information, bad treatment, and dismissing patient complaints are the seven illustrated subjects. Participants' contacts with health care providers were complicated by implicit prejudices and impediments to patient participation. The findings showed the need to address unconscious biases, fight for a healthcare system without racism, and treat pregnant Black women with decency and respect, including listening and acting on their concerns.

According to the World Health Organization (WHO, 2015), expectant mothers should get "respectful maternity care," which is defined as "care that maintains dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, enables informed choice, and provides continuous support throughout labor and childbirth" (Bohren et al., 2020, p. 114). Values training, attitude change, and interpersonal communication improve caregivers' respectful maternity care. However, their efficacy could be more evident.

Barnett et al. (2022) ran six focus groups with 31 women of color. The inductive and iterative qualitative analysis uncovered important themes from focus group transcripts. The seven emerging themes are knowledge gaps, mental health, communication with providers, support systems, policy representation, social

determinants of health, and prejudice and stigma. Women's prenatal and postnatal accounts highlight health care system shortcomings. We need to hear from the most affected to solve health care inequities. These results imply institutional and policy-level health and social care system improvements. These stories show how women of color struggle during and after pregnancy.

How much do labor and delivery nurses use Swanson's middle-range theory when caring for new moms whose babies died at birth? That is what Nurse-Clarke et al. (2019) wanted to find out. Twenty nurses who helped with labor and delivery participated in the grounded theory study. The guided content analysis method was used to look at their qualitative, in-depth interview data as a supplementary study. This study used Swanson's five care steps as priori codes. Finding a way to connect and understand what she is going through (knowing), spending extra time with her (being with), protecting her and keeping her dignity (doing for), giving her information and explanations in a precise and methodical way (enabling), and making sure she does not blame herself during the grieving and healing process (maintaining belief) are all parts of nursing care for a woman who has experienced a stillbirth.

Clinicians' interactions with women of color, specifically what was revealed and hidden from them, affected their pregnancy and delivery experiences (Altman et al., 2019). The providers' information monopoly impeded women's health care decisions. This study may inspire clinicians to enhance their communication, informed consent, and care of women of color throughout pregnancy and labor.

Nurses, nurse practitioners, and nurse midwives were studied qualitatively by Dalton et al. (2021) to see how they define patient trust in their work with pregnant and laboring women. Twenty-two nurses in various settings throughout the southeastern United States were interviewed for this study. Within the context of a system with numerous objectives, a normative theoretical approach was used. The study's authors identified five overarching themes that characterize trust as it shapes nurses' communicative aims:

1. Trust is the woman's acceptance of vulnerability and risk.
2. Trust is the woman's surrendering of control.
3. Trust as the woman's yielding to the nurse's expertise.
4. Trust is the woman's feeling heard and confiding in the nurse.
5. Trust as the woman's disclosing information.

Previous research that defined trust in terms of exposure to risk and openness to others' perspectives is backed up by these findings; new ideas are explored elsewhere. The findings are dissected based on established ties between trust and communication and the fluctuating and competing objectives nurses face in pursuing the best possible health outcomes for their patients. The quality of communication between nurses and patients may be affected by passive interpretations of trust that confuse it with women's acquiescent behavior. They also shift the focus of trust from a relational aim supporting women's autonomy throughout obstetric and intrapartum processes to an instrumental way of achieving patient participation and desired health results.

Wang et al. (2021) observed that Black and Latina women with severe obstetric problems were less likely to get effective emotional trauma therapy. Addressing implicit bias as part of institutionalized racism and improving communication to make women feel heard and informed throughout the birthing process may reduce disparities in obstetric care. Participants with significant issues reported tremendous suffering and long-term emotional impacts after birth. Due to poor continuity of care, communication gaps, and perceived neglect of their physical and emotional needs, participants were worried and disappointed.

According to research by Entsieh and Hallström (2016), expecting and new fathers' expressed interest in receiving prenatal and postnatal education. Participants valued receiving information from health care providers quickly and accurately, being well-prepared, and receiving support in the early postnatal period.

Little is known regarding the connection between age and race regarding health care experiences, even though there is published research on Black women's experiences with obstetric care, including encounters with individual and systemic racism. Using an intersectional theoretical lens, OjiNjideka Hemphill et al. (2023) investigated young Black women's perspectives on maternal health and pregnancy. Thematic analysis was used to dissect data from two focus groups with a sample size of eleven pregnant young Black women. Obstetric racism and obstetric resistance were the two dominant ideas. Subthemes, including participants' intersectional identities as young Black women, distrust of medical professionals, and traumatic birth experiences, were found to provide light on how obstetric racism shaped their healthcare experiences. Participants' strategies

for safeguarding their health while pregnant and giving birth in the face of obstetric racism formed the second overarching subject. Two of the resistance strategies discussed were finding allies and relying on reliable service providers. Due to individual and systemic racism, the quality of obstetric treatment in the United States is below par. This research was necessary because it sheds light on how personal bias and institutional discrimination affect obstetric care for young Black women.

Chambers et al. (2022) examined how clinicians see racism's impact on the pregnancies, perinatal care, and birth outcomes of Black women. The researchers conducted 25 semistructured interviews with prenatal care providers serving women of various racial backgrounds in the San Francisco Bay Area. Most participants were White and obstetricians/gynecologists or licensed nurse midwives. The interviews revealed three main themes: inequitable care delivery (such as women who experienced significant complications during labor course but were not taken seriously), surveillance of Black women and families (such as performing a urine toxicity screen on a Black baby when it was not indicated and not performing the same test on the White baby when it was), and structural care issues (such as the legacy of medical racial experimentation).

Collins et al. (2021) investigated Black women's experiences accompanied by a perinatal support professional (PSP, such as a doula) and their contacts with medical professionals during labor. The research was qualitative, and the phenomenological method was used to probe the significance of women's experiences. The authors interviewed 25 Black women to learn more about their encounters with medical professionals, their stories' significance, and their PSPs' impact. Participants tended to

classify events as either good or unfavorable. Women were more satisfied with their delivery experiences when medical staff respected them and their birth plans and worked with their PSPs. Women's perceptions that providers did not acknowledge or respect their needs were linked to their unpleasant experiences. The results stress the significance of medical professionals putting their patients first, avoiding making assumptions about them, treating them as collaborators, giving equal weight to the opinions of women, and considering them integral treatment team members. In addition, the findings corroborate the value of having a skilled but non-medical support person, like a doula, present during delivery. Consequences for how empowerment may improve birth outcomes were also highlighted.

The Challenges of Black Maternal Health Professionals

Black perinatal health professionals carry a long history of Black Americans advocating for their communities. Hunte et al. (2023) aimed to learn more about the perspectives of these experts. A descriptive and qualitative study was conducted to comprehend better how Black physicians felt about participating in a public health initiative targeting pregnant Black women. Seven nurses and community health workers participated in a focus group, and the material was analyzed using thematic analysis. Reproductive justice and community care are hallmarks of a culturally aware approach, as are (a) shared lived experience and parallel processes between staff and clients and (b) managing many changing gazes between clients, the public health department, and medical institutions. The results showed the benefits and challenges that Black nurses and community health professionals face. Education, practice, and research all require

improvement if nurses and community health workers are to be adequately prepared for and supported in culturally distinct contexts.

Summary of Literature and Conclusions

Gaps in provider-patient communication in health care settings are a recurring subject in the literature among maternal health patients. Nurses, because of their closeness to patients, must be aware of the social distrust and its historical context if they are to avoid adding to the problem. The nursing profession has an obligation to enhance patient communication by counteracting poor communication and bolstering patient, family, and community interpersonal trust (Durant et al., 2011), with a particular focus on Black maternity patients. If nurses engage in self-reflection and reflexivity to lessen the influence of their implicit biases, they are better able to interact with their patients in a manner that fosters trust, enables prevention, and deploys swift intervention (Wesp et al., 2018).

As mentioned earlier, a substantial body of research supports the claim that communication between nurses and expectant Black American women is inadequate. In a study conducted by Güner and Ekmekci (2019), emphasis was placed on the prioritization of enhancing interpersonal communication skills and purposeful reflection among nurses, along with their training in delivering care to maternity patients, particularly those belonging to the Black American population. The aim was to address the existing research void in this area as identified in the literature review.

Black maternal health patients have expressed detailed accounts of failed communication processes during birthing, and this study expands upon this knowledge

within the HSO discipline, exploring the experiences of maternal health nurses. Chapter 3 addresses the research methodology design, justification, and the researcher's role in the study. The study's methodology is expounded upon, including the criteria for participant selection, the instrumentation utilized, and the research protocols and analysis plans.

Chapter 3: Research Method

In this study, I employed a qualitative, hermeneutic, phenomenological approach to investigate the communication dynamics between maternal health nurses and Black women maternal patients at public hospitals and clinics in Maryland. I also explored the experiences of nurses regarding organizational leadership roles, the support they receive, and the communication processes within the state's HSOs. In a literature search, numerous patient-centered maternal health communication studies (e.g., Njoku et al., 2023; Wolfson et al., 2022) were found. Despite the prevalence of research on the social problem of maternal morbidity and mortality among Black women, a lack of literature confirmed that the topic had not been investigated in a way that explores the precise and original gap between nurses, HSO communication, leadership support, and patient relationships. Furthermore, there is a lack of research on the state of Maryland's efforts to address maternal mortality and morbidity within its HSOs, specifically regarding provider communication and leadership efforts.

I used the PCC conceptual framework to understand the communication processes under study and determine if a communication disconnect and a lack of leadership roles and support may contribute to the high maternal mortality and morbidity crisis facing U.S. Black maternal health patients. Due to its emphasis on the harmful effects of prolonged physiological coping mechanisms from repeated stressor exposure, the weathering framework, in which Geronimus (1992) stated that Black Americans age faster than White Americans due to recurrent social, economic, environmental, and

political stressors, like the maternal mortality and morbidity crisis, was considered, but I determined it to be inappropriate for this study inquiry seeking HSO perspectives.

In Chapter 3, the research method, the researcher's role, and the study design are presented. In addition, I describe the reasoning behind the instrumentation used, data analysis plan, and participant recruitment and selection. At the conclusion of the chapter, insights into the validity, dependability, ethical considerations, along with the section summary, are provided.

Research Design and Rationale

Research Questions

The specific research questions for this study were:

RQ1: What are the lived experiences of Maryland nurses concerning communication in caring for Black maternal health patients?

RQ2: What communication supports have been implemented among leadership for Maryland nurses that may reduce communication lapses with Black maternal health patients?

Central Concept of the Study

In this qualitative, hermeneutic, phenomenological study, I explored the lived experiences of practicing nurses in Maryland regarding their interactions with Black maternal health patients, specifically in communication, operational procedures, and organizational leadership support. Maryland was targeted because its maternal death rate falls into the moderate-to-high-risk category among U.S. states (National Center for Health Statistics, 2021). Maryland's maternal mortality rate is much higher than the

national average, and only 19.5% of its hospitals are considered “A” quality (State Rankings, n.d.). The neighboring Virginia to the south, however, is ranked second and has a 52.1% A+ proficiency rate amongst its hospitals.

Research Tradition and Rationale

The theoretical underpinnings of this investigation were grounded on Heidegger’s (1962) early 20th-century hermeneutic phenomenology proposal. This framework is constantly updated as new knowledge and understanding emerge through verbally shared experiences resulting from open-ended questions and is based on preexisting consciousness (i.e., Dasein) and lived experiences (i.e., foresight and fore-conception) that seek to comprehend human interaction in its full context (i.e., Hermeneutic circle). The hermeneutic approach was well suited for this study because it facilitated the complete extraction of experiences and perspectives when conducting semistructured interviews with Black maternity health nurses.

Heidegger (1962) explained that Edmund Husserl (the “father of phenomenology”) provided the fundamental basis for hermeneutic phenomenology with transcendental phenomenology. Husserl's method is distinct from Heidegger's in that it precludes a theoretical framework and calls for “innocent” eyes and ears as if meeting a thing for the first time to avoid biases and bracketing (epoché). However, when using Heidegger’s phenomenology, one must draw on their own experiences to get insight via foresight or prior preparation; therefore, it is difficult to ignore one’s biases and experiences (while making them known; Sloan & Bowe, 2013). Sundler et al.’s (2019)

research exhibited that Husserl prioritized descriptive phenomenology with an emphasis on natural responses and intentionality.

Tying into the literature, nursing experiences in providing maternity and newborn care were the focus of Sundler et al.'s (2019) qualitative phenomenological approach to research, which provided a natural bridge between the theoretical framework presented and the research technique of theme analysis (Chang & Wang, 2021). Central to Heidegger's method, data interpretation is expected to uncover the implicit or silent meanings incorporated or veiled in lived experiences and had affinities with thematizing meaning in hermeneutic phenomenological traditions (Saldana, 2016).

Role of the Researcher

In this qualitative, hermeneutic, phenomenological investigation, I played the role of an instrument (i.e., observer), along with developing the interview questions and inductively analyzing the data to identify themes. I did not utilize existing source codes to construct categories and themes; instead, they were created purposefully using information from the participants' interview transcripts. Hermeneutics are used to study how people and communities make sense of texts and interactions via their unique lenses of interpretation (Heidegger, 1962). Hermeneutics served as the research technique of choice because of its emphasis on building community knowledge via mutually beneficial interpretation.

For the sake of full disclosure, I acknowledge that I had no relevant personal or professional ties with any of the study participants, including any imbalances of power. As a Black mother and a researcher, though, I am aware of the prejudices that inform my

approach to this issue. In my first pregnancy, I had a near-miss experience. I assure that science, not my opinions on the subject, determined the findings of this investigation. In qualitative research, the researcher's role is emphasized because they serve as instruments, so they must be aware of their biases and views (Creswell & Creswell, 2018). To avoid researcher bias in this study, I maintained a reflexive diary and had my data analyses peer reviewed. Peer review ensures research validity and reliability (Hayashi et al., 2019). Additionally, I collected data in a semistructured interview format via Zoom and email to reduce biases. The participants' lived experiences were evaluated regarding the phenomenon of communication, and their identities and data were secured during recruitment and collection.

No researcher-participant connection existed, and all the volunteer participants were unpaid. I interviewed, collected, analyzed, and presented the data in this study. The Walden University Institutional Review Board (IRB) reviewed the informed consent form used in this study. Before recruiting participants could begin, the Walden University IRB examined the study for all ethical issues, including the methodology. Qualitative research ethical considerations include participant confidentiality, and I vowed to never reveal participants' identities throughout the study. The interviews were confidential, and participants were required to sign the informed consent form before being interviewed, which briefed the participants about the study, their involvement, my goals as the researcher, and the publication of the findings. The following human subject protections and ethical research principles remained at the forefront over the course of the study: (a) reducing damage, (b) informed consent, (c) privacy, (d) avoiding deception, and (e)

allowing withdrawal (see Resnik, 2020). Because participants had to feel comfortable sharing personal information on the phenomena, I examined the study's influence on them and their trust and treated interview data respectfully. In participant interviews, any cultural differences were acknowledged and considered, where necessary. Confidentiality was maintained throughout the study and thereafter.

Methodology

Participant Selection Logic

The planned research design involved recruiting Maryland-based maternal health nurses working in the state's public hospitals and clinics to participate in individual qualitative interviews and follow-up interviews to fill any gaps, as needed. I presented individuals with the options to participate via audio-recorded phone calls; Zoom, in-person interviews, or email. The participants in this study were maternal health nurses working throughout the state of Maryland who had a minimum of 3 years of experience working with maternal patients. The 3 years of experience requirement was implemented to likely attract both entry-level and seasoned maternity nursing professionals. All participants were post-internship and not limited in terms of gender and ethnicity. Nurses with no specific experience in maternal health care, less than 3 years of experience in maternal health, and not currently working in Maryland were excluded from the main study.

I used purposive sampling to focus on a specific, small population to meet the study's objectives. The study participants were volunteers, and I recruited them based on inclusion criteria essential to the research questions under investigation. The snowball

approach was also used to invite participating maternal health nurses to identify additional colleagues who may have been a suitable match for this study if they satisfied the requirements. I posted the recruitment flyer on social media (including Facebook, Instagram, X, and LinkedIn), Facebook maternal health nursing groups, and bulletin boards in select Maryland libraries. Eligible participants were issued official participation invitations upon completing the consent form. Participants were able to choose from different interview settings (audio-recorded phone call, in-person or email) to conduct their initial and subsequent follow-up interviews. The interview protocol included a briefing on the interview's purpose; an introduction; introductory, content, and penetrating questions; and concluding instructions (such as an explanation of follow-up interviews as necessary).

Sample Size and Data Saturation

Data saturation is used to estimate and evaluate the number of qualitative samples necessary in a study. According to Saunders et al. (2018), data saturation is the point in qualitative research where it is believed that further investigation of emergent themes has exhausted the participant cohort. According to Glaser and Strauss (1967), the potential saturation of a category is used to decide when to stop taking samples from the different groups that belong to that category. Essentially, data saturation determines if researchers are still looking for more information to help them figure out the features of the group. As the researcher sees more and more related cases, they can be sure, based on facts, that a group is whole. Researchers should be intentional to find groups with as much data variety as possible to ensure saturation is based on as much data as possible about the

topic area (Buckley, 2022). To reach the theoretical saturation point, where no new information or themes are emerging, I collected and analyzed data concurrently and sought a minimum sample size of 10 maternal health nurses currently working in Maryland. Saturation is the primary endpoint of subject recruitment.

Instrumentation

I was the primary instrument of this study because I conducted interviews, reviewed the data, and analyzed the collected data. No tools or questionnaires made by other researchers were used to gather data. A guided interview protocol that I developed and submitted for approval to the Walden University IRB served as an additional research instrument in this study. The purpose of the open-ended, probing interview questions in the interview protocol was to gather participants' responses to address the two study research questions. The interview questions (see Appendix A) were developed using my professional health care management and policy expertise and the assistance of my doctoral committee. Data were collected in the form of the participants' interview answers regarding their lived communication experiences with Black maternity patients and the levels of leadership support (e.g., presence, procedures, programs, policies, and pieces of training) provided to Maryland maternal health nurses to help them succeed in various areas, including provider-patient communication.

Pilot Study

I conducted a pilot study by administering the pilot-specific interview questions (see Appendix B) to two individuals employed in the maternal health nursing field but residing outside of Maryland. This pilot study was conducted with Walden University

IRB approval, and its purpose was to evaluate the interview questions' reliability and validity. Conducting pilot testing with individuals with whom I was not acquainted was prohibited until approval from the IRB was received. The data from the pilot were excluded from the analysis of this study. During the pilot study, I adhered to the protocols outlined for the intended investigation. Both participants were apprised of the pilot study's objective to ascertain the legitimacy of the interview queries.

Procedures For Recruitment, Participation, and Data Collection

Personal email transcripts and a high-quality audio recording were made for this study's data collection and analysis, and the participants' interview responses were easily retrievable at any time. Participants were also required to complete informed consent forms before any interviews were conducted. The signed consent forms captured the participants' cooperation, an essential aspect of the study's credibility. I conducted semistructured, open-ended interviews with maternal health nurses currently practicing in Maryland's public hospitals and clinics and asked about their personal experiences communicating with Black maternal health patients as well as the leadership support, programs, and policies available to them in their roles. The open-ended interview questions were followed by more in-depth, exploratory inquiries if necessary. The participants had the option to be interviewed over the phone, through Zoom, or in person, whichever method the participants preferred. If these other, more engaging means of data collection failed due to the availability of the nurses, I also accepted interview replies by email. To catch the verbal and nonverbal cues, body language, and voice variation, it was

highly preferred that participants took part in the interviews in person, over the phone, or in a Zoom virtual meeting.

At the individual interviews, participants were apprised about the study's goals and methods, the researcher's role, and what to anticipate during the interview (which lasted between 45 and 60 minutes). It was also apparent to the participants that their involvement was optional. The audiotaped interviews began with an official introduction from the researcher, during which the confidentiality of the participants' identities was reaffirmed. After the interviews were recorded and transcribed, the researcher informed participants that follow-up interviews are available at their discretion to help refine the data even more. Participants were given the opportunity to review my interpretations of their interview responses.

Ten of the participants in this study opted for email interviews due to time-constraints. Therefore, only one audiotaped interview took place with the 11th participant. Through the informed consent and email communications, participants were informed of the study's goals and methods, the researcher's role, and that their involvement was optional. Participants were made aware that they could remove themselves from any phase of the process at any time. Participants were given the opportunity to review the researcher’s interpretations of their interview responses. Letters will stand in for the real names of individuals participating (e.g., PA, PB [for pilot participants], P1, P2 [for main study participants]). After 5 years, the USB drive containing the data will be destroyed, electronic documents will be erased, and printed documents will be shredded.

Data Analysis (Explication) Plan

The data was analyzed using the Sutton and Austin (2015) approach, with data acquired through participant interviews. To stimulate an open dialogue, the semistructured questions were succinct, digestible, and open ended. Participants were given a short overview of the study's objective and advised of the possibility of follow-up interviews to collect further information. The data were obtained through the audiotaped and email interviews of direct participant responses, and MAXQDA was utilized to organize data and assist initially with converting categories into common themes. However, I preferred and performed manual hand-coding to supplement the MAXQDA analysis.

Issues of Trustworthiness

Credibility (Internal Validity)

Credibility is confidence in data and analysis. The researcher's credibility is enhanced through training, experience, track record, self-examination, qualitative techniques, inductive analysis, and purposeful sampling (Santos et al., 2020). The most common method for verifying findings is triangulation. Using archival research, participant observation, and interviews, triangulation may include acquiring several data types, such as studying the existing literature, observational data (nonverbal communication and nuance), and interview transcripts. Triangulation helps to dispel misconceptions about the phenomena - the more comprehensive the picture, the more persuasive and solid the judgments. I participated in sustained engagement by devoting substantial time to examining and interpreting the data, particularly during the manual

interpretation phase. The study also maintained a reflexive diary to aid in the refinement and comprehension of the participants' replies.

Transferability (External Validity)

Transferability is the extent to which the results of a qualitative study can be used in different situations or places (Renjith et al., 2021). Transferability is the responsibility of the person doing the qualitative study. I worked to improve transferability by clearly describing the research setting and the basic ideas of the study. The person who wants to transfer the results to a new situation is responsible for determining if the transfer is appropriate. I developed transferability for this study via the study design, which may be implemented in different circumstances and contexts. Purposive sampling with an anticipated minimum sample size of 10 participants promoted transferability and was intended to reach data saturation that is neither gender nor age constrained. In terms of maternal health research, this research design may be transferable to other demographics and under a related key gap area.

Dependability

To assure the reliability of this qualitative hermeneutic phenomenology inquiry, I thoroughly defined the research methodology and study design. The findings were established independent of changes in the research location or participants, demonstrating the repeatability and reproducibility of qualitative data under comparable situations (Stenfors et al., 2020). Other researchers may be able to use the data to get results that are comparable.

Confirmability

Participant and researcher bias was evaluated for confirmability. Objectivity implies that the data accurately reflects the information of the participants and that the researcher's opinions are not fabricated (Martín-Sanz et al., 2022). Repeatability was ensured by rechecking qualitative data throughout data collection and analysis. An explicit coding scheme identified patterns and codes in analyses. The data verification process (or organization of the data) prior to analysis ensured accuracy. I used a reflexive journal to capture any implicit biases. Furthermore, I ensured that the data were consistent with the study objectives and that member checking was used to confirm the accuracy, meaning and relevance of the participants' personal interview data. It should also be repeated that all interview data were de-identified.

Intra and Intercoder Reliability

In addition to follow-up interviews and clarifying inquiries, participants had the opportunity to view the study findings and provide feedback on the veracity of how their interviews were interpreted through member verification. Intercoder reliability is essential when evaluating interview transcripts (O'Connor & Joffe, 2020). I applied uniform coding to all data. Intercoder reliability has numerous applications in qualitative research, including enhancing the systematicity, communicability, and transparency of the coding process, fostering reflexivity and dialogue within research teams, and convincing a wide variety of audiences of the reliability of the analysis.

Ethical Procedures

Research ethics has five pillars: minimizing harm, obtaining informed consent, protecting anonymity and confidentiality, avoiding deceptive practices, and allowing withdrawal (Resnik, 2020). I kept the participants' identities and information private. In addition, no harm happened to the volunteers due to their participation. Everyone involved had prior experience as a maternal health nurse at a hospital or clinic in Maryland. All participants worked in nursing for at least 3 years. I provided all participants with an electronic copy of the consent form. Participants were limited to those who have signed the consent form. Until saturation was reached, I kept seeking participants to interview. No targeted hospital recruitment took place. As a result, no official approval from any organizations was necessary. I explained what safeguards were in place for the volunteers in the consent form. Participants were informed that they may refrain from answering questions, terminate the interview early, or withdraw altogether at any time. Following researcher roles and recruitment procedures helped to avoid ethical concerns. To successfully recruit individuals and collect representative data, I used a snowball sampling strategy.

Maternal health nurses in Maryland with at least 3 years of experience working in public hospitals or clinics were selected as part of this purposive sample. Since the study group consisted of working nurses in Maryland, collecting data was considered convenient. To locate more individuals who were a good fit for the study, I used a snowball sampling approach to ask current participants to refer others who may qualify. No one related to or working with the researcher was permitted to participate in the study.

During data collection, I provided individuals with code names to protect their identities. Data from published studies will be kept inaccessible for 5 years. After keeping paper records and recordings for 5 years after a study is published, the researcher will discard both the electronic and paper records. I expressed gratitude to the interviewees and included a “catch-all” question for participant freeform inputs. Additionally, I kept an objective eye on the data through self-reflection and peer assessment. The study was approved by the Walden University IRB. The approval number for this study is #08-03-23-0064679.

Summary

Background information, the explanation of the issue, the study's objectives, research questions, a theoretical framework for interpreting the analysis, the study's methodology, its assumptions, scope, and limits were all laid out in the first chapter. The literature search approach, theoretical groundwork, and literature review make up the bulk of Chapter 2. The literary search method included using a combination of library catalogs, subject headings, and advanced search options. Heidegger's hermeneutic phenomenology, historical application, and relevance to the investigation serve as the theoretical basis. The literature review covered topics such as the current state of maternal health care, the historical context of maternal mortality and morbidity, patterns in women's experiences, provider leadership roles, barriers to patient-provider relationships, the effect of COVID-19 on maternal health, the communication skills of maternal health nurses within HSOs, and the specific difficulties faced by Black maternal health nurses. Purpose, research design, researcher's role, technique, data collection tools,

process, role of the participants, concerns about trustworthiness, and ethical procedures in qualitative research are all summarized in Chapter 3. In a basic phenomenological qualitative investigation, the interview questions are framed around the PCC philosophy. This study sought to close a knowledge gap regarding the maternal mortality and morbidity crisis that disproportionately affects Black women by describing the communication experiences of maternal health nurses in Maryland who care for pregnant Black patients. This study further explored the communication supports implemented by Maryland HSO leadership to aid maternal health nurses in their operations. Information on data collection, analysis, coding, topic development, credibility indicators, and findings are presented in Chapter 4.

Chapter 4: Results

In this qualitative, hermeneutic, phenomenological study, I investigated Maryland nurses' lived experiences with communication, operational processes, and organizational leadership support when caring for Black maternity health patients. The goal was to use the PCC conceptual framework as an additional lens to increase the understanding of processes and determine if there was a potential communication disconnect and lack of leadership roles and support, which could be driving the high maternal mortality and morbidity health crisis afflicting Black maternal health patients in the United States. In this chapter, I discuss the pilot study, settings, demographics, data collection and data analysis (i.e., explication) process, evidence of reliability, and results before concluding with a summary of the chapter.

After receiving approval from the Walden University IRB, I conducted participant recruitment and the interviews while ensuring that all ethical parameters for conducting studies that recruit human subjects were adhered to. The findings of this study may influence positive social change and serve as a foundation for gaining a more profound understanding of access and delivery coordination, which may, thereby, contribute to solutions on poor maternal health communication outcomes and experiences. The study findings may also have ramifications for future academics looking to investigate further extended demographic segments of HSOs' communications tactics throughout the United States and beyond Maryland.

Research Questions

RQ1: What are the lived experiences of Maryland nurses concerning communication in caring for Black maternal health patients?

RQ2: What communication supports have been implemented among leadership for Maryland nurses that may reduce communication lapses with Black maternal health patients?

Pilot Study

A pilot study refers to a preliminary investigation undertaken on a smaller scale to prepare for subsequent and more comprehensive research (Lowe, 2019). The pilot study is conducted to ascertain the validity of the interview questions in addressing the research inquiries. In the current study, the objective of this field test was to assess the reliability of the semistructured interview questions via the recruitment and interviewing of two maternal health nurses. The recruitment, participation, and data collection procedures used in the pilot study mirrored those used in the subsequent research study. I investigated research issues without adjusting the instrument by carefully examining the two recruited pilot participants' feedback.

The recruitment flyers stated the requirements for participation in both the main study and pilot research. Nurses working in the maternal health field were required, and this study excluded nurses with no expertise in maternal health. The participation flyer for the pilot study was shared with two individuals who were ineligible for the main study yet met the maternal health nursing expertise requirement. Invitations to participate in the pilot study and informed consent forms were distributed via email. The interview

options were face-to-face, telephone, Zoom, or an email interview to provide participants with greater flexibility to communicate in the forum of their comfort and preference.

I tested the pilot interview questions, as referenced in Appendix B, with the two participants of the pilot study. It should be noted that the pilot volunteer recruitment criteria were less rigid than the actual study because the pilot participants did not need to have more than 3 years of maternal health experience or were they required to be based in Maryland. The pilot volunteers had up to 2 years of experience in the maternal health field outside of Maryland. The researcher-guided interview tool was validated using the pilot study where my aim was to ensure that the interview questions adequately addressed the research questions. Before the interview process began, the two participants signed consent forms. I also advised them that their responses to the interview questions would not be analyzed for the broader study. The two participants opted for email interviews; therefore, the pilot interview questions were emailed to them, and their email responses were obtained. The pilot was useful in that I was able to reassess the interview questions and participant responses to determine that they were acceptable for answering the study research questions. There was no need to change any of the interview questions. I used P to symbolize the pilot participants and wrote a letter to each in the order of the interview dates and times; therefore, PA was the assigned label for the first pilot study participant, and PB was assigned to the second.

Interview Setting

For this study, I recruited a total of 13 individuals: two participants from outside of Maryland for the pilot study and 11 participants based in Maryland for the central

study. Given that there were no organizational links, no special circumstances or permissions impacted this study. There were no budget barriers, and most of the interviews were conducted via email due to the nurses' reported unpredictable schedules and time restrictions. One participant opted for a Zoom interview. My first aim was to safeguard, comfort, and respect the participants' time; thus, I adopted their choice for the interview format. The participants responded to the questions based on their experiences as maternal health nurses in Maryland while caring for Black perinatal patients.

I worked closely with all the participants regarding the purpose and structure of the study. They responded to the interview questions, referenced in Appendix A, based on their lived experiences, the communities they serve, and their places of employment. Since many of the participants preferred email, I sent all follow-up questions, likewise, through email. It took roughly a month to finish recruiting and obtaining interview data. The study's recruitment flyers were distributed widely using social media sites like Facebook, X, Instagram, and LinkedIn. I began receiving responses from people interested in participating in the study within 72 hours of posting the flyer, seeing the greatest recruitment success via the LinkedIn platform. While participants in the pilot study trial were assigned the letters, PA and PB, the primary study participants were assigned a letter and a number to de-identify them. Corresponding to the interview dates and times, I assigned the participants the letter P followed by numbers ranging from 1 to 11 (e.g., P1, P2, P3, etc.). These subjects were issued these labels rather than names for ethical reasons.

I emailed the consent form to all participants, and they all agreed to take part in the study by inputting their email addresses in the electronic form. All consent documents and email trails were retained on my portable hard drive and kept in a locked, file cabinet drawer. I gathered all the emails after receiving informed consent and before sending the interview questions. As previously indicated, no personal or organizational links that may have impacted the research participants or their experiences surfaced.

Demographics

The main research study had 11 participants. Although data saturation was reached with the first seven subjects, data collection continued through 11 participants. The participants' years of experience spanned 3 to 18 years as maternal health nurses (see Table 2). Other demographic data were not collected. For the primary research study, I used the letter P followed by an assigned number to represent each participant based on the order of the interview dates and times. P1 was the first primary study participant, P2 is the second main research participant, and so on.

Table 2

Years' Experience of the Main Study Sample of Maryland Maternal Health Nurses

Participant	Years of Experience
P1	4
P2	3
P3	7
P4	5
P5	6
P6	5
P7	3
P8	18
P9	13
P10	5

P11	3

Data Collection

For this study, I interviewed 11 participants who were presently employed maternal health nurses in the state of Maryland. Most participants preferred conducting the interview by email, with several citing severe time constraints. They responded to the interview queries to the best of their abilities. I recruited some participants for this study through snowballing, with prior participants referring at least three participants due to the cascade recruitment procedure. After interviewing seven participants, data saturation was attained, but I interviewed four more participants, bringing the total to 11, which was the approximate number of participants sought in Chapter 3. At this juncture, recruiting and interviewing additional participants was no longer necessary. No in-person interviews occurred. One participant was interviewed via Zoom and partly by telephone. More than halfway through the Zoom interview, we experienced a technical difficulty but were able to complete the remainder of the interview over the telephone. The external audio recorder was able to capture the entire exchange with no interruption. I was intentional about notating intonations in the audio participant's voice while they responded to the interview questions. The remaining participants completed email interviews, where the questions were emailed for them to respond confidentially and securely via Google Forms. I submitted any subsequent queries via email as well. It is also worth noting that some individuals corresponded under aliases, while others included identifying information in their communications, such as fragments of their names. All identifiable

information from my notes and technological devices was deleted. More importantly, all identifying information was further safeguarded as specified in Chapter 3.

Due to the expeditious responses of the targeted participants, it took me a little over a month to recruit participants and obtain all the necessary data, allowing for a prompt collection process. This allowed me to begin familiarizing and immersing myself in the data. Although the option remained open, there were no in-person interviews. Individually, the maternal health nurses who responded to the interview questions submitted their responses via emails. All participants answered the same core interview questions, both email and audio recorded, thereby reinforcing the equality of the data collection procedures. After collecting the interview data and becoming immersed in it, I emailed each participant a draft of how I interpreted their answers through a process called member checking and asked them to review the accuracy of my draft interpretations of their individual interview data to ensure their comments had been captured correctly for the study. This process aided the study's credibility. I gave them a week to answer before I moved on to the next data analysis steps. Participants did not disagree with my interpretations of their responses or initiate any ethical debate.

Data Analysis

The initial step I took in the data analysis, more specifically, the explication process, was assigning labels to the participants. I employed the label "P" to denote the participants, assigning numerical identifiers to each participant following the chronological sequence of their interview dates and times. Participant 1 (P1) was

designated as the first participant, whereas Participant 2 (P2) was designated as the second participant, and so on.

I used the software program, MAXQDA, and manual coding for thematic data analysis. I imported the interview transcripts into MAXQDA first, which was followed by open coding to categorize the data. Through this method, I was able to draw insightful inferences from the qualitative data. The first stage in making sense of the data was to apply codes to the participants' responses. Participants' responses to well-defined study questions and their subquestions made it simple to sort through the codes and identify meaningful connections. Excerpts from the data produced were then organized into categories. I aggregated codes that shared references or often occurred across transcripts into apparent patterns that allowed for identifying broad categories and, eventually, themes. These themes became apparent about halfway through the interviews when processing the data and persisted until data saturation was reached.

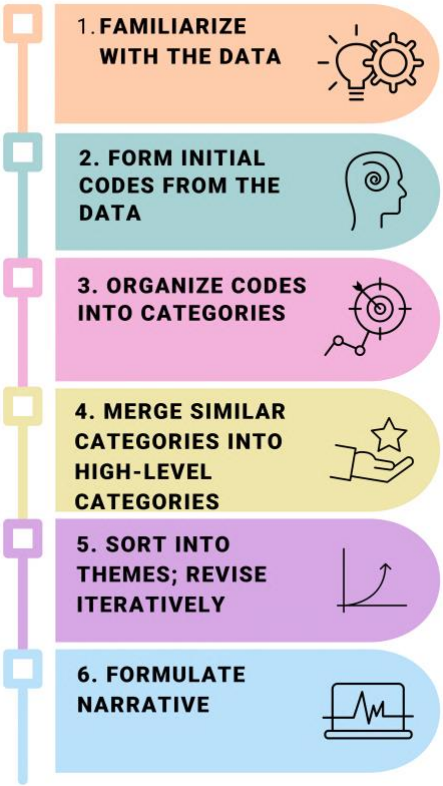
I conducted data evaluation and reflexive journaling continuously during the data collection phase. The data analysis process involved iterative procedures, requiring at least 2 hours each day for 5 days per week. I categorized the participants' repetitive words by applying interpretive and structural coding techniques. Subsequently, I started the more in-depth explication process after identifying distinct categories and themes.

In conjunction with the interview questions, keeping the research questions at the forefront helped me to identify the main categories. According to the interview queries, the primary categories included listening, education, accountability, and collaboration, followed by the identification of the main categories and subcategories. I looked for

patterns in the transcripts, line by line. I employed the thematic analysis approach of converting research data to codes to categories to high-level categories to themes that was aimed to identify patterns in the participants' responses to the research questions, as illustrated in Figure 2 (see Saldana, 2016). The first cycle of coding included the data, coding, and categories in Steps 1 through 4, followed by the second cycle of coding, which included the identification of themes and formation of narratives in Steps 5 and 6.

Figure 2

Thematic Data Analysis Process

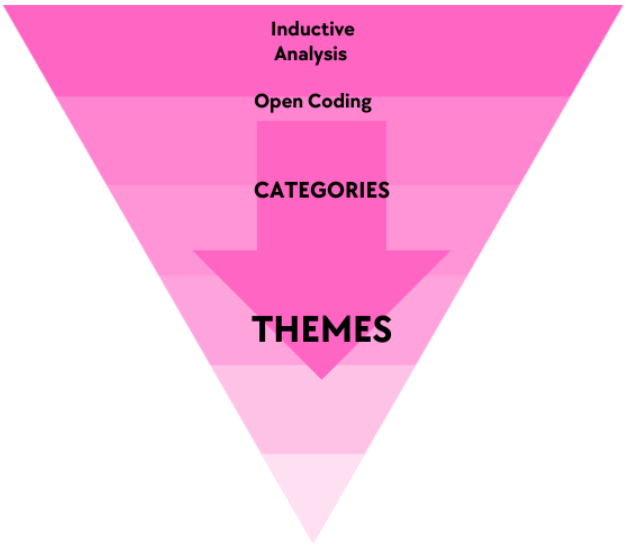


Note. Original figure from source data on thematic analysis processes. From *The Coding Manual for Qualitative Researchers* (3rd ed.), by J. Saldana, 2016, Sage.

To code the generated data and develop themes, I used MAXQDA software along with manual coding. Detailed descriptions of the actions required to complete the comprehensive inductive thematic analysis and add rigor to the study are presented in Figure 3.

Figure 3

Inductive Thematic Analysis Process



Note. Original figure from source data on inductive thematic analysis processes. From "Multi-Level Strategies to Tailor Patient-Centered Care for Women: Qualitative Interviews With Clinicians," by T. Filler, S. Dunn, S. L. Grace, S. E. Straus, D. E. Stewart, & A. R. Gagliardi, 2020, *BMC Health Services Research*, *20*(1), p. 212.

I took the following five steps to develop the emergent themes:

1. Using a Microsoft Excel file, I began organizing and cleaning the interview transcripts. Given that the interviews for the email participants were already transcribed, only misspellings were corrected across the data set. The audio interview was transcribed using Microsoft Word's dictation feature, as well as my follow-up manual transcription. I created 19 (one was a catch-all question) Excel document tabs: one for each interview question. Having 11 responses to the same query in a single Excel sheet tab was a valuable way to easily access the data and establish manual codes, categories, and themes. MAXQDA software was primarily used to organize, electronically code the data, and sort the data into preliminary categories. To become more immersed in the data, I decided to hand code to establish final codes, categories, emergent themes, and final themes.
2. Then, I selected an inductive coding method, also known as open coding, or what is observable or likely to be true. With inductive coding, all classifications are derived directly from participant responses. This differs from deductive coding, which assigns predefined codes to a data set.
3. The qualitative data set was divided into smaller samples based on the interview questions. These samples were read and repeated, and codes were developed to conceal them. I accomplished this by going through the data line by line. For example, when investigating barriers in communicating with Black maternal health patients, I was able to extract nurses' experiences with cultural differences and assign it to the cultural and linguistic barrier category.

4. These codes were categorized and inserted into the coding frame (words and phrases).
5. The most prevalent themes were identified via the more meticulous emergent coding to obtain richer connections. For example, the broader education coding was initial or provisional, followed a more refined theme across the data relating to health literacy barriers. The data saturation point was reached when codes with common points of reference or occurrences in multiple transcripts were transformed into discernible patterns, forming categories and themes. This objective was achieved in the middle of the interviews, which became evident after participant seven completed their interview. There were no discrepant cases identified in the study participant responses.

The resulting themes from Research Question 1 are documented in Tables 3, 4, 5, and 6. The resulting theme for Research Question 2 is documented in Table 7.

Themes for Research Question 1

Theme: Maternal Health Nurses Experience Burnout

Table 3

Codes to Categories to Themes Transition to RQ1: Burnout

Codes	Participants	Categories	Themes
Time and pressure	(1) (6) (7) (9)	Stress and constraints	Maternal health nurses experience burnout.
Sometimes we can get short staffed	(1) (9)	Stress and constraints	Maternal health nurses experience burnout.
A lot of documentation	(11)	Stress and constraints	Maternal health nurses experience burnout.
Carry a lot of stress	(1) (2) (3) (4) (5) (11)	Stress	Maternal health nurses experience burnout.
Stressful especially during the pandemic	(1) (11)	Stress and constraints	Maternal health nurses experience burnout.
Affected physical, mental, and emotional health	(2) (5) (6) (7) (8) (9) (10)	Stress and constraints	Maternal health nurses experience burnout.
Can be draining	(3)	Stress	Maternal health nurses experience burnout.
Left work feeling discouraged at times	(3)	Stress	Maternal health nurses experience burnout.
Limitations in resources	(5) (11)	Constraints	Maternal health nurses experience burnout.
Burden falls on the nurses	(11)	Constraints	Maternal health nurses experience burnout.

Theme: Maternal Health Nurses are Challenged With Cultural and Health Literacy Barriers

Table 4

Codes to Categories to Themes Transition to RQ1: Cultural and Health Literacy Barriers

Codes	Participants	Categories	Themes
Need for culturally sensitive communication strategies and interpreter services	(4) (10)	Cultural, linguistic	Maternal health nurses are challenged with cultural and health literacy barriers.
Different generation	(11)	Cultural	Maternal health nurses are challenged with cultural and health literacy barriers.
Language barriers and cultural nuances can hinder effective communication.	(1) (4) (7) (8) (9)	Cultural, linguistic	Maternal health nurses are challenged with cultural and health literacy barriers.
Difficulty understanding medical language	(8)	Health literacy	Maternal health nurses are challenged with cultural and health literacy barriers.
Hard to find bilingual nurses	(11)	Cultural, linguistic	Maternal health nurses are challenged with cultural and health literacy barriers.
Avoid medical jargon and complex terminology that might confuse or overwhelm the patients	(6)	Health literacy	Maternal health nurses are challenged with cultural and health literacy barriers.
Many do not know the symptoms	(11)	Health literacy	Maternal health nurses are challenged with cultural and health literacy barriers.

Theme: Maternal Health Nurses Foster Patient-Centeredness

Table 5

Codes to Categories to Themes Transition to RQ1: Patient-Centeredness

Codes	Participants	Categories	Themes
Involve them having a sense of control in their care	(2) (11)	Engagement and collaboration; rapport and trust	Maternal health nurses foster patient-centeredness.
Collaboration and partnership rather than telling them how things are going to go	(3) (4) (11)	Engagement and collaboration; rapport and trust	Maternal health nurses foster patient-centeredness.
Emphasis on education and empowerment	(3) (11)	Engagement and collaboration	Maternal health nurses foster patient-centeredness.
Providing patients and their families with comprehensive information	(8) (11)	Engagement and collaboration	Maternal health nurses foster patient-centeredness.
Respect for their cultural background and addressing any potential biases	(5) (6) (10)	Engagement and collaboration	Maternal health nurses foster patient-centeredness.
Voicing commitment to providing personalized care	(7)	Engagement and collaboration	Maternal health nurses foster patient-centeredness.
Offer regular updates on their condition	(4) (11)	Collaboration; rapport and trust	Maternal health nurses foster patient-centeredness.

Theme: Maternal Health Nurses are Key Patient Safety Advocates

Table 6

Codes to Categories to Themes Transition to RQ1: Patient Safety Advocates

Codes	Participants	Categories	Themes
Make the best decisions to reduce mortality and morbidity, monitor fetal status, help with delivery and thereafter.	(1) (2) (4) (5) (6) (9) (10)	Comprehensive care	Maternal health nurses are key patient safety advocates.
Listen and further investigate their concerns.	(1) (2) (5) (7) (8) (10)	Listening, intentionality	Maternal health nurses are key patient safety advocates.
Prevent preterm labor and low birth weights	(11)	Comprehensive care	Maternal health nurses are key patient safety advocates.
Ensure the privacy and safety of patient to provide them with best care	(2)	Comprehensive care	Maternal health nurses are key patient safety advocates.
Teach them how to advocate their positions	(11)	Comprehensive care	Maternal health nurses are key patient safety advocates.
Answer any of their queries and concerns	(2)	Listening, intentionality	Maternal health nurses are key patient safety advocates.
Find out what patients need and meet them where they are	(3) (5) (11)	Listening, intentionality	Maternal health nurses are key patient safety advocates.
Active listening and empathy	(3) (4)	Intentionality	Maternal health nurses are key patient safety advocates.

Codes	Participants	Categories	Themes
Making sure they feel heard, respected, and supported	(2) (11)	Listening, intentionality, comprehensive care	Maternal health nurses are key patient safety advocates.
Provide clear and accurate information about their health, pregnancy, and any potential complications	(4) (10) (11)	Comprehensive care	Maternal health nurses are key patient safety advocates.
Ensuring interventions are appropriate and timely	(7)	Intentionality	Maternal health nurses are key patient safety advocates.
Vigilant in recognizing potential risk factors and complications that disproportionately affect Black women	(5) (6) (7) (11)	Intentionality	Maternal health nurses are key patient safety advocates.
Advocate for policy changes and healthcare reforms aimed at reducing these disparities and improving outcomes for Black maternal patients	(1) (2) (4)	Intentionality	Maternal health nurses are key patient safety advocates.
Act as caregivers for the patient and their advocate	(1) (11)	Comprehensive care	Maternal health nurses are key patient safety advocates.
Prioritize patients regardless of race	(2) (11)	Comprehensive care	Maternal health nurses are key patient safety advocates.
Educate patients on their pregnancy milestones	(11)	Comprehensive care	Maternal health nurses are key patient safety advocates.

Theme for Research Question 2

Theme: HSO Interdepartmental Partnership

Table 7

Codes to Categories to Themes Transition to RQ2: HSO Interdepartmental Partnership

Codes	Participants	Categories	Themes
Communication between different departments	(6) (7) (9)	Collaboration; positive	HSO interdepartmental partnership
Hold regular team meetings	(2) (11)	Collaboration and structure; positive	HSO interdepartmental partnership
Evidence-based program model	(11)	Collaboration and structure; neutral	HSO interdepartmental partnership
Interdisciplinary training sessions	(1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11)	Collaboration and structure; positive	HSO interdepartmental partnership
Language line	(11)	Collaboration and structure; positive	HSO interdepartmental partnership
Standardized communication protocols	(5) (6) (7) (9)	Collaboration and structure; positive	HSO interdepartmental partnership
Incomplete or delayed communication	(6) (7) (9) (11)	Collaboration and structure; negative	HSO interdepartmental partnership
Insufficient cultural competency training	(4)	Collaboration and structure; negative	HSO interdepartmental partnership
Failing to recognize the patient as a part of the decision-making team	(3) (10) (11)	Collaboration; negative	HSO interdepartmental partnership
Evaluations are opportunities for continuous improvement	(4)	Collaboration and structure; positive	HSO interdepartmental partnership
Evaluations are opportunities to engage collaboratively with leadership	(5)	Collaboration and structure; positive	HSO interdepartmental partnership
Allow telehealth	(11)	Collaboration and structure; positive	HSO interdepartmental partnership

Results

The themes that emerged from the collected data and analysis following each of the research questions are as follows:

The four themes that emerged to answer the first research question were that (a) maternal health nurses experience burnout, (b) maternal health nurses are challenged with cultural and health literacy barriers, (c) maternal health nurses foster patient-centeredness, and (d) maternal health nurses are key patient safety advocates.

Theme 1: Experience Burnout

The participants in this study identified themselves as maternal health nurses, labor and delivery nurses, or maternal health professionals. According to Participant 7, there is "limited time for interactions due to busy schedules and high patient load." There are both rewarding and complex parts to being a maternal health nurse. Building trust and making the workplace safe takes more work. Because emergencies can require quick decisions, they can cause a lot of mental and physical fatigue. Nurses deal with many stressful situations as part of their job. Miscommunications, hidden biases, and language barriers get in the way of good patient contact. Language gaps and the need for translators add to the difficulties of the job. Historical mistrust and bias significantly affect the relationship between a nurse and a patient. Tension builds up when there is understaffing, lack of resources, and not enough breaks.

P1, P6, and P9 stated that time constraints and pressure, while being understaffed presented communication barriers when interacting with Black maternal health patients. P7 cited, "Limited time for interactions due to busy schedules and high patient load."

P9 further shared on being "under time constraints, which may interfere with comprehensive communication." Half of the participants, P1 – P5, reported moments of stress and P3 experienced feeling "drain" and "discouragement" following their shifts. P1 and P11 noted that the workload was "very stressful, especially during the pandemic."

To expand, P11 describes how COVID-19 brought about some changes within their organization:

> It was scary. It was scary because we had to do a lot more telehealth. More video. We were 100% in-person, at first. It was good in a way because it lets us know that we can do our jobs without having to "see" you. If you have a phone number and know how to connect to Microsoft Teams or Zoom, we can see you. We can get to you. It was scary, and it just changed a lot. A lot of the clients now don't even like in-person visits because they don't have to arrange transportation and other things.

P2 discussed the tolls associated with being in the role of maternal health nurse: "This workload has affected my physical, mental, and emotional health due to taking care of both mother and baby, making critical decisions and being present in both joyous and difficult moments." Regarding emotional well-being, P5 describes a notable gap in communication protocol as follows:

> Maternal nurses may also face a gap in terms of emotional well-being support. The nature of our work exposes us to emotionally challenging situations, and there might not be a robust system in place to address compassion fatigue,

> burnout, or mental health concerns. This gap could affect nurses' overall job satisfaction and ability to provide optimal care.

P4 explained the physical strain and erratic schedules associated with their experiences in maternal health work; the sentiments were echoed by P6, P7, P8, and P9. Regarding the effects of compassion fatigue on communication with Black maternal health patients, P11 stated:

> The physicians need to listen. The nurses need to listen because, obviously, when they go to the clinic, patients don't see the doctor first. You see the nurse. They tell the nurse all these things, but compassion fatigue or burnout happens. The providers are not listening. They'll say, “Well, that's the part of pregnancy.” What part? That's what I want to know. What part of pregnancy? Patients have to be more probing. Ask why. You need to make sure that the doctor is right.

P11 also discussed experiences in teaching patients to be more self-sufficient when being provided resources and being asked to follow-up:

> When I ask if they have followed-up, the response is usually, “Not yet.” Sometimes, it's like they want you to hold their hand or do it for them, but our organization teaches self-sufficiency, so I can't hold their hands as much. That stresses a lot of the nurses out, just because we do a lot of work with training just to make sure that they have all the tools that they need to be successful and birth to term. And it's hard when they don't follow through. Some of them don't follow through because they “don't feel like it”, or don't have transportation.

Theme 2: Cultural and Health Literacy Barriers

Participants expressed an overwhelming need for emotional support, more uniformity in training on communication protocols, and leveraging resources, including technological solutions. The availability of interpreting services is critical to bridging linguistic barriers. Participant 2 shared that their experiences as a nurse "have underscored the critical importance of cultural sensitivity. To ensure the well-being of pregnant individuals, it is essential that healthcare practices reflect the diverse backgrounds of our patients." P1 described the level of health literacy as "inadequate" when communicating with some patients**.**

P1 stated that "patients are not able to communicate their needs or what they are feeling". Relatedly, P11 noted that patients often "did not know what to say." P1 added:

> Language barriers and cultural nuances can hinder effective communication. Misunderstandings may arise when discussing medical terminology or treatment options.

Along the same lines, P11 discussed the need for more consistent and reliable interpretation services:

> The thing is that most places say they have interpretation services. It's just that when the clients call, they don't get connected. They'll be waiting and never get connected. Sometimes, even their discharge papers aren't explained correctly because if you know this person speaks Spanish or another language, why wouldn't you print out the Spanish version instead of giving them the English discharge?

P10 made the point that “historical injustices in healthcare may breed distrust, impairing open dialogue.” P2 echoed the position of historical mistrust in the healthcare system contributing to cultural barriers. P5 added:

> Some Black maternal patients may have historical mistrust of the healthcare system due to past experiences of discrimination and mistreatment. This can create a barrier to open communication and may require extra effort to build trust and establish a safe and supportive environment.

Likewise, P4 shared:

> In some challenging communication experiences while providing maternal health care to Black patients, I've encountered instances where implicit biases and cultural misunderstandings have created barriers. Despite my efforts to offer accurate information and support, some patients may have felt hesitant to fully engage due to historical mistrust or previous negative encounters within the health care system.

As it pertains to communicating the impact of systemic disparities to Black maternal health patients, P5 stated, “it can be difficult and may evoke frustration or feelings of helplessness.”

P11 added that it is important for doctors and nurses to talk the maternal health patients through what is happening throughout care because many “do not know what is going on”, and “do not know what you think they know.” P11 went on to discuss the stigma associated with patient home visits:

> Some patients don't want you in their house for home visits because they may be ashamed, or there may be too many people around in their living quarters. I noticed that appointments get cancelled because some clients say that they don't have enough chairs, or they may be living with their parents. I just know that they keep more appointments when they are virtual. Many will not get prenatal care because they do not want a bill.

Theme 3: Foster Patient-Centeredness

Participants described the need to enhance patient and family participation in obstetric care. Guidelines should be developed to give specific individuals receiving care and their loved ones a voice in all decisions that affect them. As stated by P4, "Prioritizing a patient-centered approach in communication can greatly enhance maternal care. Encouraging health care providers to actively involve patients in discussions, share information in understandable terms, and address their preferences fosters a sense of empowerment and strengthens the patient-provider relationship."

Improving patient and family participation is a part of maternal care practice. P7 talked about acknowledging the patient's perspective to help "foster a connection." P11 describes partnering with the patient on education:

> We do milestones reminders every month, like, "Hey, you're 30 weeks pregnant. This is what you need to be expecting." We connect with them via weekly texts about where they are in their pregnancies. We connect them on how to count their kicks. To them, it's a big thing now that a lot of times you can prevent fetal and

> maternal mortality. So, we're teaching them that - the educational piece. This education is something that they must want and desire because it's voluntary.

As stated by P3, communication style has led to some positive experiences with Black maternal health patients:

> My successful experiences in communicating with Black maternal patients often involve them having a sense of control in their care. My style of communication with patients is one of collaboration and partnership rather than telling them how things are going to go. I make it clear what to expect and keep them informed as things change as they often do.

Also, P6 described successful experiences in communicating with Black maternal patients as being "built upon a foundation of empathy, cultural sensitivity, and active listening."

Nonverbal cues are critical in how P7 communicates with patients to signify engagement and active listening by "giving the patients full attention, maintaining eye contact and also nodding to show I understand their expression."

P11 discussed encouraging patients to learn about their bodies, what pregnancy is about, and being "their own primary advocate." The participant further emphasized on allowing patients to advocate for themselves:

> Swollen ankles, huge. You're seven months pregnant. You have preeclampsia! You need to go get tested! They need to know the symptoms, what's normal and what's not. As the patient, you need to learn your body. You need to know nutrition wise what you need to do. You need to know that Black and brown

> people are subject to high blood pressure. We have gestational diabetes more because of our diets. You need to know these things. The patient needs to learn that *they* need to advocate. It's not a game.

Theme 4: Key Patient Safety Advocates

According to several participants, addressing the voids in the communication protocol, providing expectant patients and their families with the appropriate training and support, and implementing technological solutions may enhance the quality of care provided to maternal health patients and their families. As explained by P9:

> Effective communication is critical in maternity care to ensure that healthcare providers work cohesively, deliver timely and correct information to patients, and address any issues quickly. Clear communication reduces misconceptions, reduces medical mistakes, and develops confidence between healthcare practitioners and patients.

P2 and P10 reported on guiding and "advising" maternal health patients through their care, respectively. P7 noted that it is their "duty is to educate parents." P4 shared that emphasis is placed on patient "education and empowerment." Active listening, as shared by P10, is a critical communication component in "emphasizing the relevance of trauma recognition." According to P11, "taking patients at their word" is practiced but, however, describes having patients "lie and state that they had been going to their prenatal appointments and we find out that they had not when we follow-up with the doctor to get their history." P3 describes listening as "most important," elaborating that as a maternal health nurse it is imperative to truly understand what is being shared by the

patient and asking follow-up questions when needed. P2 emphasized the need to “exhibit compassion to patients during the pregnancy and postpartum journeys.” Additionally, P5 stated that providing patients emotional support is a part of comprehensive care and coordination.

P11 describes outlying generational barriers and servicing younger patients, between ages 13 and 24, that are “very, very unlikely to be heard.” P11 also stated that some of the patients have mental health conditions, such as anxiety or depression, that must also be considered in the treatment plan. The participant expanded:

> I would say at least 80% of our clients have some type of mental health disorder, so I would say when we get to know our clients (this person had depression from childhood, this person anxiety, this person is always stressed), we refer them and link them to all support services.

Further along the lines of patient self-advocacy, P11 shared:

> There are a lot of doctors that push people into C-sections that don't need them. Scheduled C-sections because it's quicker. They don't have to wait all day, and it's more money. I always tell the patients to advocate for themselves. If you don't get a serious diagnosis where something's wrong, do not have it.

P5 reflected on the continuity of care through to the delivery. P4 particularly noted the importance of ensuring that the tone “is reassuring and supportive, fostering a safe space for open dialogue.” P4 stated, “I take the time to understand their worries, address their questions, and provide clear and accurate information about their health, pregnancy, and any potential complications.”

There are still some additional challenges in finding balance in recognizing the systemic healthcare issues and establishing trust and rapport with Black maternal health patients. P6 shared that there is usually an "initial hesitation" from the patient due to systematic factors. P11 inserted that helping patients have successful pregnancies and getting them the help that they need is essential. As indicated by P5, "Striking a balance between acknowledging these issues and instilling hope and empowerment requires a delicate approach to ensure effective communication and patient advocacy."

The theme that emerged to answer the second research question is (e) HSO interdepartmental partnership.

Theme 5: HSO Interdepartmental Partnership

HSO liaisons can help to improve communication management. Based on P11's experiences on acting as a liaison between doctor and patient:

> It would help me if the doctors listened to the patients more instead of the patients asking me, and then I'm having to refer them to the doctor. That is a gap because, as a nurse, I can't diagnose you. The doctor must. I can tell them what to tell a doctor, but it's up to the doctor to hear what the patient is saying. I shouldn't have to tell them what the patient has to say. Why doesn't the doctor know firsthand? For virtual clients, there can be several symptoms they tell us, but as soon as you notify a doctor, they're like, "Tell them to go to the ER."

P9 described experiences in seeking out nuanced understandings from culturally competent coworkers in various scenarios. P1 discussed "open door policies", while P5 added, "If necessary, I connect them with other healthcare professionals or specialists for

further evaluation and treatment, ensuring a holistic approach to their care and well-being."

Along the same lines, P1 elaborated on consulting "with supervisor and colleagues along the way on best decisions to make for the patients' well-being."

Mentorship was highlighted by P4:

> Structured mentorship programs or regular supervision sessions allow me to engage with experienced maternal health nurses or clinical leads. These interactions provide a space to discuss complex cases, seek guidance, and receive feedback on my performance. This support system contributes to my professional growth, helping me carry out my responsibilities with increased confidence and competence.

P11 discussed experiences with scheduling constraints within the HSO, which affects a patient's ability to have the appropriate open dialogue with the provider:

> A lot of our patients go to the doctor, have all these things they want to talk about, and they don't get to ask their questions within a short 10–15-minute slot. They don't get to ask their questions. You can now send doctors messages virtually at some places. A lot of offices are equipped where patients can download their charts. Doctors and OBGYN's that are taking on these clients need to not be overworked. They probably have so many patients, and they can't really give the patients what they need.

Accountability of health services organizations' roles and responsibilities is very important in caring for maternal health patients. Some of the supporting statements made

by the participants (maternal health nurses) include one made by P5 who shared, “Introducing daily or shift-specific team huddles can facilitate quick updates, address concerns, and ensure everyone is on the same page. These brief meetings can enhance communication among care team members and help identify any potential issues before they escalate.”

P6 added on integrating technology solutions, which can “significantly enhance communication in maternal care settings.” P8 stated that HSOs may employ the use of data analytics to “give insights about communication trends and opportunities for development. This data-driven strategy assists leaders in identifying communication bottlenecks and tailoring improvement initiatives.” Also, regarding the use of advanced technology, P7 inserted that telehealth platforms “allow health care providers to conduct virtual visits with pregnant patients, ensuring regular check-ins and addressing questions or concerns without the need for in-person appointments.” P10 discussed the importance of patient portals to help patients to “remain informed and involved along their health care experience.”

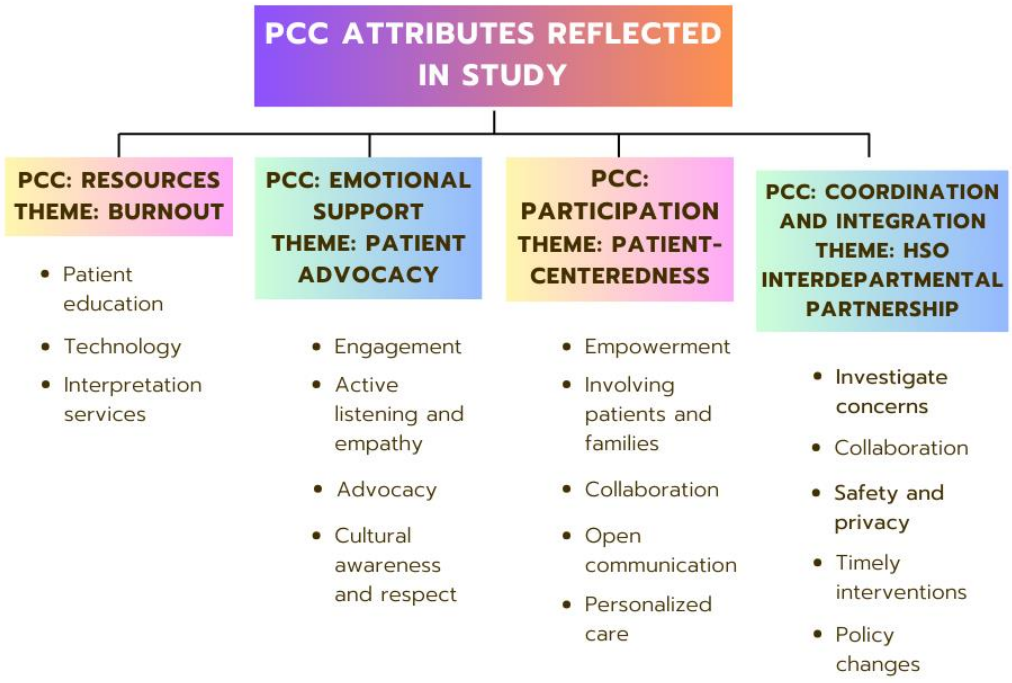
PCC

Finally, this study's finding confirmed the importance of PCC (refer to Figure 4). Instead of concentrating simply on the patient’s condition, PCC emphasizes the patients themselves. Patients and health care professionals ought to have a close, deeply established connection in which they are familiar with one another, trust one another, and collaborate to determine the most effective method of medical care. Patients are given more autonomy under the PCC model, in which decisions on their treatments and

evaluations of possible courses of action that would be most beneficial to them are made jointly with the patients. Care centered on the patient veers away from the policies of "one size fits all" that do not always lead to problems being solved completely. Since complications, unnecessary emergency room visits, and preventable diseases can be prevented with early, individualized, and preventative care, PCC is responsible for reducing health care spending and improving patient outcomes.

Figure 4

PCC Attributes Reflected in Study



Note. Original figure based on study findings and source data on the PCC tenets. From "Patient-Centeredness and Consumerism in Healthcare: An Ideological Mess," by T.

Latimer, J. Roscamp, & A. Papanikitas, 2017, *Journal of the Royal Society of Medicine*, *110*(11), pp. 425–427.

Evidence of Trustworthiness

The trustworthiness of a study is established when a qualitative researcher effectively exhibits the meticulous, consistent, and comprehensive execution of data analysis through the systematic recording and organization of the data analysis process. To establish credibility, I provided a comprehensive account of the data analysis methodology, offering sufficient information for the reader to assess its reliability. Trustworthiness was established in this fundamental qualitative investigation using credibility, transferability, dependability, and confirmability.

Credibility

Credibility refers to the level of confidence a qualitative researcher has in the veracity of the findings derived from a research study. The term "interpretive accuracy" refers to the degree to which a researcher accurately portrays or represents the reality being studied. To maintain the credibility of the research, I diligently maintained a reflexive journal, actively sought peer review, engaged in prolonged engagement for the audiotaped participant, and colleague debriefing. These measures were used to mitigate the potential influence of bias on the collected data. Credibility was established in the study by implementing standardized questions administered to all participants. Additionally, I implemented a procedure known as member checking to validate the data, whereby participants were asked to confirm the accuracy and authenticity of their statements. Participants were allowed to actively correct any inaccuracies that may have

been introduced inadvertently during the writing process. I employed the utilization of follow-up questions by email, when appropriate, to obtain more information. Individuals' ability to elucidate collected data further through the member verification procedure strengthens the analysis.

Transferability

Transferability refers to the ability to apply findings from qualitative studies to other contexts or populations, allowing for generalization. This implies that research outcomes obtained in one geographical setting can be used in a different scenario and setting. The data collection method's context is crucial in shaping the data, resulting in limited transferability in qualitative analysis. The utilization of purposeful sampling is crucial in addressing concerns related to transferability. No modifications were implemented that might impact the transferability of the study. I employed purposeful sampling and snowballing techniques to choose and enroll individuals for the study. A total of eleven maternal health nurses were selected as participants for this study, which was deemed sufficient to achieve data saturation. The demographic included in this study is the number of years of experience. The appropriate description used quotations from essential categories and concepts to ensure a thorough portrayal. This study is expected to yield consistent results when replicated under the same settings. Therefore, it is important to consider the context, the people involved, and their experiences, before drawing any broad conclusions.

Dependability

Dependability is a crucial aspect of research as it signifies the reliability and credibility of the findings, indicating that they can be replicated and remain constant over time. For instance, consider a scenario where another individual is provided with identical unprocessed data and draws an identical inference. I employed peer review and debriefing techniques to ensure the study's reliability. The data corresponded with the research questions. Whether provided to a different individual, the identical set of raw materials will yield consistent results, interpretations, and conclusions throughout the research process. This study's research methodology was defined by a logical and methodical approach and a thorough documenting process that ensured traceability. This rigorous technique was designed to assist other researchers in using the project's findings and independently replicating the study.

Confirmability

Confirmability refers to the extent of objectivity and impartiality in the conclusions of a research investigation. Confirmability, as the term suggests, pertains to the extent of outcome validation or verification by other parties. When doing research, it is customary to document the methodology employed in the research process. Another researcher may replicate your study by adhering to the experimental protocol. This technique will guarantee that the required protocol is followed and that the desired outcome is attained. Reflexive journaling and peer debriefing were employed to uphold this investigation's confirmability and protect this research from personal bias. I used reflective journaling to document the study process, noted personal bias, and made

methodological decisions to increase confirmability. I produced memos to capture the reasoning for each stage and facet of the research and trace how interpretations and conclusions were reached. I aimed to show how the interpretations were drawn from the data and how I arrived at the findings.

Summary

The two research questions showed that Maryland maternal health nurses share similarities in their communication experiences with Black maternal health patients, as well as in how they have experienced HSO support. The overarching themes of the study showed that there may also be a lack of emotional well-being support for maternal nurses. Participants shared that they may be lacking the educational, training, and staffing resources and support necessary to address issues such as compassion fatigue, exhaustion, and mental health concerns contributing to overwhelm and possible miscommunications.

Research question 1 aims to gain insight into the specific encounters experienced by maternal health nurses in Maryland concerning their interactions when communicating with Black maternal health patients. This inquiry was intended to gather stories from participants that encompass positive, negative, and neutral perspectives on a crucial aspect related to maternal mortality and morbidity in Black women.

Research question 2 is a subquestion that investigates the firsthand experiences of Maryland maternal health nurses regarding the assistance they receive from their various HSOs while fulfilling their duties in providing care for maternal health patients.

Chapter 3 provided a thorough description of the data-collection strategy, and Chapter 4 covered the execution of that strategy. There were no significant deviations during the data collection. Purposive sampling was used to choose participants from the specified area using the predetermined inclusion and exclusion criteria. Chapter 4 addresses the pilot study, breakdown of participants, results and study findings, and the development of themes from codes and categories. The four themes that emerged to answer the first research question were that (a) maternal health nurses experience burnout, (b) maternal health nurses are challenged with cultural and health literacy barriers, (c) maternal health nurses foster patient-centeredness, and (d) maternal health nurses are key patient safety advocates. The theme that emerged from the second research question was (e) HSO interdepartmental partnership. Undoubtedly, the selected thematic analysis method was appropriate for the study. This is a structured procedure for analyzing data to recognize patterns in the participants' responses and relate the findings to the research questions posed regarding the topic at hand. Chapter 5 will include an interpretation of the findings, limitations of the study, recommendations, and implications of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

In this qualitative, hermeneutic, phenomenological study, I explored Maryland nurses' lived experiences with communication, operational procedures, and organizational leadership support while caring for Black maternal health patients. The goal was to use the PCC conceptual framework to increase understanding of processes and determine if there was a potential communication disconnect and lack of leadership roles and support, which could be driving the high maternal mortality and morbidity health crisis afflicting Black maternal health patients in the United States. Participants were asked to briefly describe what immediately comes to their minds regarding the Black maternal mortality and morbidity crisis. Some of their responses are displayed in Appendix C. Most of the current study participants cited a heightened awareness in how they engage, support, listen, educate, and advocate for maternal health patients, given the disproportionately high rates of mortality and morbidity in Black women. The themes resulting from this study were compared with similar findings across the literature. A literature review centering on the social problem that non-Hispanic, Black women are up to 4 times more likely to die from pregnancy-related complications than their non-Hispanic, White counterparts (Hoyert, 2023) was conducted and revealed that patient-provider communication in health care settings, specifically regarding nurses and Black maternal health patients is lacking (Güner & Ekmekci, 2019). The current study findings can promote positive social change and serve as a foundation for gaining a deeper understanding of access and delivery coordination, which may lead to poor maternal health outcomes and experiences. This study might also pave the way for researchers to

investigate further enlarged population segments of U.S. public health care organizations' communications tactics outside of Maryland (see Alexander & Clary-Muronda, 2022; Alio et al., 2022; Vedam et al., 2019).

Key Findings

The following research questions were addressed in this study:

RQ1: What are the lived experiences of Maryland nurses concerning communication in caring for Black maternal health patients?

RQ2: What communication supports have been implemented among leadership for Maryland nurses that may reduce communication lapses with Black maternal health patients?

The analysis of the data revealed four themes that emerged to answer the first research question: (a) maternal health nurses experience burnout, (b) maternal health nurses are challenged with cultural and health literacy barriers, (c) maternal health nurses foster patient-centeredness, and (d) maternal health nurses are key patient safety advocates. The second research question revealed HSO interdepartmental partnerships, although present in various participants' settings, is lacking in consistency in some respects, such as delayed communication and interventions, as well as the lack of baseline uniformity in care plans. The theme that emerged to answer the second research question was (e) HSO interdepartmental partnership, both positive and neutral aspects.

Interpretation of Findings

The goal of this study was to fill the research gap on the topic that was identified in the literature review. This study revealed that Maryland nurses collaborate with HSO

interdepartmental support systems and training to actively engage, educate, and communicate with maternal health patients; however, several significant obstacles can impact communication effectiveness, including time constraints, personnel shortages, and lengthy hours contributing to nurse fatigue. In addition, the nurses have recognized their duties as crucial patient safety advocates in providing comprehensive patient care and enhanced decision making. Due to language, health literacy, and cultural barriers, this poses a unique set of difficulties. The existence of these issues has the potential to impact the overall job satisfaction of nurses and their capacity to deliver optimal care. As indicated in the literature review, a large body of research has suggested that nurses and expecting Black American women communicate poorly (Güner & Ekmekci, 2019). The findings of the current study emphasize nurses' interpersonal communication skills, conscious reflection, and maternity care for Black women in Maryland. Black maternal health patients have been described as lacking communication procedures during delivery, and in this HSO-centered study, I examined maternal health nurses' lived experiences of this phenomenon.

In the current study, most participants agreed that a lack of resources, such as staffing shortages; time constraints; and navigating cultural, linguistic, and health literacy obstacles, contributes to overall nursing burnout. What was most surprising and had not been previously documented in the literature, was the nurses' experiences with the absence of interpretation services to help bridge cultural and language gaps. This may have direct effects on communication practices with Black maternal health patients. The participants often asserted that patient mistrust is a crucial factor to consider in this

investigation. Considering the statistics, most participants acknowledged the intentionality of their multidisciplinary training and their active listening abilities when interacting with Black maternal health patients, especially given what is known about the targeted population.

Experience Burnout

Being a maternal health nurse has both gratifying and demanding aspects. The process of cultivating trust and creating a secure workplace necessitates further exertion. Emergencies can induce significant mental and physical fatigue due to the extended duration and imperative nature of the decision making involved. The role entails nurses being exposed to a range of emotional experiences, requiring the implementation of stress management techniques. Obstacles like communication delays, hidden biases, and language limitations hinder successful patient communication. Based on the findings from this study, nurses cited historical distrust and prejudice having a significant impact on nurse-patient interaction.

As also detailed in the literature, the current study participants noted the presence of many patients and a scarcity of breaks as factors that lead to the development of tension. The presence of communication impediments, such as differences in language and the necessity for translator resources, further compounds the challenges associated with the profession. It is worth noting that two participants (i.e., P1 and P11) made mention of the COVID-19 pandemic resulting in heightened levels of work anxiety and higher expectations. The presence of physical and mental fatigue, significant time

commitments, and the potential for personal fulfillment can be used to characterize the maternal health nurse occupation.

Cultural and Health Literacy Barriers

Based on the findings of this study, it is deemed necessary to offer maternal nurses emotional support, instruct them in communication protocols, and implement technological solutions. The study also revealed that the availability of interpreter resources is crucial in helping to bridge language barriers. From the HSO viewpoint based on this study, regular team huddles, meetings, forums, collaborative engagement, and resource support must address insufficient patient and family engagement, limited historical bias awareness, and inadequate or delayed interdepartmental communication. Participants stated the ongoing trainings in cultural competence, mentoring, supervision, feedback loops, and appropriate guidelines enhance communication. Additionally, these internal training practices assist in early intervention and aid job satisfaction.

Foster Patient-Centeredness

During prenatal appointments, the family of a pregnant patient must communicate with the maternal health nurse; however, communication protocol gaps are common, especially when families are involved. Implementing organized handoff procedures during shift changes and ensuring the availability of suitable platforms for in-person communication among health care professionals can address this issue. Nurses may find connecting successfully with patients of varied origins simpler if they get proper cultural competency training. Providing them with the training and tools they need to improve their communication skills is critical. According to the literature, there appears to be a

mutual interest in more patient-centeredness, but there remains the issue of trust in patients not feeling confident in sharing their concerns with the maternal health staff (Eide & Feng, 2020). Improving patient and family engagement in maternity care is essential. It is critical to create standards to ensure that patients and their families are adequately included in care decision-making. Based on the findings of this study, the element of patient-centeredness places some responsibility and autonomy on the patient to become more informed and engaged in their pregnancy journeys. The study also highlighted that regular HSO roundtable conversations can also help develop a consistent patient care approach.

Key Patient Safety Advocates

This study's findings reveal that it is essential to have a well-structured feedback loop in place for the evaluation of communication to guarantee continual progress. Improving maternity care communication requires all relevant stakeholders to collaborate and engage in collaborative activities. The findings highlight that is critical to provide professional counseling, implement structured handoff procedures during shift changes, promote a unified approach to patient care, create appropriate communication platforms, establish a structured mentorship program, involve families in care decision making, and facilitate HSO roundtable discussions for updates and insights to improve communication in maternal care. Based on the emergent opportunity gaps illuminated within the study, other necessary steps include creating appropriate communication platforms, promoting a unified approach to patient care, creating appropriate communication platforms, and providing professional counseling. By addressing the gaps in the communication

protocol, giving pregnant patients and their families the proper training and support, and incorporating technology solutions, the quality of care provided to these patients and their families may improve.

HSO Interdepartmental Partnership

The participants' experiences highlight the importance of HSOs providing comprehensive prenatal and postnatal care to expecting moms. The findings indicated the need to hold regular meetings to assess patient concerns, protect privacy and confidentiality, collaborate on treatment strategies, and give emotional support. The study findings revealed that inequities in health care resources can have an influence on communication in addition to financial challenges and inequities in access to health care services. According to Maryland nurses, providing training, particularly for communication protocols and leveraging analytics, can reveal communication trends and opportunities for improvement. Due to the burnout expressed by the participants, it is emphasized that nurses require extra emotional care and resources because they regularly endure exhaustion and physical pain. Integrating technological solutions can significantly improve maternity care communication. Virtual assistants can be utilized for work unrelated to reproductive health, giving nurses more time to focus on patient care, as evidenced in this study. A systematic mentorship program might also be created to improve nurses' communication abilities. The study's findings showed the need for recording postpartum care, family planning, attending high-risk deliveries, and supporting breastfeeding. Improved communication, cooperation, and monitoring of the health and well-being of both the mother and the baby provides opportunities to lessen

the likelihood of misunderstandings and mistakes. The need to be up to date on medical practices and policies and fight for patients is also emphasized, according to the results of this study.

Communication across departments should be improved to avoid miscommunication and delays in patient care, as evidence in this study's findings. Based on the HSO gaps expressed by the participants, regular feedback channels and team meetings may assist in addressing these concerns and ensuring everyone on the team is on the same page. Regular team meetings and evaluations improve communication in maternity care settings. Integrating technological solutions, such as appropriate platforms and encrypted communications, may dramatically increase cooperation. It is vital to collect input and address the problems of Black maternity health patients. Role-playing, simulations, and ongoing education can develop communication skills. Implementing remote monitoring devices and telehealth platforms can enable real-time evaluations and check-ins with patients. Regular communication audits, roundtable discussions, and root cause analyses drive continuous improvement. And importantly, HSOs should have functioning and accessible interpretation staff and services available, which is a critical gap area uncovered in this study.

Limitations of the Study

The first limitation of this study was that most participants chose to take part in email interviews instead of Zoom, phone, or in-person interviews. Only one participant completed an audio-recorded interview. Although the data from email interviews were extensive, in-person or audio-recorded interviews may have provided additional

information not disclosed in an email interview for future research. Body language, for example, was not analyzed for the participants. I was able to observe intonation with the audio-recorded interview participant.

The second limitation was the very small sample size of the study. The limited sample size may not be representative of the larger population. My objective with a limited sample size (of at least 10 maternal health nurses) was to reveal a range of viewpoints while limiting the sample size to the point of saturation (see Ravitch & Carl, 2020). The qualitative method employed hampered the research, and the results could only be extrapolated among the participants (i.e., generalizability). I recruited one more participant than expected, increasing the number from 10 to 11, and five robust themes emerged from data analysis.

The study's geographical location, Maryland, also offered certain limitations. This study design did not enable maternal health nurses outside of Maryland to share their experiences. The participants were based in Maryland and had prior experience there. I selected Maryland as the location for this study because its maternal death rate falls into the moderate-to-high-risk category among U.S. states (National Center for Health Statistics, 2021). As a result, transferability may be a limitation of the study. Transferability suggests that the findings of this study should apply to comparable findings under the same study settings (see Ravitch & Carl, 2020). Demographics and the geographical location of the study are two factors that may skew its transferability.

My status as a novice researcher and PhD candidate must also be acknowledged as a limitation to this study. To conduct unbiased research, I used a reflexive journal and

peer review to keep my biases as a researcher under control. A negative delivery experience has directly impacted me. The peer review was aligned with the data analysis because the peer reviewers had no personal investment in the maternal health area of research. Any outside variables did not impact the peer review.

Recommendations

This qualitative study uses the PCC conceptual framework to increase understanding of processes and determine if there is a potential communication disconnect and lack of leadership roles and support that may be driving the high maternal mortality and morbidity health crisis afflicting U.S. Black maternal health patients. This study established a firm basis for future researchers to advance maternal health research in health service delivery. Table 8 presents some critical areas that offer room for improvement in how maternal nurses communicate with Black patients, with the support and partnership of their respective HSOs and multidisciplinary care teams.

Table 8

Some Opportunity Areas for Improving Communication Between Maternal Health Nurses and Black Patients

Key Areas for Improvement
Time constraints
Pressure and stress
Physical, mental, and emotional well-being of maternal health nurses
Lack of resources
Heavy workload and administrative burden
Unreliable interpreter services and bilingual staff
Generational gaps not recognized
Patient health literacy
Cultural and language barriers
Patient responsibility
Physician and OBGYN presence
Ongoing communication with patient and regular updates during care

Leverage technology
Training and consideration of non-verbal queues
Patient empowerment
Attentive listening and engagement
Investigate concerns further
Empathy
Provide clear and concise information and resources
Respect and support
Early prevention and intervention
Incomplete or delayed communication
Interdisciplinary team briefings
Telehealth
Training and collaboration across departments
Openness to patient-centeredness

Recommendations for future research include repeating the study with most participants consenting to an audio or in-person interview. Body language or tone during face-to-face and audio interviews may give more information than an email interview and may generate more follow-up questions than an email interview. This study could also be repeated using a focus group format for discussions with maternal health nurses.

While state-by state research would be beneficial, as each vary by risk category and unique set of challenges, it is also suggested that the research be conducted with maternal health nurses throughout the United States, with no state limitations. This could help explain the relationship between maternal health nurses in public hospitals and clinics and Black women maternal patients and nurses' experiences with organizational leadership roles and support and state health service organization communication processes. It is also suggested that gender, age, and race be collected and included in the demographic data, as it could provide additional insights for all analyses.

Other maternal health multidisciplinary team members, such as doulas, midwives, nurse-midwives, and maternal health support professionals (e.g., sonographers, healthcare administrators, and anesthesiologists administering epidurals), should be studied further. This would broaden the investigation of perspectives, which was previously confined to solely maternal health nurses in this research. Even more, HSOs should consider conducting a needs assessment to further extract in-house opportunities for uniquely targeting and addressing maternal health communication. HSOs should ensure that additional resources are within "arms-reach" of the maternal health nurses, such as access to reliable interpretation services and other various health subject matter experts involved in the patients' overall care.

Further, on the other side of the health services scope from the HSO perspective, another recommendation for further study is to explore the value of patient-centeredness in maternal health care and how it has impacted communication from the patient's purview. Collectively, these recommendations would help to advance the health services field in relation to the Black maternal mortality and morbidity crisis (see Implications section).

Implications

Positive Social Change

According to the American Nurses Association (2018), nurses are the glue of healthcare services who hold the patients' health journey together. Positive social implications of this study include enhancing nurses' communication with Black maternal health patients by promoting open dialogue, involving families, and empowering patients.

This awareness may aid against miscommunications and provide a solid foundation for early interventions through intentionality, awareness, active listening, and engagement. The study could provide HSOs with information on how to enhance the performance of maternal health nurses on multidisciplinary labor and delivery teams. It is essential to emphasize cultural competence training and seminars to reduce prejudice. HSOs could leverage technology by utilizing modernized patient portals and electronic health record systems to provide real-time access to data and care plans, thereby reducing communication delays and lapses.

The findings of this study could contribute to the field of maternal health through the lens of health services and delivery by casting a focused light on the communication component among Black maternal health patients who did not feel heard, which required further investigation. This research filled a unique research gap and generated enlightening perspectives based on the actual experiences of active maternal health nurses. Patients, their families, nurses, and HSOs could be encouraged to implement patient-centered solutions that positively impact the disproportionately high maternal mortality and morbidity rates affecting Black women in Maryland and beyond. This study contributes to research by identifying the technological and social obstacles that afflict the maternal health field. It informs us of what has worked well for nurses and HSOs in Maryland and what areas require further development or attention.

Participants documented positive accounts of patient-centeredness and family involvement in the care process. There must be greater coherence and purpose between the educational component and the explanations given to patients. Cultural and linguistic

barriers can still be overcome with sufficient bilingual personnel and dependable interpretation services. Intentional measures must ensure that patient discharge documents and correspondence are translated into their preferred language. The comprehensive nature of maternal care necessitates the utilization of technology in conjunction with a heightened level of awareness and empathy among multidisciplinary staff. Individualized patient care should not begin and conclude with the contributions of nurses alone; multiple working elements must be well-informed and briefed.

This investigation aimed to provide valuable insights for HSOs in their efforts to support nurses in caring for Black maternal health patients. The investigation is grounded in the philosophical perspectives of Heidegger (1962), Becker (1973), and Sartre (1984), which emphasize the inherent presence of individuals in the world and their existential circumstances, the pursuit of wholeness, and the personal responsibility individuals hold for their own lives. It is anticipated that HSOs will derive practical knowledge from this investigation to assist this population more effectively. This study serves as a guide, and HSOs must examine their programs separately to determine which components must be strengthened and staffed (see Table 8). Given the heavy burden on maternal health, nurses, physicians, and OBGYNs should be more prominent, particularly in high-risk cases, rather than the nurse acting as the solitary liaison, where miscommunication is possible. Since Maryland falls within the moderate-to-high risk category for maternal mortality and morbidity rates, this study determined which aspects of nurses' experiences are well-considered and which are not.

Positive social effects of this study include imploring HSOs, maternal health nurses, and other multidisciplinary team members for maternal care to be more aware of the roles and duties of the maternal health nurses on an interdisciplinary team. This knowledge could help health care workers on a diverse care team better coordinate care, collaborate across disciplines, and make the best decisions. If maternal health nurses are supported in their roles and responsibilities with adequate staffing and resources (e.g., interpretation services), it could help improve the level of care and make it easier for pregnant Black patients to receive timely and optimal health services. The study could guide HSOs in improving interactions between Black maternal health patients and their nurses, as well as other multidisciplinary maternal care team members. HSOs should use multidisciplinary teams to address the communication blind spots mentioned in this study based on the experiences of working maternal health nurses and through a more refined needs assessment specific to their organizations' maternity departments.

The results of this study could help HSO decision-makers in hospitals and clinics best utilize the unique skills of maternal health nurses as educators, advocates, and providers of well-coordinated care to maternal health patients with the help of doctors, OBGYNs, modern technology, and support from other members of the multidisciplinary team to avoid any communication lapses. This research clarifies the need for roles, responsibilities, and tasks to be clearly defined and staffed so nurses are energized, potentially resulting in improved communication. With maternal health nurses often being the first and most crucial point of contact for maternal health patients, it is even more important for the doctors or OBGYNs to have an increased presence in hearing

patient concerns. The results of this study may also help HSOs address the communication gaps that have been found and use a higher level of awareness to improve the organization of care so that it is more patient-centered, educational, and collaborative and prepares patients for the best health possible.

Conclusion

The use of proficient and operational HSO interdisciplinary teams has significant importance in assisting nurses responsible for caring for Black maternity health patients. Based on the findings of the literature review, it is evident that there exists a substantial body of evidence documenting the phenomenon of Black patients expressing feelings of being unheard and recounting near-miss situations within the health care system. However, it is essential to note that the viewpoint of maternal health nurses about their communication experiences still needed to be explored, hence this study. In the context of critical care, the occurrence of communication failures has the potential to result in poor and unexpected outcomes. The literature review presented persuasive information indicating that the communication between nurses and Black maternal health patients is severely insufficient. This qualitative hermeneutic phenomenology study aimed to investigate the lived experiences of maternal health nurses in their communication with Black maternal health patients to help add to the body of knowledge for this unique gap. This study is significant as maternal health nurses are typically the initial point of contact and maintain proximity to pregnant patients throughout their care journeys. Additionally, it was necessary to assess the extent of assistance HSO provided to address communication deficiencies.

Nurses can cultivate trust, mitigate problems, and promptly implement interventions by participating in self-reflection and reflexivity. Based on the accounts provided by the participants, it can be inferred that burnout among maternal health nurses primarily arises from stress, resource limitations, and time limits. Maternal health nurses have difficulties with cultural and health literacy, leading to potential adverse effects on communication. Maternal health nurses endeavor to create a patient-centered atmosphere - empowering patients, and their families to actively participate in their treatment journeys. Maternal health nurses are often seen as crucial advocates for patient safety, assuming the significant role of liaising with patients and other members of the maternal multidisciplinary team, especially physicians and OBGYNs.

The HSO multidisciplinary team structure relies heavily on maternal health nurses. However, there are significant areas for improvement in delayed communication, inadequate cultural competence training, unreliable translation services, and a reluctance to adopt a patient-centered approach. The study results provide evidence to substantiate the assertion that there are deficiencies in the communication between nurses and pregnant Black American women in several crucial domains. The issue of time restrictions is a significant challenge for both maternal health nurses and patients. Nurses sometimes need more time to effectively communicate with physicians or obstetricians, while patients have limited opportunities to address their inquiries within restricted time frames.

This research provided firsthand accounts of a small sample size of nurses in Maryland on their experiences with communication while providing care to Black

maternity health patients. Additionally, the study explored the measures HSOs use to address communication challenges in the context of Black maternal health patients. The study's findings indicate that further support may be needed to assist maternal health nurses in managing their mental well-being to combat burnout. The participants expressed their worries about the insufficient attention given to various difficulties, such as compassion fatigue, tiredness, and mental health concerns. These concerns were attributed to encountered due to a lack of education, training, human resources, and general support within the workplace.

The results obtained from both study inquiries indicated that nurses inside the Maryland maternity health system had comparable and interconnected encounters while speaking with Black maternal health patients and the available assistance and guidance from HSOs. This study addressed the research inquiries by offering valuable insights into the communication practices of maternal health nurses, highlighting both effective strategies and areas that require improvement. Additionally, the study explored the support provided to these nurses by their HSOs. There were five key aspects: (a) burnout, (b) cultural and health literacy barriers, (c) patient-centeredness, (d) patient safety advocacy, and (e) HSO interdepartmental partnership. There is a solid recommendation to broaden the scope of the research, either in terms of focus groups, qualitative or quantitative measures, by including maternal health nurses nationwide, rather than limiting to a single state. Furthermore, it is advisable to augment the demographic data by including other variables such as gender, age, and race to provide a more comprehensive basis for subsequent investigation.

Additional study is required to explore the participation of various people within the multidisciplinary team involved in maternal health, including doulas, midwives, nurse-midwives, and maternal health support professionals, including sonographers, healthcare administrators, and anesthesiologists specializing in epidurals. This proposition would broaden the examination's scope beyond emphasizing maternal health nurses. Organizations dedicated to improving maternal health should prioritize the implementation of needs assessments to effectively identify and capitalize on tailored opportunities for positive engagement with pregnant Black women. In addition, HSOs must ensure the availability of essential resources, such as reliable interpretation services and a varied range of health subject matter specialists, who play a crucial role in the comprehensive care provided to patients, particularly in maternal health nursing. In addition to the established practice of relying on maternal health nurse liaisons, physicians and OBGYNs must explore other methods of enhancing patient accessibility throughout their pregnancy experiences.

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Appendix A: Qualitative Interview Questions

Research Question 1 (RQ1): What are the lived experiences of Maryland nurses concerning communication in caring for Black maternal health patients?

(1) Describe your duties and responsibilities within the health service organization as a maternal health nurse.

(2) Do you have experiences with mortality and/or morbidity of Black maternal patients?

- What words or phrases best depict these experiences?

(3) How have Black women's disproportionately high maternal mortality and morbidity rates impacted your work as a maternal health nurse?

(4) Describe your protocol for communicating with concerned maternal health patients.

(5) Describe your successful experiences in communicating with Black maternal health patients.

(6) Describe your challenging communication experiences while providing maternal health care to Black patients.

(7) Describe how your work as a maternal health nurse has affected your physical, mental, and emotional health.

(8) What roles and responsibilities do you believe the maternal health nurse should have within the health service organization, and why?

(9) Describe any barriers to communication with Black maternal patients (e.g.., time constraints, compassion fatigue, lack of formal training).

Research Question 2 (RQ2): What communication supports have been implemented among leadership for Maryland nurses that may reduce communication lapses with Black maternal health patients?

(1) Describe how you perceive your duties and responsibilities when being monitored and evaluated by the organizational leadership of a health service organization.

(2) Describe situations or scenarios that illustrate how other roles utilize or perceive the roles of the maternal health nurse within the health service organization.

(3) Describe the level of organizational leadership in the health service and whether it has affected your perception of your roles and responsibilities.

(4) Describe the communication protocol support in place to help you confidently carry out your duties and responsibilities as a maternal health nurse.

(5) Describe any gaps in the communication protocol and overall support provided by maternal nurses.

(6) Describe any specialized training designed to address the maternal health crisis among Black women.

(7) If you have been accountable for non-maternal health duties and responsibilities, please describe your experience and explain why.

(8) Describe a situation in which you were accountable for maternal health roles and responsibilities on a multidisciplinary care team, or in which you were held accountable for such roles and responsibilities.

(9) What policies and procedures would you like to see implemented by health service organizational leadership to help eliminate communication breakdowns in maternal care?

(10) Do you have anything to contribute to this conversation?

Appendix B: Pilot Interview Questions

Research Question 1 (RQ1): What are the lived experiences of nurses concerning communication in caring for Black maternal health patients?

(1) Describe your protocol for communicating with concerned maternal health patients.

(2) Describe your successful experiences in communicating with Black maternal health patients.

(3) Describe your challenging communication experiences while providing maternal health care to Black patients.

Research Question 2 (RQ2): What communication supports have been implemented among leadership for Maryland nurses that may reduce communication lapses with Black maternal health patients?

(1) Describe the communication protocol support in place to help you confidently carry out your duties and responsibilities as a maternal health nurse.

(2) Describe any gaps in the communication protocol and overall support provided by maternal nurses.

(3) What policies and procedures would you like to see implemented by health service organizational leadership to help eliminate communication breakdowns in maternal care?

Appendix C: Maryland Maternal Health Nurses Describe Black Maternal Mortality and Morbidity