The Impact of Racism and Midwifery's Lack of Racial Diversity: A Literature Review

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Introduction: The United States is increasingly racially diverse. Racial disparities in maternal-child health persist. Despite national calls for workforce diversification, more than 90% of certified nurse-midwives are white. This systematic review examines how racism and midwifery's lack of racial diversity impact both midwives and their patients.

Methods: Databases were searched in January 2016 for studies that explored 1) racially concordant or racially discordant maternity care provided, at least in part, by midwives; 2) women of color's experience of race and discrimination in maternity care provided, at least in part, by midwives; and 3) midwives of color's experience of race and discrimination in clinical, educational, and/or professional settings. Studies were excluded if they were conducted outside the United States, focused on recent immigrant populations, or didn't have an English-language abstract. Selected studies were each reviewed by 2 independent reviewers, and data from the studies were entered into literature tables and synthesized for discussion.

Results: A total of 7 studies was retained for review—3 on the experience of patients and 4 on the experience of providers. The studies show racism is common in midwifery education, professional organizations, and clinical practices. Racism and midwifery's lack of racial diversity act as a barrier to people of color completing midwifery education programs and fully participating in midwifery professional organizations. Both patients and midwives of color identified midwives of color as uniquely positioned to provide high-quality care for communities of color.

Discussion: The midwifery profession and its patients stand to substantially benefit from diversification of the field, which requires addressing racism within the profession. Structural competency is a new theory that offers an effective framework to guide these efforts.
J Midwifery Womens Health 2016;61:694–706 © 2016 by the American College of Nurse-Midwives.

Keywords: health status disparities, midwifery, professional organizations, racial disparities, racial diversity, racially concordant care, racism, structural competency

INTRODUCTION

Maternal and infant health in the United States is in a state of crisis, with morbidity and mortality rates far worse than other developed nations, despite more money spent on maternal-child health.[1] In the face of the high-tech, high-intervention, and high-cost obstetric model of care, maternal mortality is increasing.[2] Mainstreaming midwifery care has the potential to greatly reduce maternal and infant morbidity and mortality in the United States.[3]

In addition, racial and ethnic disparities in obstetric and early childhood outcomes are ubiquitous. Compared to children born to white women, children born to black women are more than 2 times as likely to die before their first birthday.[4] Similarly, children born to American Indian/Alaskan Native mothers are 1.5 times more likely to die before celebrating their first year of life.[5] Maternal mortality rates are equally if not more troubling: American Indian/Alaskan Native are more than 1.5 times more likely to die from childbirth than white women, and African American women are 4 times more likely to die than other racial groups.[2,5] The disparities have not abated over the years and are even worsening in some states.[1,6]

The United States faces 2 major challenges in maternal-child health: reducing unnecessary interventions and eliminating racial disparities in birth outcomes. Midwifery is suc-

cessfully addressing the first problem in the communities it serves.[3] It is unclear, however, if the profession is well positioned to bring the reduction in unnecessary interventions to a wider population and to successfully address racial disparities.

A growing body of evidence from medical research shows that greater racial diversity in the health care workforce will improve access to care and the quality of care for people of color, and is an important intervention to reduce racial disparities in health.[7] There is limited research, however, into the role of racism and lack of racial diversity in midwifery. This review was undertaken to present the state of the research on the impact of racism and lack of racial diversity on both midwifery patients and providers of color.

BACKGROUND

Race and Racism Framework

It is well understood that race is a social construction, not grounded in biologic or genetic differences.[8–12] Due to racism, however, the social construct of race does significantly impact people's physiologic health and lived experiences.[13,14] In her framework for understanding racism, Camara Jones describes 3 levels: institutionalized, personally mediated, and internalized.[15] This article will focus on the first 2 levels. *Institutionalized racism* is defined as "differential access to the goods, services, and opportunities of society."[15(p1212)] It is inextricably woven through institutions, bureaucracies, and social structures such that no individual can be identified as

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Quick Points

◆ Despite a national call for health care workforce diversification, more than 90% of nurse-midwives are white.

◆ Midwives of color are uniquely positioned to provide high-quality care to communities of color.

◆ Interpersonal and institutional racism are significant problems in clinical, educational, and professional settings, and act as barriers to further diversifying the profession.

◆ Cultural competency is an insufficient framework for approaching health disparities; the emerging theory of structural competency is better suited to guide midwives in understanding and addressing the ways that economics, politics, and racism promote the health and wellness of some, while degrading the health of others.

◆ Midwives should work to create a midwifery profession whose racial demographics mirror that of the populations being served.

responsible. *Personally mediated racism* is defined as prejudice, meaning "differential assumptions about the abilities, motives, and intentions of others according to their race," and discrimination, meaning "differential actions toward others according to their race."[15(p1212)] It can be both intentional and unconscious.

The terminology used to describe race in the United States evolved from census definitions that were originally developed to promote and maintain the power of the white ruling class.[16,17] The terms have changed over time and in response to a wide range of cultural forces.[16,17] Recognizing that race is a social construct, this review reflects the language used by study authors when describing race. The reader will therefore encounter the terms African American and black, which are used to identify similar and overlapping groups of people. This choice was made out of respect for the self-identity of the participants and in an attempt to offer the richest level of data and information to the reader.

Midwifery and Racial Diversity

Over the past 2 decades, the membership of the American College of Nurse-Midwives (ACNM) has remained more than 90% white.[18,19] Only 7% of ACNM members and 5.8% of certified nurse-midwives/certified midwives (CNMs/CMs) recertifying through the American Midwifery Certification Board (AMCB) can be identified as people of color.[19] Reflecting a more recent trend toward greater racial diversity in the profession, 14.5% of CNMs/CMs certifying with AMCB for the first time can be identified as people of color.[19] However, even with the recent influx of more midwives of color, white people remain dramatically overrepresented in the population of CNMs/CMs.

Meanwhile, the population of the United States is becoming increasingly diverse. According to the US Census, non-Hispanic white people made up only 62.2% of the total population in 2014, and people of color are predicted to be the majority of the population by 2044.[20] Additionally, the population served by midwives is more racially diverse than the US population as a whole.[21] The racial makeup of midwifery providers does not reflect the diversity of the communities midwives serve.

Based on an extensive literature review conducted in 2006, the US Department of Health and Human Services (Health Resources and Services Administration [HRSA]) reported that health professionals from underrepresented groups disproportionately care for underserved populations and that minority patients tend to receive better interpersonal care in race-concordant interactions (patient and practitioner are of the same race).[7] These findings are replicated in the midwifery profession. While the profession as a whole has a long history of service to underserved populations including communities of color, midwives of color are more likely to care for people of color than their white counterparts.[22] Based on the review, HRSA concluded that greater racial diversity in the health care workforce will improve access to care and the quality of patient-provider interactions for people of color and is an important intervention to reduce racial disparities in health.[7]

Structural Competency: A New Theory for Engaging With Racial Disparities and Health Care Workforce Diversification

For decades, the theory of cultural competency has been the dominant approach to training health care professionals to care for diverse populations. Proponents of cultural competency suggest that provider familiarity with the values, customs, and belief models of various racial/ethnic groups can mitigate health disparities. In practice, however, cultural competency methods often present patients as static embodiments of the dominant culture's perceptions of their race/ethnicity, perpetuating stereotypes and creating the false sense that clinicians can achieve mastery or a complete knowing of other cultures.[23,24] Another significant shortcoming of cultural competency is its one-way view focused exclusively on the culture of the patient, family, or community while largely ignoring the culture of the clinicians, care sites, and health care institutions.[25]

In *Structural Competency: Theorizing a New Medical Engagement With Stigma and Inequality,* Metzl and Hansen recognize that while trying to understand the culture of others has importance, limiting the conceptual paradigm to culture alone blinds us to deeper structural forces that confine a person's agency and produce health disparities.[26] The authors propose *structural competency* as an alternative approach. This model, consisting of 5 core competencies, is defined as the trained ability to understand how symptoms, attitudes, or

Table 1. Five Skill Sets of Structural Competency	
Skill	Description
Recognize the structures that shape clinical interactions	Consider how economic, social, and political forces impact the patient's presentation and health history and the interaction between the patient and clinician.
Develop an extraclinical language of structure	Utilize an interdisciplinary approach to study and understand how social structures impact the health of communities. Relevant disciplines include critical race theory, medical anthropology, sociology, economics, political science, and urban planning.
Rearticulate cultural presentations in structural terms	Develop the capacity to recognize and describe a clinical presentation in structural terms, especially when faced with a presentation that would typically be framed as cultural.
Imagine structural intervention	Conceive of structural interventions to address structural barriers to optimal health.
Develop structural humility	Recognize that one can never fully understand how economic, social, and political forces impact another's life and thus approach all efforts to address structural inequality with an open mind and humility.

Source: Metzl and Hansen.[26]

diseases represent downstream implications of a wide variety of upstream structural systems (Table 1). The structural competency theory asks health care providers to consider how social constructs such as race, class, and gender create stigma and inequality. This allows clinicians to better understand and address the ways that economics, politics, and racism promote the health and wellness of some while degrading the health of others.

Given the lack of racial diversity among midwifery providers, the marked racial diversity of midwifery patients, and HRSA's findings that a racially diverse workforce is best equipped to serve a racially diverse patient population, this review was conducted to identify how racism and midwifery's lack of racial diversity impacts both midwives and their patients.

METHODS

A literature search was conducted in January 2016 via PubMed, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Scopus. Search terms included "nurse-midwives," "obstetric," "labor and delivery," "health care workforce diversification," "racism," "health disparities," "culturally appropriate," and "cultural diversity." See Appendix 1 for exact query. A search using the same terms was performed for gray literature. Inclusion was not limited by date of publication. In cases where a thesis preceded a published document, the published document was included.

To be included in the review, studies had to explore one of the following phenomena: 1) racially concordant or racially discordant maternity care provided, at least in part, by midwives; 2) women of color's experience of race in maternity care provided, at least in part, by midwives; 3) midwives of color's experience of race in clinical, educational, and/or professional settings. Studies were excluded if they were conducted outside of the United States, didn't have an English-language abstract, or focused on recent immigrant populations. Exploring the impact of racism and lack of racial diversity on recent immigrant populations is complicated by confounding factors such as language barriers, disparate prior access to health care, and documentation status, and is out of the scope of this paper.

All studies were screened by 2 independent reviewers based on title and abstract using Covidence, a systematic review software tool. Many of the full-text review studies met multiple exclusion criterion. In these cases one exclusion criterion was assigned based on a hierarchy (Appendix 2).

Selected studies were each reviewed by 2 independent reviewers, and data from the studies were entered into literature tables based on the consolidated criteria for reporting qualitative research (COREQ) 32-item checklist.[27] The tables included aims, theory, data collection and sample selection, participation and setting, analysis, results, researcher identity with a focus on racial identity, and key quotes. Results and key quotes extracted by reviewers focused on the themes of racism and lack of racial diversity in the midwifery profession. After independent review, the reviewers discussed their findings and consolidated their results.

RESULTS

The original query yielded 9994 studies; 2 additional studies were identified in the gray literature search. After duplicate citations were excluded, 6223 studies were screened, with 64 proceeding to full-text review. See Figure 1 for a flow diagram of the literature extraction process.

A total of 7 studies met criteria for inclusion in this review. Three were focused on the experience of patients of color (Table 2), and 4 were focused on the experience of midwives of color (Table 3). All 7 were qualitative studies. The following sections describe the characteristics and findings from the studies grouped by patient or provider.

Figure 1. Flow Diagram of Literature Reviewed
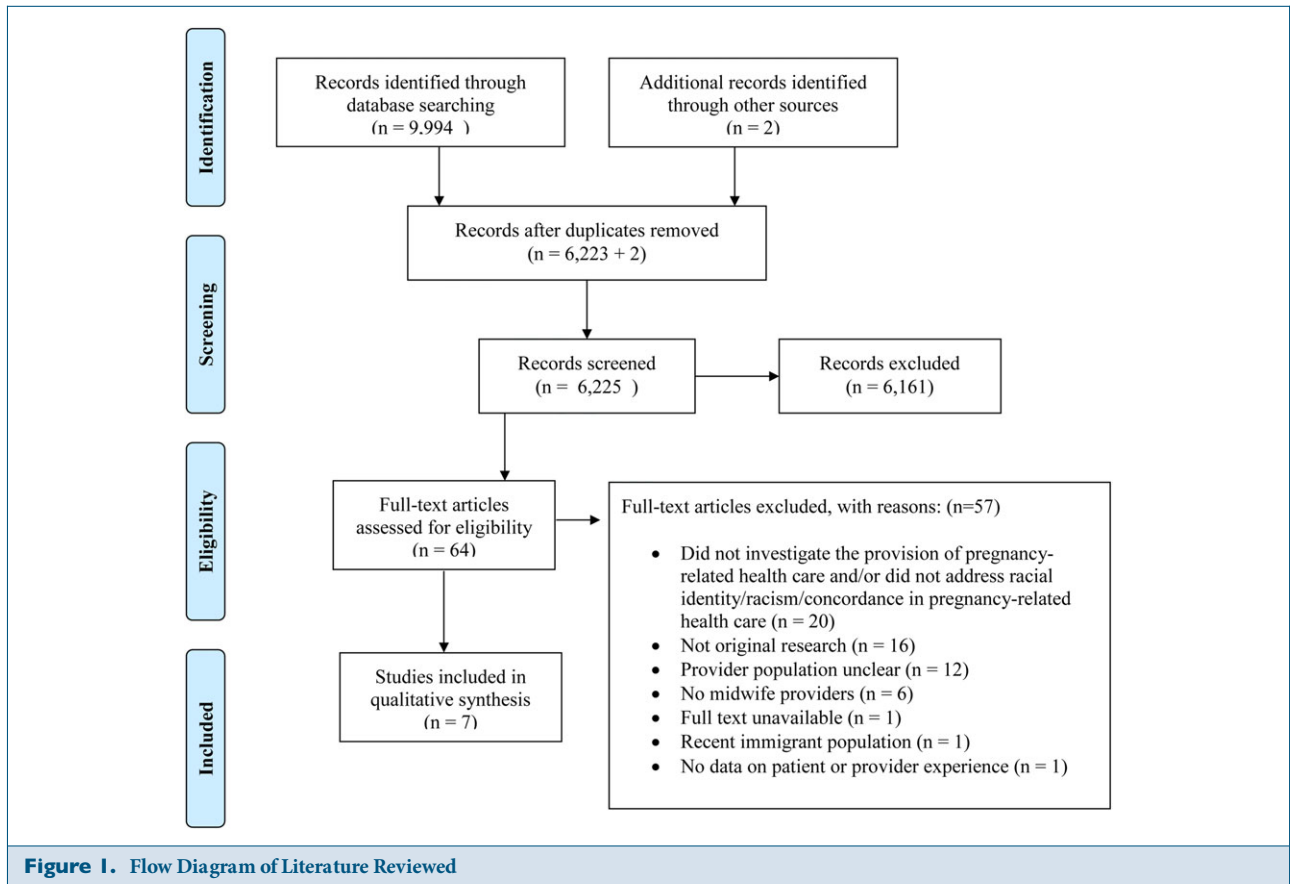
Patient Experiences

Study Characteristics

Salam Ward et al (N = 31) and Sawyer (N = 17) both used a combination of focus groups and individual interviews, while Hanson (N = 58) relied solely on individual interviews.[28–30] Salam Ward et al and Sawyer investigated the experience of African American women, while Hanson looked at the experiences of women from one American Indian tribe in the Northern Plains. Salam Ward et al specifically focused on low-income women, while the sample investigated by Sawyer was predominantly middle class. Hanson's study did not report the income level of the participants; however, the other sociodemographic information suggests an economically diverse group of American Indian women.

Sawyer's study was broad in scope and aimed to generally explore the experiences of pregnancy and motherhood for African American women. Hanson had a more narrow focus seeking to specifically understand both barriers to adequate prenatal care and solutions to these barriers. Meanwhile, Salam Ward et al's study was specifically designed to investigate "the experiences of racial discrimination during prenatal care."[28(p1753)]

None of the studies focused exclusively on care delivered by midwives. Only one participant in the Sawyer study received care from a midwife, and the number of participants who received care from midwives in the Salam Ward et al study is unknown. However, almost all of the participants in the Hanson study received care from a nurse-midwife for at least one of their prior pregnancies. A limitation of all 3 studies is that none of them explicitly investigated the race of the providers.

Study Findings

Both Salam Ward et al and Sawyer's studies explicitly name the experience of racism and discrimination experienced by their study participants, and Sawyer further describes specific coping strategies employed by the women she interviewed. Salam Ward et al found themes of differential treatment and discrimination based on race in all focus groups, with participants describing both interpersonal racism and institutional racism in prenatal care. From the data, Salam Ward et al conclude that "African American women with limited incomes perceive many provider practices and personal interactions during prenatal care as discriminatory."[28(p1753)] In Sawyer's study, she describes the context in which the African American women in her study experience pregnancy and the process of becoming a mother as including "having to deal with negativity, stereotyping, and assumptions about pregnant African American women, and fac[ing] discrimination on a daily basis."[29(p16)] The key quotes provided as examples all describe experiences of discrimination or bias in pregnancy-related health care settings. Sawyer goes on to explicitly state, "Health care providers were judged [by study participants] as racist based on their body language, how they acted, and their tone of voice, as well as by what they said."[29(p17)] Women in her focus groups described "comfort with [as] a major criteria used in the

Table 2. Three Qualitative Studies of Patients

Author/Year	Aims	Data Collection, Sample Selection	N, Participants, Care Setting	Results	Researcher Identity
Hanson, 2012[30]	To understand barriers to adequate prenatal care among American Indian women from one tribe in the Northern Plains and to investigate potential solutions.	Individual interviews. Convenience sample from which a stratified sample was chosen from each district on the reservation based on the percentage of total housing units in each district. Inclusion criteria: American Indian women from the tribe of focus, previous pregnancy, previous prenatal care at an Indian Health Service facility or clinic. Exclusion criterion: Currently pregnant.	58 Aged 18 to 77 years with average of 3.72 previous pregnancies. Less than half were employed. Half (49.1%) had some college-level education, 31.6% had a high school diploma, and the rest had not completed high school. Half were living with their partner (50.9%), and half were single and never married, divorced, or widowed. Nearly all respondents saw a nurse-midwife for ≥ one of their pregnancies. Race of providers not described.	Communication barriers included "an overall lack of trust of physicians, especially white physicians and 'modern ways of medicine.'" Solutions to barriers included an emphasis on culturally appropriate education, intervention, and prevention, including overcoming communication barriers with providers.	Race of researcher unknown, interviews were conducted by an enrolled member of the tribe who had worked previously in a health care organization, so rapport and trust were established.
Sawyer, 1999[29]	To elicit the experiences of pregnancy and motherhood for African American women.	Focus group and individual semistructured interviews. Theoretical sampling was used to solicit diversity in age, geographic origins, education, income, and health status. No inclusion or exclusion criteria stated.	17 First-time African American mothers in the immediate postpartum period, aged 23 to 40 years, most were middle-class, well-educated, and married or partnered. Large managed care organization in California, provider type varied (ie, physicians, nurse practitioners, midwives, physical therapists, counselors, doulas), race of providers unknown.	Health care providers were judged as racist based on their body language, how they acted, and their tone of voice, as well as by what they said. "Comfort with" was a major criterion used in the selection of a provider to decrease the chance of experiencing racist attitudes and treatment during care. A few stated that they made a conscious decision to not interpret an incident as racism.	White Irish American woman

(*Continued*)

Table 2. Three Qualitative Studies of Patients

Author/Year	Aims	Data Collection, Sample Selection	N, Participants, Care Setting	Results	Researcher Identity
Salam Ward et al, 2013[28]	To examine experiences of racial discrimination during prenatal care from the perspectives of African American women in a low-income neighborhood who are at highest risk for poor birth outcomes.	Focus groups and individual interviews. Convenience sample. Inclusion criteria: Self-identified as African American, aged 18 years or older, have a child one year of age or younger, experienced at least one prenatal care visit in Milwaukee, Wisconsin.	31 Black/African American (n = 29) and Hispanic (n = 2) women, most receiving medical assistance (n = 27, type of assistance was not specified). Care at various sites and from various types of providers (ie, obstetricians, midwives, and family physicians), race of providers unknown.	African American women from low-income backgrounds reported perceived discrimination relating to type of insurance and race in the receipt of prenatal care, and experiencing racial discrimination over the course of their lives. Institutional racism was highlighted more than interpersonal racism.	Race of researcher unknown; groups were facilitated by an African American woman (in 2 cases a white moderator substituted) with a note-taker (identity not described) present in the back of the room.

Table 3. Four Qualitative Studies of Providers

Author/Year	Aims	Data Collection, Sample Selection	N, Participants, Care Setting	Results	Researcher Identity
Goode, 2014[31]	To investigate the experiences, thoughts, and feelings of contemporary black midwives in the United States.	One-on-one, in-depth semistructured interviews. Snowball sampling method. Inclusion criterion: Black midwives practicing in the United States.	22 CNMs (n = 12) and CPMs (n = 10) aged 30 to 80 years, 5 to 45 years of professional experience, practicing in urban environments in various states.	Participants attributed poor birth outcomes in black women to the social operation of racism. The relatively low number of black midwives was attributed to a smear campaign by the medical establishment and racism and discrimination on the part of white midwives. Black women's underutilization of midwives was attributed to social disenfranchisement and legacies of slavery, segregation, and forced subservience as domestic help. Participants experienced professional organizations as racist environments unsupportive to communities of color.	Black
Kennedy et al, 2006[34]	To identify what midwives of color and male midwives perceive to be essential to exemplary midwifery care and determine if diverse midwives believe that their ethnicity or gender influences their practice or concepts of exemplary care.	Individual and group semistructured interviews. Purposive sampling. No inclusion or exclusion criteria stated.	15 CNMs who self-identified as black/African American women (4), Asian/Pacific Islander women (4), Latina women (3), and white men (4).	Participants believe that their race did impact their conceptualization of exemplary care and added to what they were able to offer their patients. Many participants reported that racism toward them and people of color around them was common with their colleagues and students and in their workplaces. Many described experiencing "otherness," oppression, and invisibility, and reported that this treatment resulted in significant negative consequences.	3 white women

(*Continued*)

Table 3. Four Qualitative Studies of Providers

Author/Year	Aims	Data Collection, Sample Selection	N, Participants, Care Setting	Results	Researcher Identity
McLaughlin, 2012[32]	To document the experiences of black midwives with direct-entry midwifery education; explore the social, cultural, and structural barriers facing black women in pursuit of midwifery training; and develop a summary of themes and issues to guide midwifery educators on improving their recruitment, retention, and graduation of black students.	Semistructured interviews. Snowball and purposive sampling. Inclusion criteria: Aged 18 to 65 years, self-identified as black or African American, currently practicing or recently retired direct-entry midwife, currently practicing or recently retired direct-entry midwifery educator or preceptor to black direct-entry midwifery students.	9 Aged 30 to 60 years with 5 to 30 years of experience.	Racism significantly impacts black women in the midwifery profession. Participants experienced isolation and discrimination in their education programs and connected this to attrition rates. Disenfranchisement of black communities motivated "many if not all" participants to become midwives, and 8 of 9 subjects expressed a commitment to serving the African American community. Most (n = 7) focused their work on decreasing African American maternal and infant morbidity and mortality. Participants who were educators instilled this focus in their students and worked to make apprenticeships accessible to students of color.	Japanese American
Abbyad, 2011[33]	To explore perceptions by African American health care providers of ways in which African American women prepare for childbirth and ask providers about their personal and professional experiences with childbirth.	Semistructured interviews and focus groups. No inclusion or exclusion criteria stated.	12 African American (n = 11) and white (n = 1, inadvertently invited to participate, only made one short comment during focus group); health care providers practicing in the United States: 6—registered nurses, 4; licensed vocational nurses, 1; CNM, 1 certified assistant (type of assistant not specified).	Themes included: "Traversing an unresponsive system," in which African American women are stereotyped and treated dismissively or disrespectfully. "Childbirth classes not a priority," with providers reporting that patients express feeling unwelcome by white participants. Voiced concerns about differential treatment of pregnant African American women and described attempts to positively affect women they cared for.	Caucasian researcher took notes during focus groups facilitated by African American moderator.

Abbreviations: CNM, certified nurse-midwife; CPM, certified professional midwife.

selection of a provider."[29(p17)] "Comfort with" described an assessment by patients that they were less likely to experience racism with a given provider.

Hanson, on the other hand, did not explicitly name racism or discrimination in pregnancy-related care. However, she describes a pattern of communication barriers that clearly include dissatisfaction with race-discordant care. She describes the "feeling [among study participants] that the physician did not care about the patient or his or her reasons for seeking care, and an overall lack of trust of physicians, especially white physicians and 'modern ways of medicine.'"[30(p32)] Further, Hanson issues a clear call for racially and culturally concordant care. She states, "participants … proposed an emphasis on culturally appropriate education, intervention, and prevention, [and] suggested classes with a traditional elder woman on pregnancy and health care."[30(p33)]

It is unclear if Hanson's use of the word *physician* in the above quote is intentionally used to exclude nurse-midwives. Elsewhere in the study, she explicitly contrasts the care received from nurse-midwives and physicians stating that the respondents had a preference for nurse-midwifery care due to continuity of care, longer visits with more teaching, and more frequent gender concordance. She never describes, however, a mechanism by which nurse-midwifery care is different from the specifically racial critique of "white physicians and 'modern ways of medicine.'"[30(p32)]

Finally, an interesting set of findings from both Salam Ward et al and Sawyer relates to the reluctance by participants in both studies to name racism. Salam Ward et al devote a full section of their discussion to the topic stating that some "participants [were reluctant] to discuss race without a probing question and validation from the rest of the group."[28(p1757)] Sawyer describes a similar behavior when she states that her participants both ignored incidences of racism and "made [the] conscious decision to not interpret an incident as racism."[29(p17)]

Provider Experiences

Study Characteristics

Goode (N = 22), McLaughlin (N = 9), and Abbyad (N = 12) all focused exclusively on the experience of black providers, while Kennedy et al's (N = 15) sample included black women, Asian/Pacific Islander women, Latina women, and white men.[31–34] All providers in Kennedy's study were CNMs, Goode's sample included CNMs and certified professional midwives (CPMs), while participants in McLaughlin's study were all direct-entry midwives. Abbyad's sample consisted of a range of providers including registered nurses, licensed vocational nurses, one certified assistant (type of assistant not specified), and one nurse-midwife.

Goode and McLaughlin both used individual, semistructured interviews, Abbyad used a semistructured focus group, and Kennedy et al used a combination of individual and group interviews. Kennedy et al's study was informed by the health care theories of cultural competence and cultural humility while Goode and McLaughlin's work was informed by other disciplines: black feminist standpoint epistemology and intersection-

ality theory, and phenomenology and critical race theory, respectively.

Goode's aim was the broadest, exploring the perspectives and experiences of black midwives in relation to racial disparities in maternal-child health, midwifery professional organizations, demographics of the profession, and more. Abbyad examined the experience of black providers as both providers and recipients of care. McLaughlin focused on understanding the experience of black women in midwifery education, including cultural and structural barriers and potential solutions to these barriers. The focus of Kennedy et al was the narrowest, investigating whether midwives of color and male midwives believe that their race/ethnicity or gender influences their clinical practice or their concepts of exemplary midwifery care.

Study Findings

Two of the 4 studies on providers included findings on racism in the clinical setting. Kennedy et al's study reported that racism in clinical settings was common and directed both at the providers who were the participants in the study and other people of color. Abbyad's study participants reported personal experiences of being stereotyped, dismissed, and devalued during the maternity care they received and hearing similar stories from the black women they serve.

Three studies, Kennedy et al, McLaughlin, and Goode, explored midwives of color's experiences in midwifery education; all found racism to be a considerable challenge. Participants in Kennedy et al's study cited racism and discrimination in midwifery education as a significant barrier to people of color applying to and graduating from midwifery education programs. McLaughlin noted a number of key themes regarding challenges faced by black student midwives including organizational racism, overt racism from midwifery peers, lack of willing preceptors, and aloneness. Goode's participants describe a lack of respect and care during their midwifery education. Further, the participants describe a lack of racial diversity among faculty, preceptors, and classmates, which both negatively impacts the content being taught and places undue burden on midwifery students of color, making it harder for them to succeed.

Two studies, Goode and McLaughlin, described experiences of racism within professional midwifery organizations. In McLaughlin's work, participants state that because professional midwifery organizations in the United States are largely run by white women, they lack an understanding of the context that many women of color live and work in, leading to the creation of policies that privilege white people over people of color. Goode found that black midwives perceive both ACNM and the Midwifery Association of North America (MANA) to be significantly racist organizations. Study participants described interpersonal and institutional racism, lack of organizational support for issues of importance to people of color, and a lack of commitment to racially diversifying the profession. For example, participants reported that while professional midwifery organizations were using the word *diversity* more frequently, the language was not coupled with action supportive of communities of color. Participants described the way organizations are engaging with the issue of diversity as

"performance art for white people,"[31(p123)] in which a simplistic narrative of celebrating diversity and being tolerant results in the fetishization of people of color through the consumption of ethnic food, clothing, and artifacts. Participants in both studies indicated that racism limited participation and membership by midwives of color in professional organizations.

Participants in all 4 studies shared a commitment to serving patients of color. In McLaughlin and Kennedy et al, participants expressed a passion for eliminating racial disparities in birth outcomes. Participants in Abbyad's study expressed great concern about differential treatment of African American women who are pregnant. They described feeling called to "take on the mothering role" to patients who lack social support and are "falling through the cracks."[33(p51)] Echoing this theme, a participant in Goode's study says, "When I am working with a black woman, I love on her hard."[31(p157)] She then describes some of the ways that she goes the extra mile to nurture and care for her black patients, including things like asking about her children, rubbing her back, and offering food. McLaughlin's participants reported focusing directly on decreasing African American maternal and infant morbidity and mortality and expressed prioritizing service to the African American community through strategies such as targeted outreach and accessible fee structures.

Participants in all 4 studies recognized that their racial identity as a person of color strengthened their ability to serve patients of color. As midwives in the Kennedy et al study explained, they possess survival strategies for coping with racism and discrimination, which give them awareness and strength that they are able to share with their patients and students. As one participant stated, "I've become more sensitive, perhaps because of the kinds of racist experiences I've had … I am less quick to judge, hopefully."[34(p88)] Further, the participants in McLaughlin and Goode recognize workforce diversification as central to the goal of building the capacity of midwifery to reduce racial disparities.

Researcher Reflexivity

Researcher reflexivity is an important element in qualitative research that involves considering the relationship and power dynamics between the researcher and study participants, and describing how complications and bias are addressed.[27,35] A key component to researcher reflexivity in qualitative studies on race is recognizing that racial concordance between researchers and participants can increase access to participants and certain kinds of information, as well as enhance the depth of information provided.[36,37]

Goode, a black woman, describes how her racial identity shaped her interests, guided her research questions, and facilitated access to her population of study. Of note, 3 study participants asked if Goode was black before agreeing to be interviewed. During the research process, she reports being "treated like a daughter, sister or friend" with participants often using terms such as "'we,' 'us,' and 'you know,'" reflective of their sense of shared identity and understanding.[31(p 44)] McLaughlin, a Japanese American woman, notes that her identity allowed her to access forums for midwives of color and openly sharing her experiences with racism in these forums may have helped to establish trust among potential research participants. At the same time, the depth and breadth of information shared may have been hindered by her lack of racial concordance with participants.

Three of the studies in which the primary researcher(s) was white or did not state their race (Abbyad, Hanson, and Salam Ward) attempted to establish trust and minimize the negative impacts of racial discordance by having interviews and/or focus groups facilitated by a racially concordant person. The remaining 2 studies with white researchers (Kennedy et al and Sawyer) did not describe any attempt to address how their white identity might impact the nature and depth of what people of color chose to express to them about race and racism.

DISCUSSION

The studies reviewed here represent a significant contribution to the literature on racism in the profession of midwifery. There are 3 key findings from the studies. First, racism (interpersonal and institutional) is commonplace in midwifery education, professional organizations, and clinical practices. Second, racism in midwifery and lack of racial diversity act as barriers to further diversifying the profession. Third, both patients and midwives of color identify midwives of color as uniquely positioned to provide high-quality care for communities of color.

Metzl and Hansen's theory of structural competency has great utility for analyzing racial disparities. Structural competency makes clear that understanding social disparities, including racial disparities, requires utilizing extraclinical theories and thinking in structural terms. For example, by grounding their research in critical race theory, sociology, and black feminist theory, Goode and McLaughlin are the only researchers to identify racism and the lack of midwives of color as an explicitly structural barrier impeding people of color's access to both high-quality care and midwifery education. Participants in these studies then "imagine structural intervention"[27(p 130)] through their recommendations to increase the racial diversity of midwives. Additionally, the lens of structural competency enables one to recognize the profession of midwifery as a social structure. When investigating the impact of racism within the structure of midwifery, the distinction between those served and those providing the care dissolves: midwives cannot address racism experienced by their patients without addressing racism experienced by their colleagues and vice versa.

The data are clear that the midwifery profession, midwives, and their patients stand to substantially benefit from diversification of the field. More diversity in the provider population would allow patients from Hanson's study to receive care from a "traditional elder woman"[30(p33)] during their regularly scheduled clinical visits rather than in supplementary classes offered in parallel to clinical midwifery care. Provider diversification would also likely increase the number of providers that patients felt "comfort with"[29(p 17)] as described in Sawyer. As people of color themselves, midwives of color are uniquely positioned to understand the economic, political, and social forces affecting the lives and health of the people of color who present to them for care. The data from the studies suggest that the shared experience as targets

of racism would improve understanding and communication between patients and providers and reduce perceived racial discrimination. Additionally, the research reviewed here gives voice to the themes within the midwifery service pattern data, namely, that midwives of color demonstrate a deep commitment to caring for underserved communities. It follows that increasing the racial diversity of midwives is likely to improve access and health outcomes for communities of color.

The data are equally clear that diversification of midwifery presents a formidable challenge. First and foremost, racism and lack of faculty diversity in midwifery education programs must be addressed. Participants in the 3 studies that investigated educational institutions found that racism is prevalent and greatly contributes to the attrition of midwifery students of color. These findings show that external institutional racism, such as segregated schools and race-based wealth disparities, is not the only factor limiting access to the profession for persons of color.

Beyond the educational environment, racism and lack of racial diversity in midwifery professional organizations must be addressed. Professional organizations represent concentrations of political power, social connections, and financial means. These groups have the power to set national agendas and steer the midwifery movement. Therefore, midwives of color being excluded or alienated from organizations such as ACNM and MANA effectively disenfranchises them, hindering their ability to advocate for their communities and weakening organizations that don't have access to their skills and perspectives. This happened in 2012 when MANA's Midwives of Color section resigned, stating that they could no longer tolerate the racism in the organization and that "these organizations distract us from our true mission"[31(p31)] of improving maternal and infant health outcomes for US women.

Implications for Future Research

Gaps in the literature exist but should not prevent midwives from acting now to prioritize racial diversification of the profession. Future research should investigate race concordance in midwifery care including the possibility that diversification may improve the cultural and structural competency of the whole team. Research should include the experiences of patients and providers from a wide range of racial identities including Asian and Pacific Islander, Latino, and American Indian as well as, specifically, recent immigrant populations. Best practices for effective recruitment and retention of a racially diverse student population, including research in effective methods of anti-racist education, must be identified. Studying white midwives' understanding of racism, white privilege, and health inequity could help guide trainings for white midwives and educators.

CONCLUSION

This systematic review adds to the state of the science, deepening the collective understanding of both the pressing need to racially diversify midwifery and the challenges faced when working toward diversification. The need to diversify is made clear by the finding that both patients and midwives recognize midwives of color as uniquely positioned to provide high-quality care for communities of color. This, coupled with the

severe disparities in maternal-child health outcomes experienced by communities of color, requires that diversification of the profession be a priority. The results also demonstrate that racism is found in midwifery education, professional organizations, and clinical practices, and it must be addressed in order to effectively diversify the profession. Structural competency offers an effective framework to guide these efforts.

Racism is, unfortunately, woven throughout the economic, political, and social structures that make up the United States. The US population shares a moral imperative to work to redress race-based inequalities. Midwives' calling is even stronger; the profession locates midwives as experts at the critical and sensitive periods of pregnancy and childbirth where racism extracts a particularly brutal toll. It is unconscionable that women of color face a significantly elevated risk of losing their life, or the life of their child, from pregnancy and birth. Midwives cannot turn away from this reality and must heed the call to diversify the profession.

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CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose.

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Appendix 1: Search Query

(((("Nurse Midwives" OR "Nurse Midwife*" OR "Nurse Midwife*" OR Midwife* OR midwife* OR obstetric* OR "prenatal care" OR "antenatal care" OR intrapartum OR "labor and delivery" OR pregnancy OR pregnant OR childbirth))) AND (((((((("healthcare workforce diversification" OR "healthcare workforce diversity")) OR (Workforce AND ("Cultural diversity" OR Racism OR "Healthcare disparities"))) OR (((concordant or concordance) AND (race OR racial OR races OR ethnicity)))) OR (racism OR "racial disparities" OR "racial disparity" OR "health disparities" OR "health disparity" OR "racial discrimination" OR "race discrimination")) OR ("culturally competent" OR "culturally appropriate" OR "cultural competency" OR "cultural humility" OR "culturally humble care" OR "cultural sensitivity" or "culturally sensitive care")) OR "patient-provider communication") OR (diversity OR "Cultural Diversity"))

Appendix 2: Exclusion Hierarchy

1. Full text unavailable
2. Not original research
3. Recent immigrant population

4. Describing a racial disparity but no data on patient or provider experience
5. Investigated women of color and childbirth but did not investigate the provision of pregnancy-related health care and/or did not address racial identity/racism/concordance in pregnancy-related health care
6. Wrong provider population
7. Provider population unclear