Where the System Failed: The COVID-19 Pandemic’s Impact on Pregnancy and Birth Care

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Abstract
The COVID-19 pandemic created a massive shift in health care systems, including within pregnancy and birth care. To explore how experiences of pregnancy and birth were impacted, 15 patient participants and 14 nurse participants were interviewed and transcripts analyzed using critical thematic analysis. Patients highlighted how adaptations to care were inadequate to meet their needs, a desire for support in response to stress, and the impact of COVID on patients’ experiences. Nurses identified how inconsistencies in policies impacted nurses’ ability to care for patients, the impact on nurses from hospital actions, and the impact on patients from hospital actions. Both groups discussed how system changes had disparate impacts on marginalized communities, leading to racially-biased care. This pandemic will continue to have lasting impact on pregnant and birthing families, and the nurses who care for them, and it is imperative that hospitals examine their role and any potential impacts.

Keywords
COVID-19, perinatal care, respectful care, health care systems, health disparities, Northwest United States, critical thematic analysis

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Introduction
The SARS-CoV-19 (COVID-19) viral pandemic created a massive shift in how health care systems interact with patients, staff, and the public. The maternity care system, which encompasses prenatal care, labor and birth care, and postpartum care, has experienced vast changes in structure and interpersonal interactions as an attempt to curb exposure for both patients and staff, specifically with visitor policy changes, COVID testing for patients, and reduced or clustered care (Capanna et al., 2020; Fryer et al., 2020; Peña et al., 2020). These changes have profoundly affected the experiences of patients interacting with the health care system, as well as the nurses who are caring for them.

The current health care system for pregnancy and birth care is made up of multiple layers of service provision, with transitions in location and personnel from prenatal care to labor and birth, and then to postpartum care. Prenatal care has historically emphasized frequent in-person visits, which became a de facto source of social and emotional support for the pregnant person (Coley et al., 2018; Gregory et al., 2020; Nicoloro-SantaBarbara et al., 2017). In addition, the labor and birth experience in the hospital setting often serves as the apex, magnifying the impact of nursing care on a person’s understanding of and satisfaction with their entire pregnancy experience (Lyndon et al., 2018; Simon et al., 2016). As with many health-related transitions, pregnancy and birth is primarily a social experience in which care services support not only the medical health and well-being of patients but also the development and growth from individual to parent (Hill et al., 2019; Kennedy et al., 2009). Nurses provide the bulk of this support while patients are in the hospital for birth, which translates as often being the

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most influential relationship for patients during their perinatal experiences (Edmonds et al., 2017; Lunda et al., 2018; Zielinski et al., 2016).

Prior to the pandemic, existing issues of racial discrimination, bias, and stigma against pregnant and birthing people of color (predominantly Black people) have been described, both at the individual and structural levels (Altman et al., 2019; Bailey et al., 2017; Chambers et al., 2020; Davis, 2018; Yearby, 2018). Interactions with health care providers have been shown to have great impact on perceptions of care experience, with intersections of provider power and implicit bias creating loss of agency and trust in the health care system (Altman et al., 2019; Davis, 2018). Additionally, marginalized communities often have reduced access and options for quality care, which greatly reduces the ability for people of color to find and receive care from providers they trust (Yearby, 2018). These issues, which lead to disrespectful care, mistreatment, and other sources of harm, may have contributed to the worsening disparities in maternal outcomes (McLemore et al., 2018; Vedam et al., 2019).

With the pandemic, many systems had to change or adapt care processes in order to help prevent spread of COVID-19. In-person visits changed to virtual, visits that required in-person contact used physical distancing and reduced time face-to-face, and support mechanisms such as childbirth education and group prenatal care were changed to virtual. Family members and friends were often excluded from outpatient and inpatient care, which can have disparate impacts on BIPOC families who already are less safe in the health system (Davis, 2018). In parallel, the changes enacted by health care systems also significantly impacted nurses who provide care in the hospital setting, potentially causing negative consequences on the quality of care provided (Labrague & De Los Santos, 2020; Pappa et al., 2020). This study explored how experiences of pregnancy and birth were impacted by the COVID-19 pandemic, both from the patients’ and nurses’ perspectives in order to understand the multifaceted and intersectional impacts from these adaptations.

**Methods**

Using critical thematic analysis methods (Braun et al., 2014; Lawless & Chen, 2019), researchers explored experiences of care provision during pregnancy and birth by both patients and nurses during the COVID-19 pandemic between April and August 2020.

An interdisciplinary research team was created for the purposes of this study, including researchers from nursing, midwifery, and social work, and included a community researcher who received training on research conduct and participated in all aspects of the study. Of the six researchers, three identified as Black, Indigenous, or People of Color (BIPOC); five identified as cisgender women and one as a cisgender man. Four of the researchers had expertise in qualitative methods, mainly thematic analysis, critical discourse analysis, constructivist grounded theory, and ethnography. All researchers shared an understanding of the impacts of health disparities, racism and discrimination, critical race theory, and intersectionality, all of which provide the theoretical framework and foundation for positionality for this study.

Two parallel participant groups were recruited between April and August 2020: people who were pregnant or had given birth since March 2020 (patient participants), and registered nurses (RNs) who were currently working as RNs in a perinatal setting (inpatient or outpatient) since March 2020 (nurse participants). No patient nor nurse participant was known to have had a positive COVID-19 diagnosis at the time of interview. Patient participants were restricted to those living in Washington State; however, nurse participants were recruited from across the United States to include more diverse perspectives. Recruitment occurred mainly online using social media, with targeted and snowball recruitment strategies used to assure a diverse sample of participants. Participants were recruited until emerging concepts were ascertained to be fully described and complete.

Due to the COVID-19 pandemic, virtual interviews were conducted by three members of the research team and recorded via the Zoom platform. Interviews lasted approximately 1 hour, were open-ended, and loosely guided by interview prompts when necessary. The introductory prompt asked, “Can you tell us about your experience (during your pregnancy/birth)/(while working) during the COVID-19 pandemic,” with additional prompts as necessary to guide conversation. Audio recordings were professionally transcribed, and resulting transcripts were compared to the recording for accuracy and de-identified by the lead researcher. Prior to the recorded interview, verbal consent was obtained after a written information page was provided electronically and reviewed for understanding. Video recordings were kept for future dissemination after explicit verbal consent by participants, with recordings deleted for those who did not consent. Participants were provided a $50 online gift card as compensation for their time. Human subjects approval was obtained through the University of Washington Institutional Review Board.

Researchers employed critical thematic analysis as the dominant methodology for analysis (Braun et al., 2014; Lawless & Chen, 2019), informed by other interpretive methods such as critical discourse analysis and situational analysis (Clarke, 2003; Powers, 1996). The lead researcher performed inductive coding on all transcripts to lay a foundation of concepts that emerged from the data, with themes identified for those concepts that were represented by the majority of participants. Concurrently, members of the research team conducted individual interpretive analyses for each transcript using individually-oriented methods (based on expertise). Each transcript was then reviewed and
discussed as a team, with an integrative group analysis memo described for each participant which included development of themes from concepts, constructs, and discourses identified by individual team members. Final themes were confirmed by consensus of the entire group, with all discrepancies resolved within the context of each team meeting. Themes created in the group analysis memo were then triangulated with the initial codes pulled from the full set of transcripts, and exemplar quotes identified. Lastly, constructs/themes were then arranged and organized for the purposes of cohesiveness in dissemination.

Strategies for maintaining rigor and reflexivity included frequent team meetings, group memos with a process for reaching consensus on themes and constructs, triangulation, and the use of processes from several qualitative methods to capture multiple perspectives and understandings (Braun et al., 2014; Clarke, 2003; Powers, 1996). The inclusion of a community member as part of the research team also strengthened the methodological approach, providing avenues for input from those within and caring for the affected communities.

**Results**

The patient participants represented a diverse sample of the population of birthing people in Washington State, with six out of 15 participants self-identifying as Black or African American and one participant self-identifying as transgender. A slight majority of patients (60%) were experiencing their first birth. Out of the 15 total participants, six were pregnant and nine were postpartum at the time of the interview (see Table 1). Out of 14 nurse participants, six self-identified as Black, Indigenous, or People of Color (BIPOC), all identified as female, and the average length of experience as a nurse in the perinatal setting was 6 years. Of note, two of the patient participants also identified as nurses, and two of the nurse participants were pregnant at the time of their interviews. These participants were able

| Table 1. Participant Characteristics. | Patient group | Nurse group |
|------------------------------------|--------------|------------|
| **Total participants**             | 15 (100)     | 14 (100)   |
| **Median age [range]**             | 31 [20–38]   | 34 [25–40] |
| **Self-identified race/ethnicitya**|              |            |
| Black/African American             | 6 (40)       | 2 (14)     |
| White/Caucasian                    | 6 (40)       | 8 (57)     |
| Asianb                             | 3 (20)       | 2 (14)     |
| Indigenous                         | 1 (7)        | 1 (7)      |
| **Gender**                         |              |            |
| Transgender man                     | 1 (7)        | 0 (0)      |
| Cisgender woman                    | 14 (93)      | 14 (93)    |
| Non-binary/genderqueer             | 0 (0)        | 1 (7)      |
| **Sexual orientation**             |              |            |
| Straight/heterosexual              | 13 (86)      | 12 (86)    |
| Queer                              | 1 (7)        | 1 (7)      |
| Bisexual/pansexual                 | 1 (7)        | 1 (7)      |
| **Geographic location**            |              |            |
| Washington State                   | 15 (100)     | 11 (79)    |
| Other statesc                      | 0 (0)        | 3 (21)     |
| **Parity**                         |              |            |
| First pregnancy/birth              | 9 (60)       |            |
| **Pregnancy status**               |              |            |
| Pregnant at time of interview      | 6 (40)       |            |
| Median gestational age in weeks [range] | 30 [26–37] |            |
| Postpartum at time of interview    | 9 (60)       |            |
| Median time since birth in weeks [range] | 4 [2.5–7] |            |
| Median length of time as RN in years [range] | 7 [1.5–15] |            |
| Median length of time in OB setting in years [range] | 6 [1.5–15] |            |

*aTotals do not equal 100% due to ability to choose multiple racial identities.

*bAsian identities included: Chinese, Filipino, Hong Kong, Indian.

*cOther states included: New York, Georgia, Michigan.
to choose which perspective they intended to use within the interview (often due to relevance of experience in relation to the pandemic).

Patient participants and nurse participants brought different perspectives to how the hospital systems influenced care provision. Patient participants focused upon how adaptations to care structure were inadequate to meet their needs and an expressed desire for additional support and services to respond to stress from COVID-19. Nurse participant themes focused on how inconsistencies in policies and policy implementation impacted nurses’ ability to safely care for patients and the impact on nurses from hospital actions. Both nurse and patient participants described the impacts on patients from hospital responses to the pandemic, with overlap between patient and nurse themes related to concerns about infection and exposure risk and consequent impacts on care receipt and provision, as well as noted disparities in care for BIPOC patients.

**Influences to Service Provision**

Patient participants in this study described multiple facets of their care experience during COVID-19 regarding service provision, culminating in the following distinct themes: adaptations to care structure not meeting patient needs and a need for additional support and services in response to stress from COVID.

**Adaptations to care structure were inadequate to meet patient needs.** Overall, the majority of participants described preferences for in-person visits and interactions over virtual or telehealth visits. There was a lack of connection noted in virtual visits that was missed and considered important in pregnancy and postpartum care. As one pregnant participant shared:

> When it comes to like having a visit over the phone it’s like, I know that there’s nothing wrong right now. I feel fine and I don’t really want to have that conversation. I want to be able to actually have a check in and actually have a doctor be able to check everything’s fine and make sure the baby’s heartbeat is still okay or see how my uterus is measuring and things like that are more concrete. . . . I see the phone conversation just more being like, “Is everything okay,” and me saying “Yes” and then that kind of being it.

Another participant noted how the telehealth visit she had was useless and cost her money, while what she needed was an in-person visit:

> And this telehealth situation, this monitoring from home, that’s a joke. It’s not going to work. How can you tell me that my C-section isn’t hurting when I’m telling you that it is hurting but you can’t see it. “Well maybe you should just come in.” Well, yeah. I’m going to come in. Then you took my $45. It’s crazy. It’s crazy.

That lack of connection and hands-on assessment led to feelings of isolation, loneliness, and mistrust among participants. One participant recalled the isolation she felt in relation to her providers due to virtual visits:

> Having like Zoom prenats has been—it’s just been a very different experience from what I’ve had before [. . .] it’s kind of been a bit of a lonely pregnancy in that respect.

Tele-health visits were noted to work for some things, such as needing prescriptions or quick evaluations. One participant, who had resources available to support care such as a blood pressure cuff, felt comfortable with telehealth appointments for simple needs:

> It was my first time doing a telehealth like that. [. . .]I think it was pretty successful for the purposes, for that purpose [getting a prescription restarted]. You know, if I had really had something physical going on that I needed somebody, a doctor, to touch me, it wouldn’t have worked out so well. But I, again, took my blood pressure at home and told them what it was and it seemed pretty useful.

However, many patients shared a need for reassurance and connection from their providers, and tele-health visits did not provide it. One participant shared the comfort in knowing that her provider could take care of whatever need may arise, which was not felt during telehealth visits:

> I was only being seen over the phone and I prefer to be seen in person just so that it gives me more, I don’t know, I feel like just in case I want to see ultrasound or anything I have that comes up and I want to get checked out, that scares me, that’s pretty hard to do over the phone.

**Need for additional support and services in response to stress from COVID.** Outside of how visits and interactions with providers were conducted, patient participants shared a lack of additional support modalities to compensate for the additional stress felt during this time. Participants wanted to have additional resources provided to help them cope with the changes and resulting isolation, grief, and loss that accompanied the COVID pandemic. Participants described discomfort with the uncertainty of the pandemic and a lack of reassurance from providers, as described by one participant:

> We don’t talk about how this is affecting us or what it means for the future. It’s just they leave you hanging like, “Okay, well I’m guessing everything’s okay so I’m just going to walk on out of here.” But if you could just say something nice, concise and brief but meaty it would be perfect. “Okay, like hey, I don’t know either what we’re going to do but we’re going to move through this together as best as we can.” If they could even just say that, that would be awesome.

As existing support mechanisms such as group prenatal care and childbirth education moved to the virtual space,
participants noted that they didn’t meet the additional needs for support that the pandemic inflicted upon them, leaving patients feeling unprepared and disconnected. One participant shared how the lack of hands-on education and built-in social support that accompanies childbirth classes interfered in her getting the support she needed in her pregnancy and after her birth:

“We signed up on all these online classes but we don’t think that [met] our expectations because if you actually go to the classroom they can show you what you do, like how to take care of the baby. But now it’s just like video calling. I’m just seeing their face on how did they do [it], instead of [them knowing] that the position that I’m holding is right or something. So I lost [. . .] the classes that we were supposed to need. I was so excited to join those classes because I could get a chance to meet with other mothers that we may build connections, right? But because of COVID we just don’t have the chance of doing that.”

**Impacts of Systems Change on Nurses**

As patient participants focused on influences related to service provision, nurse participants shared experiences that focused mainly on how system-level changes impacted their ability to care for themselves and their patients. The following themes were identified: inconsistencies in policies and policy implementation impacted nurses’ ability to safely care for patients and impacts on nurses from pandemic hospital responses.

**Inconsistencies in policies and policy implementation greatly impacted nurses’ ability to safely care for patients.** Many nurse participants noted that their hospitals or health care systems were vastly unprepared to respond to the COVID-19 pandemic. Even with having one initial patient diagnosed with COVID-19 prior to the first wave of outbreaks, one labor and delivery nurse described a lack of organization and planning on the part of the hospital:

“I felt like we were totally unprepared for a larger wave of patients. When we just had the one I felt like it went really well, so I was disappointed to see that in the, at least a month, more like six weeks since we’d had just the one COVID patient, that not a lot had been done to prepare in the meantime, both on a national scale and just at our hospital.

Several inpatient nurses noted feeling like hospitals were taking a reactive stance instead of looking ahead. One nurse participant shared:

“It just was very—everything’s been very reactive the whole time. Which I know, because nobody’s ever experienced anything like this but my frustration was like, ‘Why not be proactive and protect all of us?’

Nurse participants across multiple health care systems described having management tell them to NOT wear a mask at the beginning of the pandemic, despite knowledge of airborne or droplet spread of the majority of respiratory viruses. One described her experience having management interfere with her ability to protect herself:

“I was wearing a mask from day one and I kept getting told by management I wasn’t allowed to wear a mask, there was no need to wear a mask and I did anyway.”

Even continuing past the initial responses around masking and personal protective equipment (PPE), participants described a shortage of PPE that has adversely affected nurses’ ability to stay safe in their work setting, as described by one inpatient nurse about 4 months after the start of the pandemic:

“They just want me to get used to wearing one surgical mask all day long and wearing one N95 for eight hours, then putting it in a paper bag and then putting it back on my face. I think that’s just—there’s been no communication about when is this going to end? When are we going to get to the point where we can use this PPE as it’s meant to be used?”

In addition, nurse participants described the struggles coping with rapidly changing policies and the inability to feel safe in their work environment. As one nurse described, policies in her labor and delivery unit changed rapidly and were not disseminated in ways that supported transparent communication:

“I felt like at times on my shift policies would change literally every 15 to 30 minutes. You do something one way and you get an email within the hour that this now has changed and we’re doing this procedure this way and it was just constant like nobody knows what they’re doing so it was very stressful.”

Nurse participants described the moral distress of seeing their system not following, or delaying policy change towards, national guidelines for infection prevention. One inpatient nurse described feeling unsupported by management when asked about this:

“My big questions were, ‘Why aren’t we following these recommending bodies’ that are telling us that we should be wearing all of the [PPE]. But what are our guidelines for this? We don’t have guidelines. We’re not really sure what we’re supposed to do. [. . .] So our management told us, ‘A lot of your recommending bodies are saying ‘What would happen in a perfect world’ but it’s not a perfect world and we don’t have the PPE for that so we’re not doing that.’ It was kind of like, ‘Okay, thanks for that.”

Many nurse participants also highlighted the lack of transparency in how their hospitals are responding to COVID, leaving nurses to wonder about risk of exposure and ability to trust the response. One participant described feeling defeated by the lack of support and accountability from her management regarding the risks of exposure as part of her job:
Nurse participants acknowledged that they were expected to take additional risks that other providers were not, which was interpreted as nurses not being valued as part of the health care team. One participant described an interaction with an anesthesiologist in her unit that highlighted how nurses were not valued and considered expendable in the hierarchy of health care providers:

[The anesthesiologist] is sitting there telling me, “Hey, I don’t need to be exposed to this person because she has Covid and there’s one of me.” I’m thinking, “I understand there’s more nurses than you but you’re basically saying we’re expendable because we’re up in her face all the time. We’ve been in there all night trying to get her comfortable. She’s miserable.” I don’t know, it was just inappropriate and definitely not a great thing to have happen.

**Impacts on nurses from hospital response.** Overwhelmingly, nurse participants described a decreased trust that their workplace would support them and keep them safe while providing care to others. One nurse described a feeling that management wanted them to be thankful for what they are receiving instead of expecting a higher standard:

*Why am I doing this and how can I even do a job that I like if I can’t do it well and if I don’t have the proper resources to do so and if I don’t have the support from management?” I mean, if you don’t have supplies you don’t have supplies but you don’t have to tell me in that way that you take what you can get or you have what you have. And she said, “I gave you an N95 today and most people don’t have that.” I said, “Well I have two positive patients and most people don’t have that.”*

Nurses described wanting more compassion and respect from hospital administration, with one participant describing a need to be seen as an individual who is being placed at risk:

*That just really hit me. I was like, “Okay, well, I’m just a number. I’m not a person. It doesn’t matter as long as they have somebody to take care of patients.” Yeah, I get that but I guarantee most people are going to value their family and themselves more than a mass majority of patients. So I just think a little compassion can go a long way and there’s not a lot of that going around nowadays.*

Many nurse participants noted feeling expendable or disposable by hospital administration, leading to low morale and mistrust. As one participant shared:

*I think a lot of nurses feel disposable. We worked really, really hard keeping up with the changes, trying to keep ourselves safe, trying to keep our patients safe and then fighting to protect ourselves and then having—then we would have coworkers who you notice trends that they’re calling out sick a lot and you’re wondering, “Is this food poisoning (laughs),” or is this something else? Is it COVID or not? And the hospitals have sent many emails that people are not required to share if they are positive, which is really hard, especially because we cannot properly social distance on our unit.*

Nurse participants felt that they were sacrificing themselves for their patients, putting themselves and their families at risk at the expense of the need to provide care. One inpatient nurse shared her experience balancing the risks she takes at work with the resultant risks to her family:

*I think where we work we get so involved, we forget about ourselves, right? We just get so involved and then all of a sudden the thought will come, “What am I doing? Am I doing good for myself or not? Or I’m just doing everything for this patient and then I’m not thinking about my own family.” Even if I just put myself okay there, let whatever happen to me but am I doing, like, I have responsibilities for my family too, I’m just not a nurse, right? I’m a mother. When I took the oath to be a nurse, before that maybe I took oath to be a good mother.*

Several nurse participants described work-arounds that they created in order to protect themselves from ineffective response or policies. One nurse participant decided to change up the reporting structure between shifts to reduce crowding:

*So a few weeks before April I some of us charge nurses came up with an idea to split huddle up. So my L & D Unit there’s four like pods or quads. Split it up so we were kind of socially distancing more and giving out one huddle information sheet per quad and having like a leader, a quad leader, do huddle on that quad instead of the charge nurse from the off coming shift do it for the oncoming shift. So, like all these things I feel like we started to implement ourselves, caring more before the hospital started to (laughs).*

Another nurse participant stepped in to train the other nurses on proper techniques for using PPE:

*Two weeks went by and no one had been trained in donning and doffing PPE, which I didn’t realize. So I started doing it just by Zoom from home because obviously the educators weren’t going to do it so I just like had one set of PPE from global haul of work stuff that I do and was just doing it from home in my study with anybody who wanted to watch and like God forbid my managers ever found out (laughs).*

Despite a loss of trust in their workplaces and a need for more recognition and compassion from hospital administration, nurse participants described a dedication to maintaining quality care and agency in changing systems to make themselves and their patients safer.
Impacts from COVID-19 on Patient Care

Aside from responses to structural changes within the health care system, both nurse and patient participants noted that individual health care experiences were impacted by the COVID-19 pandemic. Specifically, participants described both changes in care related to perceived exposure risk and changes in care related to racism and discrimination.

Changes in care from perceived exposure risk. Many patient participants noted a change in the care they received due to perception that their providers were treating them as potential vector for COVID exposure. In particular, one participant noted feeling like that treatment led to less compassionate care:

The nurse who roomed me seemed like extremely put off by my temperature being like 99.7, as I was like crying hysterically (laughs) and she was like, “Oh my god, you have a fever!” and I’m like, “No, I don’t. That’s not actually a fever.” It was clear that people were very suddenly concerned that there was some kind of risk of exposure from their patients. [. . .] I guess the assumption she made is that I had a fever and had lied about it to the screening people and then had come in. I saw her a couple times after that and she was like really still seemed very angry with me about it even though she could see from my records obviously that it was not in fact the coronavirus (laughs).

Participants noted fewer interactions with nurses in the hospital, which translated for them to feeling less cared for during their stay. One patient participant described feeling like her support disappeared after her birth:

People were there [in labor] to support me and to make sure I was okay and then I felt like postpartum everyone disappeared. [. . .] I left as soon as I could but like people were forgetting my medication, no one came in to make sure that I had like a peri-bottle or extra pads. I had fundal check for a little while but it was like very clear that [. . .] the nurses were trying to limit exposure.

A Black patient participant even noted feeling like she stopped receiving care postpartum:

Nobody came in our room and checked on us for hours. I think that lady told them, “Just leave them in there. Like don’t go help them. Don’t go do anything.” Nobody came in there for hours. This happened in the morning. Nobody came to check on us, nobody came to ask did I need any medication or anything. So we were like, okay, well when is somebody going to come? All that stopped. We stopped getting care. That wasn’t okay.

Relatedly, nurse participants shared examples of how they felt that their care provision suffered due to the enacted changes by their workplace in response to COVID, leading to poor patient experiences. Nurse participants noted that the structural changes, mainly how administration controlled their work environment, influenced how they could provide care. One nurse described an experience realizing her care was suboptimal due to her supervisor restricting her access to PPE after reading about her previous patient’s experience:

I read [the online news story] and I said, “Why is that name so familiar?” Then it just dinged. It dawned on me. I said, “That was me. This was my patient. She gave an interview regarding my care.” That stung because I remember going to my manager’s room that day and asking for more supplies so that I could go into the room more frequently without having to break the gowns and reuse the gowns and she said, “You use what you have and I’m not giving you anything else.

Another nurse described her perception that policies were driving a change in how nurses cared for patients:

. . . the message with those patients has been to try and limit contact, which is sad. Like they’re already limited in support and then you’re wanting us as their nurse who’s trying to fill in that support gap to limit our contact with them as well.

While nurse participants described having some agency in how they structure their day, the limits on material resources and through policy impacted how they could provide care.

Changes in care related to racism and discrimination. Participants of color, in particular, noted incidents of disrespectful care and described how the racism that normally exists within the health care system was magnified due to the pandemic. One Black patient participant described the complex interplay in the effects of both racism and pandemic response:

Being of color, you already kind of deal with the standoffish approach from certain people and so like [. . .] the virus kind of gives you that reason to, it’s just like that. It’s like even though I already feel this way, now I have a reason to act this way. [. . .] Well for us it’s kind of like, “Oh, it’s the virus” but for them it’s just like, “No, it’s the virus and I also don’t like you.” That type of thing. But if you catch on to it you’re like, “Oh, no, they actually don’t like me and it’s the virus too.

Another Black patient participant, who was also a nurse, described how her educational privilege didn’t protect her from experiencing racism during the pandemic:

Of course [racism] is a thing and it’s like I’m an educated black woman. I’m a nurse. I know what’s going on with my body and I know how this stuff works and I still feel like so inferior; like to my team. That’s crazy to me. Which I’m okay with because we don’t talk about the fact that I’m a nurse because I don’t want you to treat me like I know everything and just not explain anything but they really don’t. I don’t even know if they remember I am a nurse to be honest with you.

Similar to patient experiences of how changes in care disparately affected BIPOC individuals, nurse participants also
noted the impacts of racially biased care on patients. One Black nurse described an encounter she witnessed with an obstetrical resident physician:

_Recently we had an example where a couple was in triage and there was this kind of stressful situation and they needed to talk to her about possible induction and so a second year resident went in to go talk to her about the need for induction and instead of including the father in the conversation or even introducing herself, she went in, completely turned her back on the dad, started having the conversation with the mom, didn’t acknowledge his presence at all and then later on when she was confronted about it, she said she was tired. My thing is this, is that I’ve been there 10 years and I have never seen that with any Caucasian couple or really anyone else for that matter but in particular, yeah._

Nurses also saw racism through neglectful actions with patients from marginalized communities. One nurse who worked in a high-risk antepartum unit, in which patients can stay for extended periods of time, described how preference was given to White patients for flexibility and accommodation:

_We have people who don’t speak English as a first language, […] and they just sit in their room by themselves, without their kids, without their family […] because they know they can only have one visitor a day and they follow the rules and now, you know, the squeaky, the person who already has a visitor and is now asking for more, you’re going to give it to that person and of course it just feels like it’s a white woman who is getting this. That person was also moved to a larger room. It’s like of all the patients we have on here, why is it that this patient got the larger room? Do you know what I mean? Why did we accommodate that?_

The repeated instances of racism and discrimination described by both patient and nurse participants highlight the pervasive nature of systemic racism within the health care system, present before the pandemic and exacerbated due to the pandemic.

**Discussion**

The health care system surrounding pregnancy and birth, which historically has relied on in-person care and multiple avenues of social support, fell short of expectations during this pandemic. Both patient and nurse participants highlighted several changes enacted in response to COVID-19 that adversely affected their care or ability to provide that care. The psychological impacts from those changes were significant and included loneliness, isolation, and mistrust from patients and mistrust and low morale from nurses. Importantly, both nurses and patients described how COVID amplified racially biased and disrespectful care experiences for Black women and birthing people. The inclusion of both patients and nurses in this analysis provided a deeper understanding of the impacts of systems-level changes due to COVID-19, and allowed for clearer perspectives on possible avenues for change.

In addition to existing systems not meeting patient needs, there has been an overall lack of provision of additional support mechanisms to mitigate the significant psychological effects from fear, stress, loss, and isolation that COVID has presented for both patients and nurses. Participants noted how simple reassurance from, and connection with, providers could have had vast influences on their ability to cope with the changes due to the pandemic. From the nurse perspective, participants highlighted how the response from the health care system, which relies on policies and procedures for nurses to function safely in the hospital setting, and the policy roll-out related to the pandemic, was notably inadequate, leading to a collective mistrust of management and administration. Many nurses felt unsafe and unsupported, which had a direct effect on patient care experiences.

Numerous articles have been written since the COVID-19 pandemic began in the United States around the impacts of the pandemic on maternal health care, particularly around disparities in health care and treatment (Minkoff, 2020; Niles et al., 2020). While the responses to COVID from the health care system are noted to miss the mark for most patients, Black patient participants described a care system that amplified disparities through disrespectful individual interactions as well as through lack of culturally appropriate policies. Even pre-pandemic, hospitals were common locations for BIPOC patients to experience racism and discrimination, both in the form of individual interactions with providers as well as within larger structures such as drug testing policies and insurance acceptance (Altman et al., 2019; McLemore et al., 2018; Roberts & Nuru-Jeter, 2012). The pandemic brought forth further amplification of these issues as well as adding in new struggles, as seen mainly within patient-provider interactions. As the pandemic continues on, there is a great need to focus on how policies and changes enacted at the health care system level affect marginalized communities (Davis-Floyd et al., 2020; Niles et al., 2020).

The apparent value placed on frontline workers such as nurses was also highlighted in this study in descriptions of the apparent disregard by management for nurses’ safety and wellbeing within the systems of care. Nurse participants described feeling de-valued and expendable, which then impacted morale and moral distress in having to balance the risks of COVID-19 versus the need to care for patients. There is growing literature around how frontline workers’ health and well-being has been repeatedly undervalued during the pandemic, leading to increased burnout and the perpetuation of trauma to a woman-dominant profession such as nursing (Bahn et al., 2020; Clavijo, 2020; Thomason & Macias-Alonso, 2020). Considering the impacts to the nursing workforce from the COVID-19 pandemic, both in terms of those leaving the field and those getting ill, there needs to be critical reflection by hospital management about how they can
better support those workers who are being asked to risk their lives to keep their institutions functioning.

This study also illuminated how both nurses and patients have great mental health needs that are not currently being addressed in many settings, as indicated by feelings of isolation and disconnect from patients, and feelings of burnout and moral distress by nurses. Increasing mental health assessment, support, and services for both patients and nurses could help improve a person's state of wellbeing amidst crisis. Evidence is clearly illuminating a mental health crisis that was caused by the pandemic for both patients and health care workers (Ayaz et al., 2020; Berthelot et al., 2020; Pappa et al., 2020), and health care systems should be instituting additional measures and supports to help those affected.

Another action distilled from this study was to increase the transparency, communication, and reassurance around policy changes and provide support that mitigates the potential impacts of those changes. Nurses needed transparency in knowing why policies are changing and how to mitigate potential impacts from those changes. Patients needed to understand those policies that affect them and receive reassurance from providers to mitigate some of the uncertainty around what to expect. Levels of stress and anxiety on both patients and nurses are high in response to the pandemic (Berthelot et al., 2020; Labrague & De Los Santos, 2020), and there is a need for clear, organized, and transparent communication at all levels: patient, nurse, and management.

This study should be viewed within the setting of several limitations. Given the need to physically distance during the pandemic, all interviews were conducted via a virtual online platform (Zoom), which may have limited the non-verbal and conversational quality of the interviews. Additionally, as with most qualitative research, these results are not generalizable and are meant to illuminate depth of perspective, and therefore different settings may yield different perspectives. However, the vast changes related to COVID-19 on hospital systems have likely been similar across the United States due to national and professional guidelines that have been enacted in the United States. In addition, demographic information outside of racial, sexual, and gender identities, such as socioeconomic status, was not captured in this study, which may have influenced perspectives of those who participated. The rapidly changing nature of the pandemic also may limit the relevance of the identified themes as systems and structures changed notably through different phases, and so results need to be interpreted within that context. This study also held many strengths, as seen in the diverse population of participants in both the patient and nurse groups, allowing for non-dominant perspectives to surface within the interviews and analyses. This study illuminated multiple recommendations for care improvement, coming from both the patient and nurse perspectives. Future research should include a deeper qualitative exploration as to the relational dynamics in place within the health care system, particularly between nurses and management.

While the COVID-19 pandemic has tested the U.S. hospital systems in many ways, there is considerable impact being felt by both patients and nurses in the context of hospital pregnancy and birth care. As highlighted by participants in this study, the systems in place did not adequately support patients or the nurses caring for them, and efforts are needed to make sure that changes at the systems levels have the health and wellbeing of both patients and nurses in mind. All system changes should be tailored to address the needs of pregnancy and birth care and to assure that the impacts from these changes are equitable (Shorey & Chan, 2020). This pandemic will continue to have lasting impact on pregnant and birthing families, and the nurses who care for them, and it is imperative that hospitals examine their role and any potential impacts.

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