Explaining Reproductive Health Disparities: Violence in the “Colorblind” Institution of Medicine

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Medical policies have resulted in violence that has a formal role in regulating the reproductive rights of women of African descent in the United States from the Jim Crow era (circa 1965) to present day (2021), resulting in significantly racialized reproductive health disparities regardless of social or economic influences. This thesis explores why reproductive violence against African-American women persists, regardless of women’s own class and educational background. I have focused on the potential impact of two structural components that I hypothesized contributed to the perpetuation of reproductive violence against Black women and persistent health disparities. The two factors explored in the thesis are: 1) the lack of Black representation in this field of medicine and 2) the devaluing of Black pain. My project employs a historical lens to analyze whether reproductive violence has varied over time both in nature (i.e., severity of violence, and mechanisms of bias and manipulation) and in outcome (i.e., changes in the demographic characteristics of women affected). Such an analysis of reproductive rights has contributed to my contemporary understanding of the roots of ongoing disparities in reproductive health outcomes—particularly racial bias and discrimination (perpetuated by physicians, teachers, and healthcare practitioners), both of which stem from structural racism.
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Introduction

Reproductive rights have historically and continue to be restricted for Black women in the United States. The father of modern gynecology, James Marion Sims, performed experiments and perfected his technique on slave women (Washington 2008: 61). Centuries later, federally funded clinics replicated Sims’ methods by conducting sterilization and eugenics practices disproportionately on Black women (Roberts 2017: 74). Today, in the twenty-first century, quotes like this—from an expectant Black mother—demonstrate the ongoing problem: “We had already decided on a home birth, because of concerns about negative birth outcomes for Black women in America—according to the Centers for Disease Control and Prevention, the risk of pregnancy-related deaths is more than three times greater for Black women than for White women, pointing, it seems to me, to systemic racism” (Turner-Smith and Betancourt 2020: np/3/20/2021). Such statements fill media reports and social media conversations but have not led to systemic change.

My research explores why reproductive violence against African-American women persists, regardless of their class and educational background, making the issue more universal within this community. I focus on two key structural components that I hypothesize contribute to the perpetuation of Black-White reproductive violence and health disparities: 1) the lack of Black representation in this field of medicine and 2) the devaluing of Black pain.

The first section of my thesis is historically framed. Here, I will compare distinct periods of reproductive violence perpetrated against Black women since the founding of the United States. In this opening section, I discuss previous methods of violence, who the violence impacted, and the severity of the violence. The data for this section is secondary sources and historical epidemiological data that encompass both public policy and reproductive health practices.
The remainder of the thesis focuses on the contemporary era. In previous studies, researchers have focused on the intersection of race, gender, education, income, employment, and other demographic factors. In doing so, previous studies tended to weight external factors (e.g., insurance type, educational level, nutrition) more heavily than they should have. In my thesis however, I seek to demonstrate that although a number of factors are important, the race-gender relationship is the most fundamental (Jackson, Phillips, Hogue, and Curry-Owens 2001: 96). Thus, I explore why class or education as factors affecting maternal health are not sufficient to explain ongoing reproductive violence. By taking an intersectional lens of race and gender, I have determined why current maternal health disparities have surpassed previous mechanisms of violence.

In the final section of my thesis I focus on understanding how structural racism impacts reproductive health in the contemporary United States. My primary areas of focus will be maternal health and mortality disparities. It is in this section that I explore contemporary epidemiological data (public health studies) that pertain to the lack of representation in the medical field within America and devaluing of Black pain.

In order to explain this contemporary race-gendered variation of reproductive violence, I argue that it is necessary to explore two specific factors that have allowed for the perpetuation of Black-White reproductive health disparities: 1) the lack of Black representation in positions of authority within the healthcare institution and 2) the devaluing of Black pain. However, before discussing these factors more in depth and understanding how each of them are manifested in everyday life, it is important to “zoom out” and understand how I arrived at the conclusion that Black-White reproductive health disparities are an outcome of reproductive violence (see Figure One, found in Appendix One).
Key Literature and Varying Explanations

Reproductive violence is a form of medical violence. Scholar Johanna Shapiro (2018) defines medical violence as: “a curious product of the physician’s arrogance, trappings of technique, and the laity’s faith that medicine can solve all problems… In these instances, the patient becomes a kind of victim, treated differently and damagingly by a physician who (usually unwittingly) has set aside the patient’s humanity.” (p. 2). Because reproductive violence encompasses both women becoming victims of physicians’ choices and women experiencing pain as a consequence of medical procedures, I understand reproductive violence to be a form of medical violence.

Many sociologists and other social scientists have engaged in conversations surrounding reproductive coercion and abuse (Silverman and Raj 2014: np/3/28/2021; Fleury-Steiner and Miller 2019: 1228; WomensLaw.org 2020: np/3/28/2021). However, previous studies have tended to focus on domestic abuse and intimate partner violence rather than explicitly defining or conceptualizing reproductive violence in the context of healthcare providers executing said violence. One overlapping theme amongst scholars who study reproductive coercion and abuse in the context of intimate partner violence, and scholars who look at how reproductive violence manifests in the context of the healthcare system itself, is an emphasis on the notion that women who encounter any form of reproductive “violence” also lose reproductive control (Silverman and Raj 2014: np/3/28/2021; Fleury-Steiner and Miller 2019: 1228; WomensLaw.org 2020: np/3/28/2021). However, in their 2014 publication, Silverman and Raj indicate that they understand reproductive coercion to also: “consist of behaviors that directly interfere with contraception and pregnancy, reducing female reproductive autonomy. The two forms of
reproductive coercion are pregnancy coercion and contraception sabotage” (see definitions in Appendix Three) (Silverman and Raj 2014: np/3/28/2021). Other scholars have created similar definitions (Fleury-Steiner and Miller 2019: 1228; American College of Obstetricians and Gynecologists (ACOG) 2013: 1; Virginia Sexual and Domestic Violence Action Alliance 2018: 9 and 10). This broad definition leaves room for reproductive violence to be analyzed through the scope of medical violence, patient-provider relationships, and poor healthcare outcomes that are all explored in this thesis.

There is a debate amongst scholars within and across the social sciences over the cause of racialized reproductive health disparities in the United States. Evidence varies and this literature review synthesizes arguments on both sides and takes into consideration leading voices in these debates. Some scholars argue that disparities stem from factors at the intersection of race, socioeconomic status, and gender; while others argue that although race may impact reproductive violence, it is not as significant as some scholars have suggested. By merging human rights, public policy, political science, sociology, and public health frameworks, I was able to study examples of gendered medical violence throughout US history. However, unlike most social scientists, my project does not wholly rely on a multi-causal argument; rather, I argue that while these factors causally contribute to reproductive health disparities, they are not sufficient to explain the persistence of racialized maternal health disparities in the US.

*Historical Reoccurrence of Violence:*

I have relied extensively on secondary source material to lay the groundwork of the historicization of reproductive violence. Maria Fannin (2019) discusses the historicization of violence against Black women that mirrors the contemporary mechanisms of violence my project
seeks to analyze (p. 39). Within this article, Fannin highlights modes of reproductive violence that fall within the two categories my project seeks to explore: Black pain and Black representation within the healthcare field. For the purposes of this thesis project, I will be referencing Fannin’s conceptualization of Black pain. In her article, she understands Black pain to be “Differential access to pain relief, reproductive justice activists argue, [which] determines who suffers and who is relieved of pain… the experience of pain is a consequence of social differentiation in which one group’s pain is deemed more worthy of sensitive treatment than another’s” (2019: 25).

The first example Fannin discusses is pain management during childbirth during the Antebellum Period. More specifically, Fannin highlights that anesthetics were developed and utilized on White women who were perceived to be both “civilized” and “sensitive,” whereas African-American women were not anaesthetized during the birthing process because they were perceived as individuals who did not experience pain (Fannin 2019: 39). Another example Fannin’s article provides is interview data which reveals that Black, Asian, and Hispanic women often describe being pressured into accepting epidural pain relief instead of an analgetic or even a local anesthetic, in order to expedite their labor process, and/or are more likely to experience epidural failure (including during cesarean sections) (2019: 25; ACOG 2017: np/5/1/2021).

Fannin also explores the implications of structural racism and structural violence as they

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1 Structural racism: “is defined as the macro level systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups (Powell 2008). The term structural racism emphasizes the most influential socio ecological levels at which racism may affect racial and ethnic health inequities. Structural mechanisms do not require the actions or intent of individuals (Bonilla-Silva 1997)” (Gee and Ford 2011: 116).

2 Structural violence includes “social structures that impede individuals, groups and societies from reaching their full potential. In medicine, it means institutions and established societal modes of functioning that lead to impairment and limitations in human life. Their existence is so normalized and established that they are almost invisible and therefore either willfully or naively overlooked or ignored. Structural violence is based on the idea that certain societal patterns (of social relations and roles, economic arrangements, institutional practices, laws etc.) are so firmly entrenched that they are perceived as a ‘given,’ just the way things are. Sources of suffering are deeply
pertain to Black mothers, when she claims that Black women’s reproductive freedoms are curtailed by the “racist legacies of the mythologies surrounding Black womanhood, and by the class-stratified US healthcare system” (2019: 38). All in all, Maria Fannin’s article fully articulates the historic origins of contemporary modes of devaluing Black pain, and a lack of Black representation and advocacy in the healthcare institution.

Fannin asserts that the devaluing of Black pain is not a new phenomenon, but rather an example of historicized violence when saying, “In the contemporary United States, the legacies of racialized hierarchies of labor pain remain: devaluing the experiences of Black birth givers’ pain and requests for pain relief is one of the ways in which the maintenance of racial inequality is enacted in the US medical system” (2019: 39). Fannin’s insights are complemented at another level by Johanna Shapiro’s work, which discusses why victims subject themselves to abuse or do not fight back against medical violence. Shapiro (2018) claims that “As an intrinsically vulnerable population, patients are susceptible to multiple forms of violence. Faced with the ordeal of ongoing distress and perhaps impending death, the willingness to make a trade-off between acceptance of a certain amount of violence for the potential reduction of such misery becomes understandable, even appealing.” (2018: 5). It is important to note that Black women are particularly vulnerable because they are members of more than one vulnerable population in this context: they are women, Black, and a patient.

Reproductive and Medical Violence Based on Socioeconomic Status:

Many social science scholars agree that while socioeconomic status is a driving force in reproductive and medical violence, factors such as race or ethnicity also play a key role.
Although they may vary in opinion regarding the degree to which socioeconomic status is the primary factor—social scientists tend to emphasize it over all other factors. Lu and Chen’s (2004) article suggests that although race may impact reproductive violence, it may work in conjunction with additional factors, or may not be as significant as we often believe. Thomas Volscho’s (2011) research findings also support this idea because he indicates that between the 1990’s to the early 2000’s, although gender and race are important influencers, women who might not have otherwise been sterilized³ (Latinx women and non-Hispanic White) were often subjected to such violence if they came from low-income backgrounds (pgs. 684 and 5). Each of these studies concurs with Shapiro, William, and Augusto’s (1983) conclusion: sterilization is utilized as a means of population control; however, this form of violence is largely attributed to targeting a particular socioeconomic stratum rather than a specific racial group (p. 1854). However, Tucker, Berg, Callaghan, and Hsia’s (2007) article finds that Black and non-Hispanic White women are nearly as likely to develop a pregnancy and birth complications⁴, yet Black women are two to three times more likely to die of such complication (p. 249). Ultimately, Tucker et. al conclude that the question of why Black women die at higher rates when they are just as likely as White women to suffer from pregnancy complications has not been answered because the racial component of this question has been left out of the conversation very frequently as each of the authors above have exemplified (2007: 249).

³ “Sterilization describes a process that destroys or eliminates all forms of microbial life and is carried out in health-care facilities by physical or chemical methods” (CDC 2016: np/3/20/2021).
⁴ “Complications of pregnancy are health problems that occur during pregnancy. They can involve the mother’s health, the baby’s health, or both. Some women have health problems that arise during pregnancy, and other women have health problems before they become pregnant that could lead to complications. It is very important for women to receive health care before and during pregnancy to decrease the risk of pregnancy complications.” (CDC 2020: np/3/20/2021). Examples of pregnancy and birth complications include: hypertension, preeclampsia, diabetes, anemia, hyperemesis gravidarum, and more (CDC 2020: np/3/20/2021).
Some social scientists claim that income is a driving factor behind health disparities in communities of color generally, but Black communities in particular, resulting in higher rates of acts violence (namely sterilizations) for low-income Black women. For example, Stern (2005) analyzes a shift towards more severe and “focused” sterilization practices once federal funding supported eugenics practices in the mid-twentieth century; these sterilization practices primarily targeted low-income communities of color (p. 1132). This therefore begs the question of whether eugenics and other forms of reproductive violence increased in severity once they became state-sponsored or state-enforced, thus suggesting that some structural factor undergirds and supports the disparities in reproductive violence in a historical and contemporary sense.

Downing, Thomas, Bullock (2007) build upon the relationship that Stern suggested by drawing a link between socioeconomic status, reproductive health, and support by highlighting that low-income Black women were more likely to be advised by their physicians to limit their childbearing (e.g., by recommending long-term or even permanent birth control practices) than were White women in the early 2000’s (p. 1803). Thomas Volscho’s 2011 article moves beyond Stern, Downing, Thomas, and Bullock’s emphasis on economics, instead introducing the concept of “reproductive racism” to explain racialized health disparities in the contemporary sense. Empirically, Volscho analyzed disproportionate rates of sterilization racism practices in America specifically pertaining to the drug Depo-Provera (a long-acting birth control product) and found that this drug has been prescribed disproportionately to women of color (specifically African-American and American Indian women), especially those from low-income communities (2007: 674 and 684). Borrero, Moore, Qin, Schwarz, Akers, and Creinin’s (2009) article expands on
Volscho’s discussion and finds that there is a disproportionate utilization of sterilization amongst women of color in comparison to their White contemporaries (p. 122).

_Race-Gender Lens, with Stress as the Cause:_

The sociologists and political scientists cited above diverge from the broader silence in the literature on the implications of reproductive health disparities for Black women generally. These articles broadly frame their research through an intersectional lens but vary in terms of how influential they consider additional factors to be on health disparities. Factors such as income and wealth, education, and family background/upbringing can all impact birth outcomes as well as complications and are all potentially relevant.

It is important to note that some sociologists concur with the notion that the Black-White reproductive health disparities amongst women in the US can be attributed (in part) to the perpetual stress of systemic oppression and racism, starting from gestation. In fact, a true understanding of reproductive health disparities and outcomes cannot occur absent a framework centered on race. Lu and Chen’s (2004) article ultimately found that “the addition of stress constructs to the stepwise regression model minimally affected the association between race-ethnicity and preterm⁵ birth, and none of the stress constructs were significantly associated with preterm birth” (p. 691). Giscombé and Lobel’s (2005) article echo’s these sentiments when indicating that although socioeconomic and behavioral factors influence health and mortality outcomes, these factors cannot fully account for the racialized health disparities without considering the influence of prenatal stress (p. 662).

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⁵“Preterm birth is when a baby is born too early, before 37 weeks of pregnancy have been completed… A developing baby goes through important growth throughout pregnancy—including in the final months and weeks. For example, the brain, lungs, and liver need the final weeks of pregnancy to fully develop” (CDC 2020: np/3/20/2021).
Jackson, Phillips, Hogue, and Curry-Owens (2001), made a similar assertion, claiming that although it has been presumed that education, employment, and income provide a shield against poor health outcomes in Black infants (p. 96). Rather, epidemiological data suggests that stress is a particularly large factor contributing to Black-White infant health disparities because regardless of socioeconomic status or educational attainment, Black women as a group suffer from racism-related stress (Jackson, Phillips, Hogue, and Curry-Owens 2001: 96). These stressors, according to Jackson et. al negatively impact birth outcomes in Black mothers (2005: 96). Moreover, Nuru et al. (2009), similarly to Lu and Chen’s 2004 article, conclude that childhood trauma due to racism negatively impacts experiences of Black women throughout the course of their entire life (p. 35). David and Collins (1997) employed findings that resurfaced decades later in Nuru et. al and of Lu and Chen’s studies, ultimately concluding that racial differences in birth weight persist independently of numerous social and economic risk factors, suggesting that reproductive risk factors (like stress) may contribute to negative outcomes (David and Collis 1997: 1210 and 13). Finally, Rosenthal and Lobel (2011) employ a race-gender lens to arrive at the same conclusion: stress (particularly stress caused by racism and a lack of structural support) has created the racialized disparity in birth outcomes (p. 982).

Political Science and Political Psychology Inequality Studies:

While many studies have focused on the implications of social structures and causal factors on patients, very few have sought to understand how these things impact healthcare practitioners—particularly the racial and ethnic demographics of physicians and medical students. Research by political psychology scholars and political scientists converge around the finding that historically excluded populations are under-represented both in politics and in the
professional ranks of the healthcare field. Because Black women are underrepresented in the obstetrics and gynecology field, they are at a comparative disadvantage in advocating for themselves professionally within the field, and thus face greater negative outcomes than their White counterparts. Various authors emphasize the importance of having representation for communities of color in order to ensure that their voices are heard. Dovidio, Penner, Albrecht, Norton, Gaertner, and Shelton (2008) claim that both implicit (prejudice and stereotyping) along with explicit (verbal behavior) biases together affect health care outcomes directly. Dovidio et al. illuminate how inter-racial interactions often produce mistrust amongst African-American patients (2008: 478).

Ultimately, Dovidio et al. have greatly expanded upon a debate attributing racialized maternal disparities in part to a lack of Black representation in the healthcare field. Dovidio et al. have argued that implicit and explicit biases directly impact health care outcomes; the authors then demonstrate how interracial interactions often produce mistrust amongst patients (2008: 478). King’s 2003 article, which provides a similar debate to Dovidio et al., highlights that patient-provider relationships often negatively impact health outcomes in Black patients and suggests that if more Black patients had Black physicians, trust would increase, and thus there would be more positive health outcomes (p. 366). LaVeist and Carroll’s 2002 article also arrived at a similar conclusion when demonstrating that African-American patients who were treated by African-American doctors exhibited greater satisfaction than those who were treated by White and non-White doctors, suggesting that increasing the overall number of Black health care providers in the US would increase positive outcomes for Black patients (p. 940).

*Summarizing and Reconciling Current Literature with my Explanatory Framework:*
All in all, scholars across multiple disciplines (including sociology, human rights, political psychology, and political science) have each contributed to the conversation surrounding maternal mortality, medical racism, and medical violence within the US. While many of their arguments are compelling and have considerable merit, only a few scholars discuss the key causal role that race and gender play in combination to spur Black-White maternal health disparities in this country.

One group of scholars finds that there is in fact a major problem with maternal health in the US but find that this is not so much a race-gendered problem as it is the consequence of lack of infrastructure and support for low income communities. Many proponents highlight that although race dictates higher rates of sterilization in communities of color, sterilization has also increased tremendously amongst low-income White women (Shapiro, William and Augusto 1983: 1853). Thus, the targets of sterilization often depend more on one’s social class than anything else (Shapiro, William and Augusto 1983: 1854). However, a group of scholars pushes against this argument by claiming that an even smaller niche of low-income Americans is truly disadvantaged: Black women from the working and underclass. Within this frame, low-income Black women have higher reproductive health disparities because they experience explicit and implicit racial biases in addition to lacking proper prenatal care, nutrition, and/or healthcare infrastructure that many low-income women also experience.

Another group of scholars argues that the reason there are so many suboptimal outcomes for Black mothers is because there are not enough Black physicians. Rather than framing their argument through a race-gender lens, many scholars have claimed that race relations negatively impact various sectors of society, health care included. Consequently, African-Americans collectively often receive suboptimal care (LaVeist and Carroll 2002: 937). Finally, some
scholars have argued that although socioeconomic status and representation are a problem, racism, particularly the everyday racism Black women have experienced their whole lives, has created so much stress for them that poor health outcomes become nearly inevitable. Utilizing race-related stress as a causal factor expands the population being discussed to include all Black women rather than women from particular socioeconomic strata. Many utilize this argument to undergird the assertion that even if all other variables remain constant, differential levels of Black maternal health persist (Tucker, Berg, Callaghan, and Hsia 2007: 249 and Tangel, White, Nachamie, and Pick 2018: 845).

As a social scientist, I have developed a project to explore why Black mothers in general (regardless of income, background, education, etc.) are systematically more disadvantaged than their White counterparts in the context of reproductive health. While factors such as education or income are casually significant, are not sufficient to explain the persistence of racialized reproductive health disparities in America. I argue that the reason for the perpetuation of reproductive violence (itself reflected in higher rates of maternal mortality, smaller birth weight in newborns, and postpartum complications), is because health care institutions generally (and the field of obstetrics and gynecology in particular) lack sufficient representation of African-American women and devalue Black pain.

Previous research has begun to explore why Black women’s pain and experiences during childbirth are so different from their White counterparts; however, most scholars have lacked measurable data, and instead utilized theories and descriptions (in isolation) that were widely accepted within the field as true. Thus, I seek to join the contributions of the scholars who have made arguments pertaining to each of the previously mentioned topics in order to demonstrate that racialized maternal health disparities do not have a one-dimensional cause.
Implications of this Alternative Engagement with the Literature:

Many of the scholars cited within this literature review assume income is one of the primary determinants of these poor health outcomes (Stern 2005: 1132 and Downing, Thomas, Bullock 2007: 1803). I argue that as a result, they fall prey to colorblind racism, “the set of ideologies and discourses that uphold contemporary racial inequality by denying either its presence or its significance” (Burke 2017: 857). My project diverges from previous literature in that it acknowledges the role that socioeconomic status plays in health outcomes, but also understands that when education and income are “controlled” for causally, Black women are still disproportionately affected by higher rates of maternal death than their White counterparts. More specifically, I argue that there is a growing persistence of Black women being impacted by reproductive violence, however, low-income communities of color still experience a higher concentration of this violence.

This project sought to expose a crucial puzzle that exists in the real world, and also transcends simplistic yet persistent one-dimensional explanations. In doing so, I not only synthesized the current literature that discusses this race-gendered relationship, but I also went further by drawing both from critical race theory and politics of inequality scholarship in order to fully highlight this race-gender specific paradox that previous literature has failed to fully explore. Moreover, the two sub-questions my project seeks to answer speak directly to the field of political science. Racialized disparities and the impacts of structural racism as well as lack of representation for people of color are heavily studied within political science; yet, they have not been utilized to discuss the issue of racialized maternal and infant health disparities.
More specifically, the notion that a lack of Black representation within higher-level positions in the healthcare field contributes to negative maternal health outcomes. On a broader scale, this also exposes a lack of Black representation in the senior reaches of obstetrics, which in turn, contributes to poor maternal health. My research thus directly speaks to the lack of Black representation in the institution of health care in general, which in turn is linked to the lack of representation of Black women within the US Government, Congress, positions of power in other professional arenas, and other political entities. It is important to note that people of color who work in the healthcare industry are disproportionately represented in “lower-level” positions such as nursing assistants, home health aides, etc. (Paraprofessional Healthcare Institute (PHI) National 2018: 3). Thus, there must be a structural component that bars them or greatly hinders them from attaining the higher-level positions where their representation is lacking. Similarly, the idea of female representation in these institutions directly contributes to the debate in American politics regarding how best to give women equal access to healthcare and professional support in sectors where they remain under-represented.

**Historical Antecedents and Contemporary Examples**

Black, Indigenous, and people of color (BIPOC) women in the United States have experienced forms of reproductive violence, dating back to slavery and the Antebellum south, and the Tail of Tears and the genocide of Indigenous peoples. This mechanism of oppression is truly as old as the country itself. I have provided specific examples of reproductive violence that have impacted African-American women throughout US history in order to fit the examples within the context of reproductive violence that my project seeks to explore – specifically, the nature of Black pain and lack of representation in the fields of obstetrics and gynecology. It is
also critical to note that there are numerous examples and manifestations of reproductive violence that have historically and are currently occurring. I have simply chosen to provide examples that are most relevant to the context I am studying, but within the framework of political science, an additional notable example of reproductive violence against Black women is rooted in the concept of the White power structure (usually the State) forcefully removing Black children from their mothers and essentially declaring a war on Black motherhood; we see this forced removal of children extending from slavery well into the latter half of the twentieth century during reforms of the US welfare system (Roberts 2017: 153, 4 and 9).

*Experiments on Slaves and Henrietta Lacks:*

Slave experimentation was a natural occurrence integral to a state-supported ideology that rendered slaves and subsequently African-Americans less valued and unequal relative to White Americans. For example, former US President Thomas Jefferson performed a vaccine experiment on over two hundred slaves in order to determine the efficacy of a cowpox vaccine (Washington 2008: 59). Moreover, James Marion Sims, the father of modern gynecology, “is an important figure in the history of experimentation with African-Americans because he so well embodies the dual face of American medicine to which racial health disparities owe so much.” (Washington 2008: 61). Scholar Harriet Washington argues that Sims is too often revered as a women’s health pioneer and benefactor, while his dark past of performing painful and unanesthetized experiments, without consent, on eleven slave women for a period of four years has often been glossed over (Washington 2008: 61 and 4). His treatment of them was so cruel that the several (White) male doctors who had initially come to assist Sims left within the first year, leaving the women to restrain one another and support each other through the process.
It is important to note that Sims was aware of anesthesia because it had been discussed in the medical community by the 1840s and he was willing to administer it to women who lacked “apparent regard for its trouble or risk” (Washington 2008: 65). By 1852, Sims had published a paper on his success with vesicovaginal fistula operations, which he perfected through the abusive and unethical surgeries he performed on the eleven African and/or African-American women (Washington 2008: 66).

Henrietta Lacks has in some sense become the face of Black womanhood and in a larger context, motherhood. During her biology class, Erika Johnson, Lacks’ great-granddaughter, and her classmates used cells from a widely used line (known as HeLa), which originated from tissue taken from Henrietta Lacks who had died in 1951, at age 31, from cervical cancer (Nature 2020: 7). Prior to her death, physicians at Johns Hopkins Medical Center who had diagnosed, and treated Lacks’ disease also took samples of Lacks’ cancerous cells and gave those samples to researchers (Nature 2020: 7). Lacks’ DNA was anonymized without her or her family’s knowledge or consent, and was replicated and utilized for medical research decades after her death. It was not until late 1990’s, when Johnson and her classmates used Lacks’ DNA during a class experiment, that Lacks’ family made this discovery. Thus, Lacks, echoing the pervasive pattern of African-American women who came before and after her, experienced many types of reproductive violence. These included being stripped of her agency and ultimately dehumanized in the name of medical research.

“In the laboratory, her cells turned out to have an extraordinary capacity to survive and reproduce; they were, in essence, immortal. The researcher shared them widely with other scientists, and they became a workhorse of biological research. Today, work done
with HeLa cells underpins much of modern medicine; they have been involved in key discoveries in many fields, including cancer, immunology and infectious disease.” (Nature 2020: 7).

Lacks’ story shows a fundamental and unmalleable attribute/mannerism of macro-level institutions at large, but the healthcare system in particular: a necessity to perpetuate racial inequities through mechanisms of oppression (and in the context of Lacks and this project, the mechanism of oppression is reproductive violence) (Nature 2020: 7). Moreover, Lacks’ story exemplifies the notion that Black bodies (especially Black women) have and continue to be de-valued (as a matter of degree, in some cases completely) by the White power structure that undergirds macro-level institutions within the United States. For example, decades after her death, physicians and researchers who were still studying HeLa cells and publicly sharing Henrietta Lacks’ medical records with the public (even to the point of disclosing her cells’ genome online) without her family’s consent (Nature 2020: 7).

Eugenics and Sterilization Practices:

Eugenics became a popular practice in the United States by the Great Depression and eugenic techniques were mechanized primarily through forced hysterectomies (Roberts 2017: 70). Southern segregationists’ opposition towards “intermingling between Blacks and Whites” and fear of Black political advancement led them to advocate the use of eugenic practices on African-Americans (Roberts 2017: 70). One of the movement’s most vocal advocates was a White feminist, Margaret Sanger, who is often lauded for being a “birth control pioneer” and feminist (Washington 2008: 195; Roberts 2017: 72-6). Through her strategic efforts and alliances
with legislative lobbying organizations, Sanger was able to effectively institute eugenics practices that disproportionately targeted Black mothers (Roberts 2017: 74). This ultimately resulted in state-sponsored discrimination and forced sterilization (Farber 2008: 243). Farber (2008), argues that “over 60,000 forced sterilizations were already performed in the United States on mostly poor (and often African-American) people confined to mental hospitals. The practice of forced sterilizations for the ‘unfit’ was almost unanimously supported by eugenicists. The American Eugenics Society had hoped, in time, to sterilize one-tenth of the U.S. population, or millions of Americans.” (p. 244).

Sterilization practices became relatively commonly practiced on African-American mothers by the 1930s (i.e., fully three and a half decades prior to the end of Jim Crow) (Threadcraft 2018: 2). By the 1970s, the United States was in the midst of a number of civil rights movements including: the second wave of feminism, Black power and community development, Indigenous peoples’ rights, lesbian, gay, bisexual, transgender, queer (LGBTQ+) rights, the AIDS and HIV pandemic, and the Vietnam War. Within this as the social context, scholars such as political scientist Shatema Threadcraft (2018) argue, the United States still had the time to continue its attacks on Black and Brown mothers: by 1970, Black women were sterilized twice as frequently as White women, a vehicle that enabled the White power structure to maintain its power through population control (p. 3). Over the next two decades, sterilization practices—particularly abortions and birth control such as Depo-Provera (and later in the 1990’s, Norplant)—had become normalized to the point where they were federally funded (Threadcraft 2018: 2). In Killing the Black Body, Dorothy Roberts (2017) argues that one of the reasons why reproductive violence was so successful during this time was because Black women often lacked
access to safe and well-run family planning services, and this rippled over into mortality rates for Black mothers (p. 101).

**Research Design**

The ultimate goal of my research was to explore how each of my key factors (i.e., the lack of professional representation of African-American OB-GYNs and the devaluing of Black pain) influences the perpetuation of reproductive violence against Black women. I chose to pose my research question and explore the literature by focusing on my two causal factors in this manner because each factor explicitly highlights the degree to which violence has impacted Black women, frames the type of research I should be looking for, and presents parameters to ensure that I limit my inquiry to the factors at hand. My goal was to find data that can be measured in order to explore various facets of each factor. For the purposes of this project, measurement is significant because it highlights how a particular factor manifests in society: if we cannot measure something, we cannot demonstrate that it exists.

I utilized secondary sources (such as academic journal articles and university-press books) to document racism in scientific explanations of human physiology and behavior that result in concrete outcomes for patients. I also used primary sources (such as public health and professional association data) to document lack of representation of Black physicians.

My aim was to analyze the role race plays in the healthcare system. Therefore, I framed reproductive violence historically to show that the contemporary mechanisms my thesis is focusing on are not sporadic or a modern phenomenon, but rather just the most current manifestations of each mechanism (Black pain and skewed professional representation). I also specify how and under what conditions reproductive violence persists by zeroing in on a discrete
set of indicators (such as epidural distribution and/or failure, and the number of Black obstetricians and gynecologists) that enable me to operationalize the key factors I explore in the thesis (see Figure One).

Research Question One:

How heavily are Black people represented in positions of authority within health care?

I hypothesized that one of the reasons why reproductive violence against Black women in the United States has continued for centuries while going virtually unchecked, is because there is a lack of Black physicians—specifically obstetricians and gynecologists (OB-GYNs). Thus, I reviewed primary source materials from professional and medical organizations including: the American College of Obstetricians and Gynecologists, the American Gynecology Association, the American Medical Student Association, the American Medical Association, and the Center for Disease Control. I also reviewed public health and epidemiological data analyzed in secondary sources such as medical journal articles, medical association presentations and discussions. The purpose of exploring these sources was to obtain data pertaining to the percentage of Black representation in the healthcare system and the implications of representation on societal inequality.

Research Question Two:

How pervasive is the devaluing of Black pain? Is it only a contemporary phenomenon or one that has historically occurred?

I have drawn primary accounts of celebrity and high-profile Black women whose first-person narratives and personal anecdotes reveal the pervasiveness of contemporary maternal
health discrimination. Additionally, I have collected these accounts both from conventional print and electronic media (such as The New York Times and National Public Radio) and from social media platforms (such as Twitter). I have also analyzed primary sources (such as reports issued by professional associations including CDC, AGA) and secondary sources such as academic journal articles (e.g., published in PubMed and Ovid Journals) that focus on medical histories or that assess medical textbooks. My aim has been to unpack the specific nature of this factor by documenting the racialized and gendered imagery and language within American medical education and in physicians’ publications. By revealing this imagery and by analyzing survivors’ accounts, I can explore whether the medical community upholds the notion that Black and White patients tolerate pain to different degrees, and/or views this tolerance as a result of genetic differences.

Methods

This project utilizes both primary and secondary sources to research the phenomenon of disproportionate, racialized maternal death in the contemporary United States. My primary source materials are from healthcare providers and associations (American College of Obstetrics (ACOG), and American Medical Association (AMA)), government agencies (the Center for Disease Control (CDC)), and primary news reports from celebrities (found on NPR, CNN, and in Essence and Vogue magazines). The secondary sources are drawn from scholarly studies accessible through library databases and medical journals. Data from healthcare associations and government agencies provided statistics, numeric rates, and outcomes, and thus were measured as such. However, personal histories and secondary source data often reiterated stats from the
aforementioned primary sources, integrated personal anecdotes, and discussed research findings from scholarly projects; thus, this diverse data was operationalized.

My research process spanned from July of 2020 to March of 2021. In order to ensure uniformity during my research search process, I consistently used the keywords “racial disparities in ___” for each of my indicators (see Appendix Four). Moreover, I tried to confine my searches to data from 2008 to the present (2021) in order for my data to be as current and applicable as possible; and did not look beyond the mid to late 1980s when searching for contemporary literature. Although I was initially apprehensive about confining my data search to these specific parameters, I was able to find numerous and diverse sources that ultimately reinforce the same narrative: Black women are disproportionately impacted by reproductive violence (see Figure Two, found in Appendix Two).

Data Analysis and Findings: Two Causal Factors that Explain Disproportionate Black Maternal Deaths

FACTOR ONE: African-American Representation in Positions of Authority Within the Healthcare Industry

Black Underrepresentation in the Medical Community:

The last US population demographics report released by the Census Bureau in 2019 states that non-Hispanic White American comprise 60.1% of the total population, Black Americans comprise 13.4%, American Indian and Alaska Natives comprise 1.3%, Asian Americans comprise 5.9%, Native Hawaiian and Pacific Islanders comprise 0.2%, and Hispanic and Latino Americans comprise 18.5% (Census Bureau 2019: np/3/10/2021). Thus, when contextualizing these demographics within the frame of my project, there are about four and a
half times as many White Americans as African-Americans in the population at large. I had initially predicted that this proportion would translate to some degree into the demographics of medical students, physicians, and specifically OBGYNs.

Yet, I quickly discovered that although there has been a slight variation in studies, it is clear that the Black community (a term I use loosely in this context knowing that there is a wide range of education levels, professions, and income in part because of African and Caribbean immigration) has been unable to keep up with the majority of other racial and ethnic communities in terms of high-level representation in medicine. While other racial groups⁶ (i.e. Asian, American Indian, White and many more) have experienced an increase in medical school enrollment since the late 1980’s, “Black students’ enrollment in medical schools over the last 40 years has only increased by 1.2%” (Acosta 2020:np/3/10/2021; Acosta 2020: 3 US Census 2020: np/5/1/2021). Today, African-Americans comprise only seven percent of total medical school enrollment (Acosta 2020: np/3/10/2021).

This stagnation in enrollment speaks to the larger issue of growing social inequality that ultimately results in the educational pipeline⁷ shrinking, which in turn feeds into the racialization in the healthcare field (Kent, Ricketts, and Boshara 2019: np/3/20/2021). This is because, as inequalities are perpetuated over generations, those who have privilege, have greater access to other things (i.e. higher education, home ownership, intergenerational wealth, etc.). Thus, the growing income inequality in the United States is exacerbating the inequities within social

⁶ Racial and ethnic categories were taken from the US Census.
⁷ The Educational Pipeline: “conveys the importance of viewing student progress as a continuum leading from high school into postsecondary education and through to the completion of a college degree. The Educational Pipeline, rather than viewing K-12 schooling and postsecondary education as separate entities, estimates...patterns of student progress from the 9th grade through four key transition points...” (Higher Education 2006: np/5/1/2021)
systems including but not limited to health care and education. Moreover, these obstacles make it harder for Black Americans to keep up at the same rates as other races and ethnicities.

By way of illustration, Dr. David Acosta (Chief Diversity and Inclusion Officer at the Association of American Medical Colleges (AAMC)) argues: “A diverse country needs a racially and ethnically diverse physician workforce. And the path to diversity in the workforce starts with the students at our medical schools” (Acosta 2020: np/3/10/2021). With this in mind, I can now understand why the 1:4.5 ratio (where African Americans only comprise 13.4% of the population while non-Hispanic White American comprise 60.1%) was not present in the 2019-2020 racial and ethnic breakdown for medical residents regardless of specialty (Census Bureau 2019: np/3/10/2021). Rather, the Association of American Medical Colleges (AAMC) reported that 50.8% of the student population was White, while only 5.5% was Black; thus, the demographic ratio expanded to 10:1 (2021: np/3/10/2021).

When you examine the diversity distribution in the obstetrics/gynecological community specifically, it becomes clear that the race-gender disparities we see in maternal mortality rates are similar to those of physicians in this field. Black women are overly affected in maternal mortality and complications, despite the fact that within the field of obstetrics, a higher percentage of Black doctors (about eleven percent) practiced gynecology than any other non-White race or ethnicity (AAMC 2020: np 3/10/2021; Amutah-Onukagha 2020: 4- 8; AAMC 2010: 75). However, because White Americans comprise more than half of the population, they still had (and continue to have) a higher volume of practicing physicians overall (AAMC 2010: 75). An AAMC report from 2008 indicates that the populations are comparable to that of medical school enrollment insofar as there were 3,338 Black ob-gyns in comparison to 20,408 White ob-gyns, which is equivalent to nearly a ratio of 1:7 Black to White obstetrics and gynecology
residents (AAMC 2010: 75). This ratio of OBG-YN residents demonstrates a 1.5 times greater population gap than that of the general US population.

In the context of gender however, the demographic distribution is clear: Boyle (2021) says, “Women make up a larger percentage of residents in obstetrics and gynecology (83.8%), pediatrics (72.4%), and family medicine (53.7%), while men make up a larger percentage of residents in diagnostic radiology (73.0%), anesthesiology (66.9%), and emergency medicine (64.1%)” (np/3/10/2021). When you disaggregate these numbers further, by gender, you see that out of the 3,338 Black ob-gyns, 2,439 of them were Black women. In comparison, White women comprised 11,840 of the 20,408 total White ob-gyns (AAMC 2010: 76). This falls just over the 50:50 line, while Black physicians saw almost a 75:25 relationship.

These trends are integral to understanding the causal story central to my thesis, and the ready availability of gender and racially disaggregated primary data on medical school enrollment and professional attainment makes it possible to explore this factor in depth. This data has become more accessible in part because the culture of social media has led to a greater need to keep the public informed, but also due to the resurgences of the Black Lives Matter movement in the spring of 2020 and calls for more transparency within major social and government institutions with regards to racism and racial disparities.

**Racial Stereotypes and Biases Often Impact Medical Practice and Outcomes:**

My initial hypothesis about racialized maternal health outcomes in the US paralleled David Acosta’s response to the question of what kinds of practices influence or even create racist outcomes in healthcare. As Acosta argues: “[I]t's really the racist ideas that have been embedded in our policies and practices over time that have led to these exclusionary practices that we
experience today, inequitable opportunities. And that's ultimately led to the poor outcomes that intentionally target and impact specific population groups but also preserve the status quo” (Acosta 2020: np/3/10/2021). My own research confirmed this narrative; I emphasize the notion that persistent reproductive health disparities are caused by macro, intergroup, and individual-level interactions.

Dr. Malika Fair (Senior Director of Health Equity Partnerships & Programs at the AAMC), argues that reproductive violence—particularly through the form of conscious and unconscious racism against Black women—is not a novelty. Rather, it is deeply ingrained in the US healthcare system’s structure (Fair 2020: 5). Thus, she juxtaposes two examples of reproductive violence enacted through differential levels of anesthetic distribution, saying:

We can see evidence of this dating back to the early 1800s when the so-called father of modern gynecology, Dr. [James] Marion Sims, experimented on his female slaves with no anesthetic because it was a common belief that Black people did not feel as much pain as White people. If we bring it to the present, we still see differences in the care that is given to Blacks and Whites. These data are collected by the Agency for Healthcare Research and Quality and over a 16-year span. Their data shows 80% of the quality of care differences between Blacks and Whites have stayed the same or gotten worse (Fair 2020: 5).

Fair suggests that racial bias and structural oppression, which have historically informed the health care system, are apparent at all levels and “across all levels of learners,” which in turn has strained patient-provider relationships and led to poor health outcomes for Black mothers (Fair
She argues that the medical community has utilized exclusionary and/or experimental practices in the past, and that this informs patient-provider contemporary relationships as well (Fair 2020: 5). More specifically, historical trauma through the form of transgenerational and intergenerational racism has impacted many African-Americans, resulting particularly in patient distrust, perceived hostility and noncompliance (i.e. both by patients with aspects of their care regimen, and by physicians with professional protocols), as well as less patient-centered communication (James 2017: 5 and Acosta 2020: np/3/10/2021).

The AAMC cites limited diversity in the medical profession as one out of many factors (working in conjunction with others) that contributes to the racially disproportionate maternal mortality rates in the United States (AAMC 2020: 13). Dr. Philip Alberti, Senior Director of Health Equity Research & Policy at AAMC, discusses how structural racism has manufactured a growing system of inequality:

Racis[t] ideologies are at the foundation of our country's system. That kind of structural racism kills too, and that's the third mechanism. Take segregation as an example. Scientists have shown segregation explains much of the racial ethnic inequity in education, in income and employment and the social determinants of health. So, by systematically preventing Black communities from having access to resources like quality education, good jobs, affordable housing, etc., segregation purposefully creates health inequities (Alberti 2020: 6).

Structural racism, which again, manifests itself through macro, intergroup, and individual-level interactions, often allows health care professionals’ implicit or explicit biases to go relatively
unchecked (AAMC 2020: 14 and Sidanius, Pratto, Martin and Stallworth’s 1991: 695). Thus, one of the reasons why racial stereotypes and implicit biases are perpetuated in reproductive health is because physicians are either complicit or want to reaffirm their position in the social hierarchy (Sidanius, Pratto, Martin and Stallworth 1991: 695). Such biases often present themselves through doctors spending less time with Black patients, which increases the likelihood that Black patients receive less effective care. Although people of color will comprise most of the US population by 2050, there are still significant racial disparities that persist in health care generally, but women’s health care in particular (the American College of Obstetricians and Gynecologists (ACOG) 2018: 1).

Thus, these biases underlie the tendency to underestimate patient pain and/or to leave such pain under-treated, and the dismissing of patient complaints (AAMC 2020: 14). Obstetrician-gynecologist, Neal Shah emphasizes the role of implicit bias: “The common thread is that when black women expressed concern about their symptoms, clinicians were more delayed and seemed to believe them less…there is a very fine line between clinical intuition and unconscious bias” (AAMC 2020: 14). Similarly, in a 2017 study the AAMC reported that “22% of black women report discrimination when going to the doctor or clinic” (AAMC 2020: 15). It is important to note that 1) not everyone who did experience discrimination reported it, and 2) there is a slight probability that patients overlooked instances of bias or interpreted other interactions to be acts of discrimination when they were not (or at least not intended to be).

Moreover, in an article, published in 2019, the AMA appears to perpetuate the stereotype that Black Americans are unhealthy, uneducated, and clearly incapable of reducing their high hypertension rates and thus chronic heart and stress-related diseases. The article lists four ways to address blood pressure with Black patients: identify lifestyle challenges (e.g., living in poor
neighborhoods where it is hard to remain active, access transportation, or regularly eat vegetables—all factors listed in this article); boost medication adherence (e.g., there is a narrative that Black patients do not take medication as directed, or that they opt to stop because doctors do not communicate possible side effects that eventually appear); health literacy (again, this narrative centers on Black patients who may “nod approvingly” when in actuality they did not follow the technical language); and finally, include family members (i.e., have family present in order to increase the likelihood that Black patients take their cardiovascular risk and need for modification seriously) (np/3/28/2021).

The results of a 2018 ACOG study—in addition to supporting evidence from members of the AAMC and obstetrics and gynecology community—strengthen my confidence that Black professional representation in the OB-GYN field matters significantly in explaining disproportionate health outcomes (ACOG 2018: 1). Having more Black physicians would help to combat the reproductive violence to which Black women are often subjected. A 2007 study conducted by Downing, LaVeist, and Bullock echoes that of the ACOG. This article, similar to that of the ACOG, suggests that ethnicity and social class influence healthcare providers’ stereotypes and implicit biases (Downing, LaVeist, and Bullock 2007: 1806).

*Interactive Effects of Representation, Education, and Action on the Health Disparities of Black and Brown Patients:*

The first step in effecting change is moving beyond perfunctory and disingenuous explanations such as “there are a few bad apples,” and actually taking the time to understand how history has informed the prevalence of contemporary practices (Acosta 2020: np/3/10/2021 and AAMC 2020: 15). Then, steps must be taken not only to address and uproot structural
racism, but also as David Acosta argues, “to ensure that these harms will not be repeated as we move forward” (Acosta 2020: np/3/10/2021). The policy implications of my findings in this thesis align with Acosta’s sentiments: I argue that in order to overcome the current reproductive health disparities, discourse and education are the two first steps.

Scholar Philip Alberti builds off of Acosta’s suggestion and advocates for extending a bridge between communities of color in general—focusing specifically on forging connections between the African-American community and White Americans—through “data, dollars, and discourse” (Alberti 2020: 7). Under this model, data takes first priority insofar as Alberti believes patient data should be collected in order to develop effective intervention techniques (Alberti 2020: 7). Alberti argues that data must be collected not only through self-identified race and ethnicity data, but also by looking at variable social factors such as income and education (Alberti 2020: 7). Next, Alberti advocates for the promotion of health equity by investing and procuring goods and services locally, “because community wealth is community health” (Alberti 2020: 7). Here, Alberti is touching upon the political inequality central to disproportionately poor outcomes in maternal health for women of color in the United States and for Black women, in particular. Finally, he encourages the use of discourse as a form of advocacy (Alberti 2020: 7). More specifically, Alberti argues that “Healthcare organizations should advocate for policies that promote health, regardless of whether they are healthcare policies. Because the time has come for us to broaden our lens” (Alberti 2020: 7). Thus, Alberti and other members of the AAMC suggest that in order to effect lasting change, there should be a greater emphasis on cultural competence, safety, quality, and respect along with a greater focus on the non-clinical and social needs of Black women (AAMC 2020: 15).
The United States Centers for Disease Control and Prevention (CDC) has developed a measurement for maternal mortality; CDC surveillance findings, in turn, can be used to frame pregnancy-related deaths, defined as “the death of a woman while pregnant or within 1 year of the end of pregnancy from any cause related to or aggravated by pregnancy” (CDC and Hoyert and Miniño 2020: 15). As of 2017, Black women have the highest rates of maternal mortality at a rate of 41.7% (per 100,000 births), followed by American Indian or Alaska Native women with a rate of 28.3% (per 100,000 births), Asian or Pacific Islander women with a rate of 13.8% (per 100,000 births), White women with a rate of 13.4% (per 100,000 births), and Latinx and Hispanic women with a rate of 11.6% (per 100,000 births) (CDC 2020: np/3/10/2021).

According to the CDC, since the implementation of this surveillance system in 1986, the number of reported pregnancy-related deaths has more than doubled from a rate of 7.2 deaths per 100,000 births in 1987 to 17.3 deaths per 100,000 in 2017 (CDC 2020: np/3/10/2021).

Although the CDC argues that the reason for this increase is unclear—insofar as they are unsure as to whether there has been an increase in risks—the agency ultimately concluded that changes in how deaths were recorded may play a role (including the addition of a pregnancy checkbox to death records, and the development of computerized data linkages between death and birth records). Chronic health conditions such as hypertension, diabetes, and chronic heart disease may also be placing American women at higher risk of postpartum complications (CDC 2020: np/3/10/2021). In my thesis research, I found that although the development of a maternal mortality surveillance system was a step towards reducing maternal mortality nationally, the CDC lacked an explanation for the stark maternal mortality disparities along racial lines. Rather, I found that the CDC utilized very pointed and intentional language and examples when speculating as to why these disparities exist. More specifically, after providing data regarding the
racialized maternal mortality rates, the only additional discourse surrounding these disparities is a sentence which states: “Variability in the risk of death by race/ethnicity may be due to several factors including access to care, quality of care, prevalence of chronic diseases, structural racism, and implicit biases” (CDC 2020: np/3/10/2021; Bailey et al. 2017: 1453-1463; Howell 2018: 387-99; and Hall et al. 2015: 60-76).

I believe that the language employed by the CDC during its 2020 report on disparities in maternal deaths, in particular—in addition to seven out of the nine articles and reports I found published by the CDC—is very intentional insofar as the “proper” buzz words (i.e. implicit biases, structural racism, etc.) were used (albeit sparingly) during the conversation about these disparities (CDC 2020: np/3/10/2021 and CDC 2021: np/5/2/2021). However, I am still critical of their language, reports, and even surveillance system because at least on the surface, very little work seems to have been done that has affected substantial and long-lasting change. Rather, most of the CDC’s reports draw attention to racial disparities, but usually have a fleeting and superficial discussion on structural racism and discrimination. For example, in the materials I analyzed that were published by the CDC prior to 2020, the agency acknowledged and attributed the racial disparities in maternal mortality to lack of education, employment, healthcare, transportation, and wealth, in addition to chronic illnesses and stress that also disproportionately impact Black and Brown people. While relevant, these factors, at least in the manner often presented in CDC reports, do not tell the full story. Rather, they offer a literally White-washed account of maternal deaths.

My analysis of CDC data leads me to conclude that this is because prior to March and April of 2021, there was little to no discussion of why Black women have higher rates of chronic diseases and stress or even why communities of color lack effective social services and wealth.
Structural and everyday forms of racism (i.e. microaggressions\textsuperscript{8} and implicit biases) are only considered to potentially play a role (see related critiques by Leonard, Main, Profit, Carmichael, and Scott 2019: 34 and 5). Moreover, the discussion of education, income, and wealth, while relevant to the conversation regarding maternal mortality, is nevertheless insufficient in explaining why African-American women with college and advanced degrees are 5.2 times more likely than their White counterparts to die from postpartum complications (CDC 2019: 762-4).

This absence of probing discourse on structural racism prior to 2020 and 2021 by the CDC and many mainstream agencies speaks to the larger culture in the United States regarding discussions of race—particularly the notion that racism is so fundamental to the country’s founding and functioning that it has been and continues to be present in most if not all of its institutions. Yet starting from Spring 2020 onward, I detected a clear shift in language utilized by the CDC in reports surrounding maternal mortality; where there was a more overt engagement with themes of structural racism. I speculate that this occurred in large part because of the resurgence of the Black Lives Matter movement, major media coverage of civil rights nationally and transnationally, and a palpable vocalization from African-Americans (and their allies) that structural racism will no longer go unchecked. In fact, I argue that it was not until 2021 that the CDC truly started discussing racism within the discourse of American healthcare. For example, in an article that was published and revised in April of 2021, the CDC finally defined racism and discussed its structural implications:

\textsuperscript{8} “Microaggressions are the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership. In many cases, these hidden messages may invalidate the group identity or experiential reality of target persons, demean them on a personal or group level, communicate they are lesser human beings, suggest they do not belong with the majority group, threaten and intimidate, or relegate them to inferior status and treatment” (Sue nd: 1).
Racism is a system—consisting of structures, policies, practices, and norms—that assigns value and determines opportunity based on the way people look or the color of their skin. This results in conditions that unfairly advantage some and disadvantage others throughout society. Racism—both interpersonal and structural external icon—negatively affects the mental and physical health of millions of people, preventing them from attaining their highest level of health, and consequently, affecting the health of our nation (CDC 2021: np5/3/2021).

Within this definition, the CDC highlights a couple of ways in which the healthcare institution at large can be influenced by racism. First and foremost, it highlights that because racism itself is a system, it consists of structures, policies, practices, and norms, all of which comprise and enable the American healthcare system to thrive (CDC 2021: np5/3/2021). Thus, the CDC suggests that because the healthcare system is its own institution, it too is dependent on each of these “influencers” so to speak, it follows that it will be susceptible to various forms of racial oppression. The CDC also highlights that the racist system in America has created an uneven-playing field, where some people are unfairly advantaged, while others are disadvantaged—highlighting that even though many White and White-passing people are not actively attempting to oppress Black and Brown people, because we have a system that values White and White-passing people, they are inherently advantaged (CDC 2021: np5/3/2021). Finally, the CDC draws an even more explicit connection between racism and disparities in healthcare outcomes.

9 “White-passing is when someone perceives a BIPOC person (Black, Indigenous and People of Color) as a white person, for whatever reason. Some BIPOC people labeled white-passing are viewed as having more privilege than other individuals in their community. Historically and today, people have used white-passing to their advantage for safety and opportunities (like education, jobs or travel access), as well as to uplift others in their community who might not have the space to speak out” (Candelario 2020: np/5/4/2021).
when emphasizing that racism occurs in the interpersonal and structural context, both of which influence healthcare practitioners and ultimately the health and wellness of Black and Brown people in America. I believe that the CDC put a lot of thought into this definition in order to rectify its ignorance or desire to “play things safe” (by not discussing racism in depth) in the past (CDC 2021: np5/3/2021 and CDC 2021: np5/4/2021).

Moreover, I think that just as numerous corporations, organizations, celebrities, etc. spoke out and played their part in the mobilization of awareness around structural racism from spring 2020 onwards (whether genuine or not is an entirely different question), the CDC also felt the pressure to move beyond its traditional narrative and incorporate more in-depth analysis of how structural racism may have impacted racialized maternal mortality disparities. For example, in an urgent press release, Rochelle P. Walensky MD, MPH, director of the CDC and administrator of the Agency for Toxic Substances and Disease Registry (ATSDR), declared racism to be “a serious public health threat” on April 8, 2021 (CDC 2021: np/5/3/2021). In fact, she “add[ed] action to words,” by highlighting numerous new efforts the CDC is leading “to accelerate its work to address racism as a fundamental driver of racial and ethnic health inequities in the United States. She also unveiled a new website “Racism and Health” that will serve as a hub for the agency’s efforts and a catalyst for greater education and dialogue around these critical issues” (Walensky and CDC 2021: np/5/4/2021). Indeed, prior to 2020, I could only find the term “structural racism” or even simply, “racism” referenced in three reports (each of which used the term once or twice) out of the over seven related to racial disparities (CDC 2020: np/3/10/2021; CDC 2019: 764; CDC 2020: np/5/2/2021). Yet by April and October of 2020, as well as April, 2021 and onward, articles, reports, and press releases were formulated and
specifically dedicated to this topic. This explicit referencing of race by the CDC in the wake of the 2020 Black Lives Matter protests is more than a coincidence; I believe it is causally related. In fact, during her media statement in April of 2021, Walensky also said,

What we know is this: racism is a serious public health threat that directly affects the well-being of millions of Americans. As a result, it affects the health of our entire nation. Racism is not just the discrimination against one group based on the color of their skin or their race or ethnicity, but the structural barriers that impact racial and ethnic groups differently to influence where a person lives, where they work, where their children play, and where they worship and gather in community. These social determinants of health have life-long negative effects on the mental and physical health of individuals in communities of color.

I cannot help but attribute this “what happens to one of us, happens to all of us,” attitude to the displays of allyship that formed in the midst of the Black Lives Matter protests. While it is good that the Centers for Disease Control have not only acknowledged the role of racism in US society at large (and healthcare in particular), and also made it a point to track the ways in which racism can be challenged if not eradicated, this still indicates that many of these things could have and should have been employed by the CDC prior to the BLM protests. For example, on their page dedicated to discussing how racism is a public health threat, the CDC also discloses that “A growing body of research shows that centuries of racism in this country has had a profound and negative impact on communities of color… These conditions—often referred to as social determinants of health—are key drivers of health inequities within communities of color, placing
those within these populations at greater risk for poor health outcomes” (CDC 2021: np/5/3/2021). In an article published back in 2019, the CDC discussed the concept of social determinants of health, claiming that health is influenced by social (i.e. discrimination, income, and educational level) and physical (i.e. place of residence, transportation systems) environments, as well as health services (i.e. access to quality care) (CDC 2019: np/5/4/2021). However, in this publication, the CDC did not elaborate on the impact of these external factors (e.g. social and physical environments, and health services) on the social determinants of health, suggesting that they knew or had an idea of the influence of discrimination (racial and otherwise), but did not want or see fit to elaborate until about two years later. While it is possible that the CDC was not as educated, or at the very least did not seek to further understand the impact of racism and racial discrimination, the fact remains clear that they were aware of the pervasiveness of racism on healthcare outcomes in America, but did not publicly address nor denounce racism until pressure was applied and accountability was placed during the Spring of 2020 and onward.

In the new and improved explanation of the social determinants of health, the CDC has not only revised the external factors they had listed in 2019, but also provided hyperlinks and individual explanations for each one (features that were not included prior to 2021). Rather than attributing social and physical environments, as well as health services to social determinants of health, the CDC has listed five more specific determinants: 1) healthcare access and quality, 2) education access and quality, 3) social and community context, 4) economic stability, and 5) neighborhood and built environment (CDC 2021: np/5/3/2021). These more specific social determinants of health highlight the ways in which structural and interpersonal racism can influence the health and healthcare of Black and Brown Americans.
FACTOR TWO: the devaluing of Black pain

How Racist Narratives Around Black Pain and Black Motherhood Impact Black Mothers Today

(*generalized stereotypes and policy):*

Narratives of race being a biological mechanism have existed prior to the inception of this country, with people such as James Marion Sims (i.e., the father of modern gynecology) sustaining and teaching the belief that descendants of the African diaspora (including African or Caribbean immigrants, Black Americans, second-generation immigrants) do not feel as much pain as White people do (Fair 2020: 5 and Acosta 2020: np/3/10/2021). David Acosta problematizes the notion that race is a biological mechanism as opposed to a social construct, specifically by relating a vignette from medical school that demonstrates the pervasiveness of such stereotypes within the medical community:

... when we talked about some of the different formulas and the algorithms used, we still take race into consideration when we figure out the glomerular filtration rate, you know, for renal functioning… Where there's actually a converting factor that, if you are Black, essentially impacts, you know, the calculation of that particular formula. And the problem with that is that… by setting a different standard for African-Americans with the renal function, that really may miss some of the complications due to hypertension, diabetes (Acosta 2020: np/3/10/2021).

Thus, when we place this narrative within the context of reproductive health and Black mothers’ experiences throughout pregnancy and childbirth, it is no surprise that Black pain is often
overlooked or devalued. Moreover, Black mothers face the additional burden of being both Black and a woman: they have been and continue to be subjected to multiple stereotypes and varied forms of discrimination. Law professor Andrea Freeman argues that the first stereotype of Black motherhood arose during slavery in order to justify the separation of families for the profit of slave-owners (Freeman 2020: np/3/10/2021). Before long, the “mammy” caricature became a popular stereotype of Black caretakers and was particularly effective at portraying Black mothers as indifferent to their own children (Freeman 2020: np/3/10/2021 and Ferris State University Jim Crow Museum nd: np/3/29/2021). This notion of indifference reappeared more than once throughout US history, as prior to “mammy,” Black women who were slaves, were often demonized and called “Jezebels;” during the administration of President Ronald Reagan, traded the previous terms for a catchier label, “welfare queen”—yet another example of Black mothers’ indifference toward their children or motherhood (Roberts 2017: 10-8).

Scholar of demography Ann Morning (2008) documents the change in biology textbooks’ discussion of race from one of racial instruction and illustrating phenotypic traits, to now providing genetic accounts of race. Joe Feagin’s findings echo Morning’s observations insofar as he discusses how the conversations about race within the medical and biological field have evolved over time. Feagin (2017) finds that although racist incidents have diminished over time, the medical field as a whole has not done enough to discuss the “reality of contemporary White racism” (p. 54). Feagin claims that the main reason why racism has endured in the medical community is because it has become institutionalized and thus ingrained within the actions of healthcare professionals (2017: 54). According to the article, “medical practitioners, researchers, and educators have been among the slowest professionals in U.S. society to accept the now
established scientific view that ‘race’ groups are socially not biologically or genetically, constructed…” (Feagin 2017: 55).

Moreover, racial minorities are underrepresented in visual and textual content in medical textbooks (Khan and Mian 2020: 1009; Louie and Wilkes 2018: 39). The lack of textual representation can lead to misdiagnosis or a lack of diagnosis because medical complications can manifest on lighter skin pigment differently than those with more melanin. Thus, both the lack of representation in textbooks and the lack of conversation within the medical community to combat racial prejudice have together contributed to the devaluing of Black mothers’ pain. Janice Sabin’s (2020) article discusses this concept of Black pain more generally by exploring the common narratives within the medical community surrounding African-Americans’ pain tolerance and biological composition. Some of these narratives include: “Black people’s nerve endings are less sensitive than White people’s … [or their] skin is thicker than White people’s.” Therefore, Black patients are systematically undertreated for their pain relative to their White counterparts (Hoffman, Trawalter, Norman Oliver 2016). Hoffman, et al. (2016) attribute this phenomenon to the historic belief that Black and White people were genetically different (p. 4297; Martin and Silverstein 2013). In their article, they document the variations of racial differentiation in the scientific and medical fields throughout history in order to highlight that its presence in contemporary healthcare decisions should not be a surprise (Hoffman, et al. 2016: 4300; Martin and Silverstein 2013).

The perpetual demonizing of Black mothers has led to the development of permanent narratives, myths, and forms of discrimination. Such discrimination, in turn, has concrete effects (analyzed in this thesis) which combine to contribute to the racialized maternal mortality rates I analyze here (Freeman and July 2020: np/3/10/2021). Freeman argues that such racialized
narratives and myths are political: they “have a direct impact on laws and policies” that inform reproductive health (Freeman and July 2020: np/3/10/2021).

**How the “Strong Black Woman” Trope Influences the Devaluing Black Pain (and a related life histories):**

Originally, I had speculated that Black women would suffer from higher rates of maternal mortality and postpartum complications because their pain is not taken seriously in some aspect of pain management, or because physicians and nurses oftentimes do not truly hear the patient's complaints. Therefore, I believed that this hypothesis would be most clearly demonstrated through epidural distribution rates.

Upon carefully analyzing multiple secondary source articles from medical journals and other specialized publications, however, I realized that my data demonstrated a different outcome. Namely, White women had higher rates of epidural use than Black women. I then realized that the story was not as linear as I predicted. I had initially thought that Black women would receive epidurals in greater numbers than their White counterparts because although Black women are assumed to have a higher pain tolerance, it would be “easier” for a gynecologist in the labor and delivery team to just give the Black patient the epidural in order to speed up the birthing process.

However, when the data indicated that Black mothers are receiving fewer epidurals than their White counterparts, it reinforced my assumption—but in a different way. The phenomenon of Black women experiencing lower rates of epidural and anesthetic use is reflective of the larger concept that Black women are “strong” and pain-tolerant (hence, the erroneous belief that they do not need epidurals). Thus, this trope which dictates that Black women have a high degree of
fortitude and thus can overcome even the most difficult of obstacles, translates over to Black women having higher degree of pain tolerance and less need for pain management or consistent healthcare provider check-ups. The strong Black woman trope, while seemingly harmless—if not uplifting—has led to less epidural usage by Black women (who may themselves believe they are capable of laboring effectively without the help of an epidural and/or have been told repeatedly by society that they are strong enough to cope with the pain). As a result, the strong Black woman trope often propels, rather than cripples reproductive health disparities (specifically during the birthing process).

Regardless of the underlying logic, the outcome of not receiving an epidural can still negatively impact Black women, because their pain cannot be relieved. Thus, although the disparities in some reproductive healthcare practices may have some positive implications, “Disparities in health care utilization are shown to contribute to the disparities in health outcomes” (Hsieh, Shah, and Balasubramaniam 2020, np). Similar arguments are made by (Lancaster, Schick, Osman, and Enquobahrie 2016: np/3/28/2021; Lancaster, Schick, Osman, and Enquobahrie 2012: np/3/28/2021; Rust, et. al 2004: 459 and 60; and Caughey 2016: 297 and 8). Consequently, the question becomes, what perpetuates the persistence of racial tropes in the healthcare system? I argue that one explanation may be the need for non-Black (likely White) physicians to boost their self-worth by devaluing Black pain and/or by enacting the learned belief that Black pain tolerance is higher.

*Life History: Serena Williams*

Although she had not experienced health problems during her pregnancy, tennis icon Serena Williams had a cesarean delivery because her daughter’s heart rate dropped while Serena
was experiencing contractions (Williams 2018: np/3/19/2021). More problems arose after her
daughter was born. During the week after childbirth, Serena experienced a number of serious
health problems including a pulmonary embolism, tied to such intense coughing that it caused
her C-section incision to pop open (Williams 2018: np/3/19/2021; Howard 2018: np/3/19/2021).
When describing a firsthand account of how events transpired, Serena suggested that her health
or pain was not properly being monitored when saying:

First my C-section wound popped open due to the intense coughing I endured as a result
of the embolism. I returned to surgery, where the doctors found a large hematoma, a
swelling of clotted blood, in my abdomen. And then I returned to the operating room for
a procedure that prevents clots from traveling to my lungs. When I finally made it home
to my family, I had to spend the first six weeks of motherhood in bed. (Williams 2018:
np/3/19/2021).

During an interview with Vogue Magazine (2018), Williams went into greater detail about her
postpartum health complications and alluded to the fact that her pain and discomfort were initially
not taken seriously by nurses (Williams and Haskell 2018: np/5/2/2021 and Lockhart 2018:
np/5/2/2021). Rather, they believed her to be confused and disoriented from her pain medication,
and it was not until Serena had made additional requests that health care practitioners began
running any tests (Williams and Haskell 2018: np/5/2/2021 and Lockhart 2018: np/5/2/2021). I
think her word choice is very intentional in the quote above. She says things such as “endured as
a result of the embolism,” “finally made it home,” and “then I returned to...” several times over
the course of the interview (Williams 2018: np/3/19/2021). I interpret her syntax to be an
innuendo toward a possible lack of consistent monitoring by health care providers, or their not taking her complaints seriously until she became persistent. This is particularly emphasized when she expresses gratitude for her privilege of having access to a good equipment, doctors, and nurses, but not necessarily that they were all utilized appropriately. And I think that this careful word choice reflects how Black mothers from wealthier backgrounds are nevertheless still highly impacted by reproductive violence.

**Life History: Tatyana Ali**

In her 2019 essay published in *Essence Magazine*, actress Tatyana Ali discusses similar issues that my thesis addresses, particularly the recurring narrative in which African-Americans are often associated with a “culture of poverty.” This harmful stereotype, Ali argues, has led to unfair treatment of Black and Brown people in the United States (Ali 2019: np/3/19/2021). Ali prefaced her child-birthing anecdote with data from a research paper published in a medical journal that determined, “mistreatment is experienced more frequently by women of color, when birth occurs in hospitals, and among those with social, economic or health challenges.” (Vedam, et al. 2019: 1).

Ali disclosed that she had an emergency c-section to deliver her first son in 2016 after an experience that she described as her pregnancy “going completely off script” at the end. In her essay, Ali describes her birthing process to a degree that I feel her message can only be properly conveyed if I provide the quote in its entirety:

> For reasons that I have come to know are pretty much textbook, my low-risk pregnancy resulted in extremely questionable actions on the part of those attending and an
emergency c-section. My labor was harried, filled with people I didn’t know screaming at me. My doula, concerned with her status at the hospital, who knew I wanted a natural birth, persistently advised me to take an epidural. I agreed, and the epidural left me unable to move. One doctor slammed his forearm on top of my belly in order to force my son down as though I were a tube of toothpaste. My delivery room had become a circus. There were people everywhere but no one to help me deliver. After the suction cup on my baby’s head failed repeatedly, I feared for his safety and finally asked for a c-section. By the time they rolled me into the OR, I had passed out completely from the trauma of the Zavanelli maneuver. My husband, advocating for our baby and me the entire time, was as traumatized as I was. Postpartum, I was told by someone in the hospital that I had a pelvis shaped like a man’s. I now know that comment was cruel and ridiculous. The worst part of our trial was that our son spent several days in the NICU as a result of his harrowing birth (Ali 2019: np/3/19/2021).

In the latter part of her essay, Tatyana Ali discusses the aftermath of her hospital delivery on her nuclear family dynamic. Specifically, she describes a period of guilt and shame that she experienced because she had not followed through on her home birth idea (Ali 2019: np/3/19/2021). Moreover, she describes a period of healing that she and her husband had to go through together in order to protect their son from any additional harm (Ali 2019: np/3/19/2021).

It is important to note that events similar to those described by Tatyana are commonly experienced by Black and Brown women throughout the United States. The difference is, a majority of them do not have the platform or resources that Tatyana Ali (an entertainment star since childhood) has. Hence, most cannot speak to the frequency of this violence beyond their...
own experience. I think that one of the reasons why Ali was so traumatized by her child-birthing experience, is because she recognized that not all women have a person to advocate on their behalf, or the monetary resources or benefits that come from moderate celebrity. They cannot afford any emergency procedures, additional healthcare providers, legal counsel if things do go wrong, and/or to share their horrific story in the media.

Ali discussed how the trauma of a hospital birth for her first pregnancy impacted her decision to self-educate on Black maternal mortality rates in the US and get involved in the Black Mama’s Matter Alliance (BMMA) during her second pregnancy (Ali 2019: np/3/19/2021). The second time around, she utilized her newfound knowledge of Black and Indigenous midwifery and doula care to inform her childbirth process (Ali 2019: np/3/19/2021). During the pregnancy of her second child, Tatyana Ali and her husband had taken home birth classes and opted for a Black midwife who she said “has made appointments for ultrasounds and gone over the results with me, taken blood and provided information regarding vaccinations and genetic tests. Add to that respect, emotional support, postpartum home visits, love, guidance, and always, the awesome power of choice” (Ali 2019: np/3/19/2021). Ali emphasized a greater need for respect and support for Black mothers during pregnancy and the birthing process, and ultimately found that an at-home birth was better suited to fulfilling these needs.

*Physician and Nurse Inaction and Silencing (and related life history)*:

Black women are faced with daily oppression from multiple fronts (often as a result of intersectional discrimination across the axes of race and gender). This all comes to head within the context of reproductive health in the United States. More specifically, Black women encounter the intersectionality of race and gender within health care generally, but particularly
within the field of obstetrics and gynecology where racial disparities are stark and universal across the entire racial group. As discussed above, the overlooking and/or devaluing of Black pain is as old as the US itself; thus, it is no shock that these beliefs, attitudes, and biases are reflected in opioid and anesthetic distribution data. In fact, Johnson et al.’s (2019) research exemplifies this point by highlighting disparities in pain management and patient discomfort in and outside of the obstetrics community (p.1156-8). Johnson et al. (2019) indicate that:

In non-obstetric populations, differences in pain treatment among Black and White patients have been reported… Among patients presenting to the emergency department with abdominal pain, White patients were more likely to receive any analgesia compared with both black children and adults. This differential treatment is a health inequity. Moreover, for all patients, ensuring appropriate treatment of pain is an important part of opioid stewardship—which is a public health issue, given the current opioid epidemic (p. 1156).

Furthermore, their research illustrates that within the context of child birthing, White women still receive greater attention and pain relief (Johnson et al. 2019: 1158). White women often experience more frequent and/or thorough pain assessments than their BIPOC counterparts who report higher pain scores (Johnson et al. 2019: 1158). This overt discrepancy in healthcare-provider-pain-management must be (at least in part) influenced by tropes such as the strong Black woman.

As recently as 2016, Johnson et al. report, physician biases have become so pervasive within the medical community and the US at large that 75% of participants in their study
conducted on a group of laypeople, and 50% of participants in their study conducted on a group of medical trainees “endorsed at least one false belief about Black individuals (i.e., Black patients had thicker skin than White patients or that Black patients’ blood clots faster)” (Johnson et al. 2019: 1161). Again, we see how implicit biases and stereotypes can easily be transferred into the context of clinical assessments of Black patients, and consequently can lead to racial disparities in patient outcomes (Johnson et al. 2019: 1161). This study also demonstrates how implicit biases can be particularly pronounced in stressful situations such as in an emergency room, because we often resort to mental shortcuts when resources or time is constrained (Johnson et al. 2019: 1161).

Life History: Jodie Turner-Smith

Similar to Tatyana Ali, Jodie Turner-Smith, another Black actress and mother recently had a home birth (Grant 2020: np/3/19/2021). In the early days of her pregnancy, Turner-Smith and her husband, actor Joshua Jackson, had determined that they wanted an at-home birth because they were concerned that the racialized negative birth outcomes would impact both mother and child. Turner-Smith attributed systemic racism to these high rates of maternal mortality, but also found Covid-19 to be an additional reason to confine her childbirth to her home (Ali 2019: np/3/19/2021). During her home delivery, Turner-Smith labored for nearly four days but having felt “what every single woman deserves to have: full agency in determining my birth support” (Maitland 2020: np/3/19/2021; Turner-Smith and Grant 2020: np/3/19/2021).

Epidurals:
About 69% of White women utilize an epidural during the birthing process, Black women follow behind with a rate of 62%, and other women of color receive epidurals proportionately less (Osternman and Martin 2011: 1). I had initially predicted that Black women would have significantly higher rates of epidural use in comparison to other racial and ethnic groups. But my thesis research revealed that epidural use is high generally within the United States at large; Black women falling around the average of all groups (61%). Thus, when analyzing the racialized epidural distribution and usage rates, I became focused on why Black women experienced the inverse of my prediction.

My research indicates that differential rates of epidural use may be a blessing in disguise for Black mothers because studies have determined that giving patients epidurals makes them unable to labor effectively and therefore possibly puts them at greater risk (especially for things that could have been prevented like a c-section) (Min, Ehrenthal, and Strobino 2015: np/3/29/2021 and Lancaster, Schick, Osman, and Enquobahrie 2012: np/3/28/2021). Osterman and Martin (2011) argue that epidural use can create poor conditions during labor and delivery such as fetal malposition, fetal distress, maternal hypotension and/or fever, and a longer second stage of labor (p. 2). Yet, with many of these complications slightly averted, the disparities in epidural use speak to a larger problem where Black mothers’ pain is left untreated or at the very least, insufficiently treated.

Rust, et al. (2004) is one of many studies that have illustrated an association between race and epidural use, which is lower use amongst non-White races (p. 459-61 and Lancaster, Schick, Osman, and Enquobahrie 2012: np/3/16/2021). Mistrust of the healthcare system, provider bias, differences in pain perception, cultural practices and beliefs, etc. were cited as explanations for why Black and White women have differential rates of epidural use (Rust, et al. 2004: 459-61).
Russ, et al. (2004) suggest that patient-provider relationships are important when discussing epidural distribution along racial and ethnic lines (p. 61). Specifically, they say that patient-provider relationships are extremely complex, which in turn, makes the outcome of this study a little hard to definitively explain.

However, the authors highlight that “racial disparities in treatment were unmasked only when both the gender and race of the physician and the patient and the underlying cause of the pain were taken into account. One must also acknowledge that these differences in pain management could represent real (whether conscious or unconscious) racial/ethnic bias. Although overtly expressed bigotry seems rare, assumptions or stereotypes about patient preferences or pain tolerance may be more common” (p. 460 and Weisse, Sorum, Sander, and Syat 2001: 211-7). Rust, et al.’s (2004) emphasis on the race-gender dynamic present within patient-provider interactions suggests that the reason why Black women collectively have higher rates of post-partum complications and maternal mortality as a result of epidural use (and other possible factors) is ultimately because of intersection of race and gender.

C-Sections (and related life histories):

My initial hypothesis was that Black women would be given more c-sections because this procedure often results from a medical emergency during the birthing process and since Black women often suffer from complications during childbirth, a cesarean is the likely outcome. This prediction was largely confirmed by my secondary source research. For example, I during my research process, I read numerous articles by authors who have conducted their own studies and confirmed the general claim that Black women have the highest rates of cesarean in the United States (the percentages vary from article to article, but they all display a ratio of at least 2:1
Black-White c-sections) (Tangel, White, Nachamie, and Pick 2018: 845; Butwick, Blumenfield, Brookfield, Nelson, and Weiniger 2016: np/3/16/2021; Bryant, Washington, Kuppermann, Cheng, and Caughey 2009: 459; Min, Ehrenthal, and Strobino 2015: np/3/29/2021; Caughey 2016: 297; and Valdes 2020: 1 and 2). Additionally, the majority of studies I read determined that the racialized cesarean rates are less influenced by causality as they are merely associated (Butwick et al. 2016: np/3/16/2021). Some of these associations include: historic and contemporary inequities, patient-provider interactions, beliefs and perceptions of providers and/or patients, cultural barriers between patients of color (specifically Black women) and their providers, mistrust, misunderstanding, etc. (Butwick et al. 2016: np/3/16/2021 and Tangel, White, Nachamie, and Pick 2019: 843 and 6). For example, within the context of a cesarean delivery, it is possible that some medical decisions regarding mode of anesthesia during delivery may be influenced by physician preference and bias (Butwick et al. 2016: np/3/16/2021)? So, again we see these recurring themes of provider bias, stereotypes, etc. influencing Black mothers’ healthcare.

Life History: Beyonce Knowles-Carter

After the birth of her twins Rumi and Sir in 2018, singer-songwriter Beyoncé Knowles-Carter disclosed that she had suffered from preeclampsia (Howard 2018: np/3/19/2021). Due to complications from the illness, Beyoncé had an emergency cesarean delivery and her children were placed in the NICU (newborn intensive care unit) (Knowles-Carter 2018: np/3/19/2021). I argue that Beyonce, Allyson Felix, and many more Black women in this country are at a comparative disadvantage to their White counterparts when suffering from preeclampsia and additional birth and postpartum complications because of their race. While a cesarean delivery, a
preeclampsia diagnosis, or being a Black woman, alone are nothing to warrant concern, when you combine race—particularly being Black—with either or both of these birth complications, the racial implications and disparities become apparent; insofar as Black women in American disproportionately experience preeclampsia and/or cesarean deliveries which in turn can create additional birth or postpartum complications—all of which warrant concern (Howell and Howard 2018: np/3/19/2021; U.S. National Library of Medicine 2019: np/3/19/2021; Tangel, White, Nachamie, and Pick 2018: 845). In the 2018 piece she wrote for Vogue Magazine Beyoncé discussed the toll that both pregnancy and a c-section took on her body: “After the C-section, my core felt different. It had been major surgery. Some of your organs are shifted temporarily, and in rare cases, removed temporarily during delivery. I am not sure everyone understands that. I needed time to heal, to recover.” (Knowles-Carter 2018: np/3/19/2021). Here, Beyoncé echoes the claims made by healthcare providers and scholars, that a cesarean delivery is not a minor optional procedure, but rather a very serious and physically taxing one (Getahun, Strickland, Lawrence, Fassettm, Koebnick, and Jacobsen 2009: 1 and 2).

Life History: Allyson Felix

In her essay published in Glamour Magazine, Olympic Track and Field Gold-Medalist Allyson Felix, discusses how removed she felt from reproductive health complications, although she was educated on racialized maternal mortality rates, etc. within the United States. In fact, Felix said: “... I knew the statistics: Black women are more than three times as likely to die in childbirth as White women. I understood that this was a problem, but I still didn’t think that it could affect me because I’m a professional athlete. I exercised throughout my pregnancy; I ate right” (Felix 2020: np/3/29/2021). However, after her 32-week checkup, Felix was rushed to the
hospital for an emergency cesarean delivery because she was suffering from preeclampsia, an illness she admits had never been on her radar because she associated maternal health and wellness with physical activity, eating a balanced diet, and perinatal care (Glamour and Felix 2020: np/3/29/2021; and Felix and Mackenzie 2020: np/3/29/2021). Allyson Felix admitted that she had not taken the time to educate herself about preeclampsia because she was unaware of what to look for or ask about (Glamour and Felix 2020: np/3/29/2021; and Felix and Mackenzie 2020: np/3/29/2021).

Demonstrably, even in contexts in which African-American mothers have taken the time to prepare and educate themselves on aspects of reproductive health to ensure that they are not at a disadvantage, external factors (such as stress caused by racial oppression, provider bias, undetected or initially overlooked illness (because it does not manifest the same for all races and ethnicities), etc.) tied to macro-level institutions interfere. As a result, Black mothers experience stress that translates concretely into co-morbidities such as high cholesterol, hypertension, heart disease, etc., all of which negatively affect maternal health and wellbeing.

*The Racial Underpinnings of Comorbidities (specifically hypertension and stress-related illnesses) that Lead to High Rates of Maternal Mortality:*

In 2017, the CDC published data on the rates of death for women in the United States. The data disclosed that the rates of death due to pregnancy complications are as follows: Black women: 3% of all deaths; White women: 1.4% of all deaths; Asian and Pacific Islander women: 2.2% of all deaths; Native American women: 1.2% of all deaths; Hispanic women: 2.5% of all deaths (CDC 2019: np/5/5/2021). Moreover, in their article, Tangel, White, Nachamie, and Pick (2018) argue:
Our results confirm the findings of a multitude of studies showing racial and ethnic differences in rates of maternal mortality, with Black women being disproportionately affected. In our adjusted models, Black women were 90% more likely than White women to die in-hospital; the same was true in stratified analyses by Medicaid and private insurance populations, with an especially strong increased likelihood of inpatient mortality in a population of black patients with private insurance. (p. 845).

This finding starkly demonstrates that even among women with higher education and/or income—proxied by having private health insurance—deaths are not only prevalent but actually more likely than among those without such insurance. Moreover, Tangel, White, Nachamie, and Pick’s (2018) study determined that even when “patient-level comorbidities and hospital characteristics” have been controlled for, Black women are still significantly more likely than their White counterparts to undergo cesarean delivery (p. 843). Their study places considerable emphasis on insurance type but whether they are on Medicaid or not, Black women are at greater risk of cesarean delivery. In fact, it is likely that if you hold a private insurance policy, you are at even higher risk than if you did not. Thus, the narrative then becomes: Black women who have private insurance are at particularly high risk of c-sections and thus postpartum complications and possibly death. The question then becomes (similar to what I am probing in my thesis) what conditions have led to more highly educated and wealthy Black women disproportionately being impacted by negative birth outcomes and high maternal mortality rates?

In an effort to address structural racism in the contemporary context, the CDC published an article that highlights why deaths due to pregnancy complications, and other medical
complications or pandemics/epidemics disproportionately impact Black and Brown Americans. Part of their statement reads, “The data show that racial and ethnic minority groups, throughout the United States, experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts. Additionally, the life expectancy of non-Hispanic/Black Americans is four years lower than that of White Americans” (CDC 2021: np/5/4/2021). Black women suffer from greater hypertensive diseases than their White counterparts; and as a result, chronic hypertension and preeclampsia during pregnancy are more common amongst Black women than White women in the United States (Howell and Howard 2018: np/3/19/2021). Additionally, generally speaking, Black women are more likely than their White counterparts to develop preeclampsia during pregnancy (U.S. National Library of Medicine 2019: np/3/19/2021). In fact, in 2014, Black mothers had a rate of 69.8 preeclampsia deliveries per 1,000 deliveries in comparison to 43.3 per 1,000 deliveries for White women (Fingar, et al. 2017: 10 and 1). Moreover, “African-American women are 60 percent more likely to have high blood pressure, [in comparison] to non-Hispanic White women.” (US Department of Health and Human Services (HHS) and U.S. Department of Health and Human Services Office of Minority Health (OMH) 2021: np/3/19/2021).

With regards to why Black Americans in general experience higher rates of hypertension, in 2011, Flavio Fuchs argued:

“Biological differences in the mechanisms of blood pressure control or in the environment and habits of whites and blacks are among the potential causes. The higher prevalence of hypertension in blacks living in the United States instead of Africa
demonstrates that environmental and behavioral characteristics are the more likely reasons for the higher prevalence in blacks living in the United States. They could act directly or by triggering mechanisms of blood pressure increase that are dormant in blacks living in Africa.” (p. 379).

This notion that Black Americans do indeed have higher rates of hypertension, but causes are unknown is very common in the medical community and reiterated in numerous articles. Moreover, research often echoes the arguments presented by Fuchs insofar as researchers impose their own beliefs regarding what biological differences influence the racial differences in hypertension.

The American Medical Association (AMA) espouses a similar narrative that implicitly blames “the Southern diet… [a diet including a high volume of] fried foods, organ meats, processed meats, egg, egg dishes, added fats, high-fat dairy foods, sugar-sweetened beverages, and bread” for being a key reason for the racial disparities in hypertension (Albert Henry 2018: np/3/19/2021). Yet this conclusion is both prone to stereotypes and is overly simplistic. For one, it does not address the clear issue of environmental and nutritional racism, but it also, essentially lumps African-Americans into a group of unhealthy eaters that purportedly bring their health problems upon themselves. The narrative is both unjustified and also “safe” because this narrative allows the AMA and any others who hold a similar belief to say that they have solved the answer to a serious question without probing all of the possible causal factors and/or influences (i.e. macro-level institutions’ use of systemic oppression and the stress inherent in dealing with this systemic oppression). The AMA has even elicited quotes from a number of accredited doctors who advocate against “the Southern diet.” (Albert Henry 2018: np/3/19/2021).
The AMA’s advice takes on a patronizing in character, but my appraisal of it may be rooted in my own research connected to the thesis project, which has revealed a much more complex and multi-causal story. Based on my research, the AMA’s 2019 report plays directly into the broader stereotype-laden generalizations made about Black Americans (e.g., primarily living in low-income, unsafe, food-desert neighborhoods; with little to no basic medical knowledge or ability to take their condition seriously). The US Department of Health and Human Services (HHS) perpetuates a similar narrative, attributing obesity, high cholesterol, and cigarette smoking to the high rates of hypertension and heart disease (HHS 2021: np/3/19/2021). Lackland (2014), echoes the notion that the cause of unequal hypertension is ultimately unknown yet at the same time proposes a range of stereotyped health conditions that Lackland argues influence the racialized disparities, including: salt intake, body mass, resistant and refractory hypertension (pgs. 2-4).

Thus, I have found that the AMA, CDC, and other scholars or organizations that sustain similar beliefs, have engaged in acts of commission (mechanizing through dietary recommendations and “the Southern diet” for example) and omission (i.e. omitting recommendations of how to treat hypertension and under recognition of a health issue). As a result, commission and omission often result in overtly racist gestures that exacerbate high rates of comorbidities and poor birthing outcomes, but there are still aspects of comorbidities that are directly related to the social structure itself (i.e., stress-related comorbidities).

It is also important to note that while I am very critical of such statements by major medical associations, US Government agencies, and scholars, I am not ignorant to the reality that as of 2019, the poverty rate for White Americans was 7.3%, but African-Americans it was more than double, at 18.8% (Talk Poverty 2019: np/3/19/2021). So, it is understandable that many of
the things the AMA, HHS, and other policymakers and scholars discussed were relevant. However, I think that just as similar factors cannot fully explain why Black women, regardless of income, education, or background suffer from higher rates of maternal mortality and post-partum complications, the factors emphasized by the aforementioned groups are insufficient in explaining the high rates of hypertension that impacted Serena Williams and Beyoncé Knowles and thousands of other Black mothers in America.

**Conclusion**

This thesis project has sought to answer the question of why disproportionately racialized maternal mortality persists in the US by exploring two factors, framed here as sub-questions: 1) are Black people underrepresented in positions of authority within the healthcare system; 2) how pervasive is the devaluing of Black pain? I analyzed primary sources (including data from public health associations); secondary sources (including peer-reviewed medical journal articles); as well as personal testimonies (including those of high-profile Black women such as Beyoncé, Serena Williams, and Jodie Turner-Smith) in order to situate my study within historical and contemporary perspectives and to trace the influence of these factors on the evolution of disparities in maternal health.

Obtaining measurable data was my key challenge. I determined that data pertaining to Black pain is measurable because the epidemiological data pertaining to c-sections and epidural failure can be operationalized. Data pertaining to Black gynecologists and OB-GYNs is measurable because public health organizations publish reports and articles with statistics and other quantitative documentation on racialized differences in the number of medical professionals by sub-specialty and rank. I have employed an historic lens in order to
contextualize the contemporary data on reproductive health disparities and demonstrate that reproductive violence against Black women has occurred systematically throughout history. Ultimately, I hoped to have convincingly demonstrated that Black-White reproductive health disparities are caused both by the devaluing of Black pain and by the lack of Black OBG-YNs and healthcare workers.

I also acknowledge that I have been highly critical of how professional organizations and government entities used their data, as well as how they measured and analyzed it to show the trends over time. For example, although I have been very critical of the CDC in particular, I have still utilized their definitions, terminologies, and cite the data findings of this government entity because currently most scholarly and healthcare agency reports, have recognized the CDC’s data as being the “the exemplar.” But there is still a long way to go. When considering what steps they should take next in their quest to address structural racism in healthcare, I think the CDC should increase their transparency by having more consistent and in-depth data. This increased transparency serves not only to educate and engage medical students, teachers, and healthcare practitioners; but ultimately transparency benefits society at large. I think transparency kills two birds with one stone in a sense, because by educating healthcare workers about the impacts of racism on healthcare outcomes, physicians and other healthcare workers are encouraged to address these disparities and ensure Black and Brown patients are given proper care, this in turn increases their likelihood of avoiding or at the very least, overcoming medical complications, and thus death due to a medical (i.e. birth or postpartum) complication. Thus, I encourage the CDC and other healthcare organizations in the US to be as open and inclusive as possible. It is important to note that this form of transparency includes providing increased representation of people of color in medical textbooks and increased representation in professors and educators in
the medical field. In doing so, medical students will be exposed to a more representative
depiction of society, and thus their patients. Which will hopefully dissuade the development of
implicit or explicit biases, resulting in less poor outcomes for Black and Brown people. All in all,
one of the things I have tried to do within this thesis is give African American women their
voices to command media and institutional attention on a health issue that disproportionately
impacts them.
### Appendix One

**FIGURE ONE – Key Variables and Related Operationalization**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Indicator/ Mechanism of Oppression</th>
<th>Type of Measurement</th>
<th>What will be Measured</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>The devaluing of Black pain caused by implicit and explicit racism and biases</td>
<td>Cesarean sections</td>
<td>Analysis of operationalized data</td>
<td>Generalizations made from scholars who have already conducted a research study; the total racial/ethnic distribution of c-sections</td>
<td>The Association of American Medical Colleges (Feagin, Morning, and Sabin); the American College of Obstetricians and Gynecologists (Acosta and Fair); scholars including: Tangel, White, Nachamie, Pick; Beyonce Knowles-Carter and Allyson Felix</td>
</tr>
<tr>
<td>The devaluing of Black pain caused by implicit and explicit racism and biases</td>
<td>Epidural distribution and/or failure</td>
<td>Analysis of operationalized data</td>
<td>Generalizations made from scholars who have already conducted a research study; the total racial/ethnic distribution of epidural distribution and/or failure</td>
<td>The Association of American Medical Colleges (Feagin, Morning, and Sabin), The American College of Obstetricians and Gynecologists (Acosta and Fair); scholars including: Osterman, Martin, and Russ</td>
</tr>
<tr>
<td>The devaluing of Black pain caused by implicit and explicit racism and biases</td>
<td>Silencing or overlooking patients’ requests</td>
<td>Harder to measure given the scale of my project</td>
<td>Generalizations made from scholars who have already conducted a research study</td>
<td>The Association of American Medical Colleges (Feagin, Morning, and Sabin), The American College of Obstetricians and Gynecologists (Acosta and Fair); scholars including: Johnson, Asiodu, McKenzie, Tucker; Tatyana Ali and Jodie Turner-Smith</td>
</tr>
<tr>
<td>The devaluing of Black pain caused by implicit and explicit racism and biases</td>
<td>Distribution of Anesthetics (quantity and/or frequency)</td>
<td>Harder to measure given the scale of my project</td>
<td>Generalizations made from scholars who have already conducted a research study</td>
<td>The Association of American Medical Colleges (Feagin, Morning, and Sabin), The American College of Obstetricians and Gynecologists (Acosta and Fair); scholars including: Hsieh, Shah, and Balasubramaniam; Serena Williams</td>
</tr>
<tr>
<td>The lack of Black representation in positions of authority within the healthcare system</td>
<td>Number of Black doctors</td>
<td>Analysis of qualitative data</td>
<td>The total African-American doctors (gynecologists and OB/GYNs) population vs. the total African-American population</td>
<td>The American College of Obstetricians and Gynecologists; the Association of American Medical Colleges; the American Medical Students Association, (Acosta, Fair, and Alberti); the Census Bureau; the Center for Disease Control; scholars including: Sidanius, Pratto, Martin, Stallworth, and Boyle</td>
</tr>
<tr>
<td>The lack of Black representation in positions of authority within the healthcare system</td>
<td>Number of Black healthcare administrators</td>
<td>Analysis of qualitative data</td>
<td>The total African-American healthcare administrator’s population vs. the total African-American population</td>
<td>The American College of Obstetricians and Gynecologists; the Association of American Medical Colleges (Acosta, Fair, and Alberti); the Census Bureau; the Center for Disease Control; scholars including: Sidanius, Pratto, Martin, Stallworth, and Boyle</td>
</tr>
</tbody>
</table>
Appendix Two

*FIGURE TWO* - a Causal Story Laid Out by the Methods Described in the Methods Section

Figure Two: The Causal Map of my Project

- **Structural Racism**
  - Belief in Biological/Genetic Differences in Pain Tolerance
  - Reluctance in Accepting that Race is not Biologically or Genetically Determined
  - Racist Legacy and Class Stratified Healthcare System

- **Structural Violence**

- **Medical Violence**

- **Reproductive Violence**

- **Racial Stereotypes and Implicit Biases**
  - Silencing or Overlooking Patients’ Requests
  - Cesarean Sections
  - Epidural Distribution and Failure
  - Devaluing Black Pain
  - Distribution of Anesthetics (Quantity and How Readily)
  - Nurse or Physician Inaction

- **Lack of Black Representation in Positions of Authority Within the Health Care System**
  - Number of Doctors
  - Number of Health Care Administrators
Appendix Three - Key Concepts and Definitions

• Birth Complications: “Complications of pregnancy are health problems that occur during pregnancy. They can involve the mother’s health, the baby’s health, or both. Some women have health problems that arise during pregnancy, and other women have health problems before they become pregnant that could lead to complications. It is very important for women to receive health care before and during pregnancy to decrease the risk of pregnancy complications.” (CDC 2020: np/3/20/2021). Examples of pregnancy and birth complications include: hypertension, preeclampsia, diabetes, anemia, hyperemesis gravidarum, and more (CDC 2020: np/3/20/2021).

• Colorblind racism: “the set of ideologies and discourses that uphold contemporary racial inequality by denying either its presence or its significance” (Burke 2017: 857).

• Contraception sabotage: “may include hiding, withholding, destroying, or removing female-controlled contraceptives (e.g., oral contraceptives, intrauterine devices, contraceptive patches) or deliberately breaking or removing a condom during sex or failing to withdraw in an attempt to promote pregnancy despite a female partner's wishes to prevent pregnancy” (Silverman and Raj 2014: np/3/28/2021).

• The Educational Pipeline: “conveys the importance of viewing student progress as a continuum leading from high school into postsecondary education and through to the completion of a college degree. The Educational Pipeline, rather than viewing K–12 schooling and postsecondary education as separate entities, estimates… patterns of student progress from the 9th grade through four key transition points…” (Higher Education 2006: np/5/1/2021)

• Microaggressions: “the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or
negative messages to target persons based solely upon their marginalized group membership. In many cases, these hidden messages may invalidate the group identity or experiential reality of target persons, demean them on a personal or group level, communicate they are lesser human beings, suggest they do not belong with the majority group, threaten and intimidate, or relegate them to inferior status and treatment” (Sue nd: 1).

- Pregnancy Coercion: “describes forms of male partner behavior that are intended to erode a female partner's ability to resist complying with a male partner's wishes that she become pregnant or that she continue or terminate a pregnancy” (Silverman and Raj 2014: np/3/28/2021).

- Preterm birth: “is when a baby is born too early, before 37 weeks of pregnancy have been completed… A developing baby goes through important growth throughout pregnancy—including in the final months and weeks. For example, the brain, lungs, and liver need the final weeks of pregnancy to fully develop” (CDC 2020: np/3/20/2021).

- Sterilization: “describes a process that destroys or eliminates all forms of microbial life and is carried out in health-care facilities by physical or chemical methods” (CDC 2016: np/3/20/2021).

- Structural racism: “is defined as the macro level systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups (Powell 2008). The term structural racism emphasizes the most influential socio ecological levels at which racism may affect racial and ethnic health inequities. Structural mechanisms do not require the actions or intent of individuals (Bonilla-Silva 1997)” (Gee and Ford 2011: 116).
- Structural violence includes “social structures that impede individuals, groups and societies from reaching their full potential. In medicine, it means institutions and established societal modes of functioning that lead to impairment and limitations in human life. Their existence is so normalized and established that they are almost invisible and therefore either willfully or naively overlooked or ignored. Structural violence is based on the idea that certain societal patterns (of social relations and roles, economic arrangements, institutional practices, laws etc.) are so firmly entrenched that they are perceived as a ‘given,’ just the way things are. Sources of suffering are deeply embedded in these ordinary, taken-for-granted patterns, including ill health and the inability to adequately access remedies” (Shapiro 2018: 3).

- White-passing: “when someone perceives a BIPOC person (Black, Indigenous and People of Color) as a white person, for whatever reason. Some BIPOC people labeled white-passing are viewed as having more privilege than other individuals in their community. Historically and today, people have used white-passing to their advantage for safety and opportunities (like education, jobs or travel access), as well as to uplift others in their community who might not have the space to speak out” (Candelario 2020: np/5/4/2021).
Appendix Four- Key Search Terms for Online Bibliographic Searches

- Racial disparities in cesarean deliveries
- Racial disparities in epidurals
- Racial disparities in epidural us
- Racial disparities in patient silencing
- Racial disparities in inattention to patients
- Racial disparities in labor pain management
- Cesarean delivery rates by race
- Epidural use by race
- Epidural distribution by race
- Epidural rates by race
- Patient silencing
- Inattention to Black patients
- Inattention to Black mothers
- Silencing Black patients
- Silencing Black mothers
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