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The Harms of Willful Ignorance: Maternal Healthcare Providers' Insight on Racial Disparities

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Table of Contents

Abstract

Black women in the United States die in pregnancy and childbirth at alarmingly high rates. According to The Center for Disease Control, black women are two to three times more likely to die from pregnancy-related causes than white women. The black-white racial disparity is even greater in New York City, and The NYC Department of Health has found that black mothers in NYC still face higher rates of harm even when accounting for risk factors like educational attainment, obesity, and neighborhood poverty level. Drawing on 18 interviews with NYC-based Obstetricians, Labor and Delivery Nurses, and Midwives, this study examines how the providers who care for women in pregnancy and in childbirth make sense of and define the problem of racial disparities in maternal and infant mortality and morbidity. Building on the Theory of Racial Ignorance and the concept of Colorblind Racism, this study finds that women's healthcare providers victim-blame and claim ignorance while offering racialized explanations for racial differences in outcomes. It is clear that if educational attainment and socioeconomic status do not explain this disparity, it is acutely a racial disparity, and therefore should be of great interest to sociologists and other social scientists who seek to understand how race can deeply affect people's health.

"How can we possibly confront racial injustice in America without tackling this assault on Black women's procreative freedom? How can we possibly talk about reproductive health policy without addressing race, as well as gender?" – ***Dorothy Roberts***

"There is nothing more frightful than ignorance in action." – ***Johann Wolfgang von Goethe***

Introduction

In 2018, a few months after giving birth to her baby girl, Alive Williams, tennis star Serena Williams let the world in on the medical ordeal she suffered during labor and delivery. Serena had a history of pulmonary embolism, and when she alerted the medical team taking care of her that she was in severe pain and knew she had a blood clot – symptoms she was acutely familiar with due to her medical history – her healthcare providers ignored her requests for the proper tests (Vogue 2018). When Serena told her story, she drew national attention to the reality that black women fare much worse than white women in pregnancy and in childbirth and that maternal healthcare providers do not always take the pain of black women seriously.

The crisis of racial disparities in maternal and infant mortality and morbidity is well documented. According to The Center for Disease Control, black women are three to four times more likely to die from pregnancy-related causes than white women (CDC 2018). The Department of Health and Human Services report that preeclampsia – a hypertensive disorder that is potentially dangerous during pregnancy – is 60% more common in black women than in white women (Fingar 2017). The black/white racial disparity in infant mortality is actually greater today than it was in 1850 (Villarosa 2018). Infant mortality rates for black babies are 11.4 per 1,000 live births in contrast to 4.9 per 1,000 for white babies (CDC 2016). The United Nations Committee on the Elimination of Racial Discrimination has called on the US to eliminate this racial disparity (CRR 2013). However, "there has not been an official federal count of deaths related to pregnancy in more than 10 years," and only half of US states and a handful of cities have a maternal-mortality review board that looks into individual cases of pregnancy-related death (Villarosa 2018). In short, this is a well-documented problem to which very few wide scale solutions have been suggested or implemented.

In New York City in particular, the black-white racial disparity is even greater than the disparity in the country as a whole, with 51.6 maternal deaths per 100,000 live births for black women compared with 15.9 for white women (NYS DOH 2018). New York City is a site of a stark gap in racial disparities in maternal mortality, and thus an important place to study providers' conceptions of the disparity in their city.

Possible explanations for this disparity are abundant, including manifestations of interpersonal racism such as implicit bias, physicians' beliefs in biological fallacies about race such as beliefs that black patients' pain tolerance is higher than that of white patients, and the physical toll of stress due to the daily experience of racism for women of color. Other possible explanations include institutional forms of racism such as access to care, including racial neighborhood segregation and the complicated American healthcare system that prioritizes patients with more expensive insurance. Likely each one of the aforementioned factors plays a role in the racial disparities we see in morbidity and mortality for black women and infants. However, the New York City Department of Health has found that despite accounting for differences in educational attainment, "obesity[1]," or neighborhood poverty level, black mothers in NYC face significantly higher rates or morbidity and mortality (NYC DOH 2016). Women of any other race who are "obese" fare better than black women who are not (NYC DOH 2016). It is clear from the findings of the New York City Department of Health that this problem is, at least in NYC, acutely a racial disparity, and therefore should be of great interest to sociologists and other social scientists who seek to understand how race can deeply affect people's lives and health.

[1] I put obesity in quotes because it is both a scientifically invalid as well as a harmful and stigmatizing categorization of people. I will later discuss the racist origins of fatphobia, and the ways that this categorization of bodies contributes to medical racism and to societal and medical harm against all bodies classified in this way.

Because obstetricians, nurses and midwives are in many instances the very people who care for pregnant and laboring women, as well as the people devising plans for how to address racial disparities in outcomes both at the state level and within their institutions[2], it is important to understand how providers make sense of maternal and infant racial health disparities. Thus, this research seeks to answer: How do healthcare providers of pregnant women[3], including doctors, nurses, and midwives in NYC conceptualize the crisis of racial disparities in maternal and infant mortality and morbidity? What are the racial logics or discourses that shape their construction of this explicitly racialized problem? Through doctors, nurses, and midwives' explanations of racial disparities, I find that despite their insistence that they care about this problem and want to see it resolved, providers victim-blame, claim ignorance, and offer racialized explanations for disparities in maternal outcomes.

Literature Review

Racism and Health Disparities

Racism is alarmingly pervasive in the medical profession; a reality that stems throughout the history of the practice of medicine within the United States. A frequently cited study in the

[2] I spoke to respondents who were on statewide committees to address racial disparities in maternal care, and to people who had worked in a government capacity reviewing maternal mortality cases to make recommendations to the state for addressing disparities. In order to protect the identity of my respondents I cannot be more specific than that, but I talked to people in decision making roles including safety related administrative roles within their hospitals that have task forces to address this issue.

[3] I want to acknowledge that this paper engages with language about reproduction and childbirth primarily through identifying birthing people as women. I may oscillate between using the terms woman, or child bearing person. In the realm of reproductive health care, many doulas in particular are working to be more inclusive in their language around childbirth, recognizing that not all people who give birth identify as women. In medical practice, using gender neutral language acknowledges gender variant experiences of parenthood and helps to de-link gender from pregnancy and childbirth to affirm non binary and trans experiences as well as to challenge the binary gender system (Castañeda and Searcy 2015). This shift is important and necessary particularly within the context of medical providers and doulas giving care. For the purposes of this paper, however, conceptualizing the experiences of black child bearing people has historically been linked to the identity of these individuals as *women*, and at times needs to be identified as a simultaneous oppression of gender and race that is particular to the experience of black women.

Journal of General Internal Medicine (Green 2007) helps explain whether physicians show implicit bias in decision making for care of black patients. Using vignettes, the researchers tested how physicians care for black and white patients presenting with coronary artery disease. The results indicated that physicians showed unconscious bias in their clinical decision making. As physicians' pro-white bias increased, they were more likely to treat white patients and not black patients using thrombolysis (a lifesaving treatment for blood clots).

Despite widespread scientific consensus that race is a socially constructed category, beliefs that black and white people are biologically different still persist within medical settings. In 2016, a psychology study by researchers at the University of Virginia found that black patients receive inadequate treatment for pain compared to white patients (Hoffman et al 2016). The researchers tested whether people with medical training believe black people feel less pain than white people, and whether they would recommend fewer or weaker pain medicine to black patients in comparison with white patients. The study found that white medical students often believe racist biological fallacies such as "black people's skin is thicker than white people's skin" and also found that "individuals with at least some medical training hold and may use false beliefs about biological differences between blacks and whites to inform medical judgments, which may contribute to racial disparities in pain assessment and treatment" (Hoffman 2016). The researchers suggest that physicians' difficulty in empathizing with patients of color may contribute to this problem.

Another study shows that despite racial parity in some of the most common causes of maternal deaths, there are stark racial differences in case fatality rates (Tucker 2006). The researchers looked at national data sets for five life threatening conditions in pregnancy including preeclampsia, eclampsia, abruptio placentae, placenta previa, and postpartum

hemorrhage for the years 1988 to 1999. Researchers found that while black women did not have a higher prevalence of these conditions than white women, they were two to three times more likely to die from the conditions (Tucker 2006). These researchers urged for increased design of interventions to improve health outcomes for black women with these serious conditions.

Racism and Provider Socialization

The reality of the American medical school system is that doctors in training do not learn about race or racism in medical school. Physicians, and white physicians in particular, can be understood simply as human beings socialized into society the same way everyone else is, and just like most of the general population they likely never explicitly learn that race is a social rather than a genetic category. John Hoberman in his book *Black and Blue: The Origins and Consequences of Medical Racism* writes that aspiring doctors enter medical school with convoluted beliefs about race that are worked into the medical sphere, as part of a tradition he calls "racial folklore." Hoberman writes:

> The racial folklore that has infiltrated medical thinking along with the rest of our society fills the heads of doctors just as it permeates the general population; the difference is that stigmatizing racial folklore can do special harm in the medical context. The folklore includes; "*racialization*, the process that creates biological rationales for defining racial differences; the category consisting of *'white' diseases'* that are compatible with a folkloric 'white' racial essence; the concept of black 'hardiness' that presumes the special toughness and primitive status of the black organism; and, most fundamental of all, the *complexity principle* that presumes that black human beings are less complicated organisms than whites (Hoberman 2012).

According to Hoberman, this folklore continues to shape physicians thinking about race and has "demonstrated a remarkable stability over the past two centuries" (Hoberman 2012). Hoberman shows that the racist beliefs he deems "racial folklore" contribute to physicians' feelings about their patients and subsequently their treatment decisions. Other scholars have documented this

racial folklore and found that physicians believe race is biological and that the "human genomic variation maps neatly onto American racial categories (Braun et al. 2007; Baer et al. 2013; Hunt et al. 2013; Tuckson et al. 2013)" (Bolnik 2015). The same studies have shown that many physicians believe it is these genetic differences between races that explain racial disparities in health outcomes. These doctors have either not been exposed to, or have a schema which enables them to ignore "a sizable body of scientific literature shows that most health disparities are caused by social and environmental factors" (Bolnik 2015). Later, I will argue that this schema can be understood as a process of willful ignorance (Mueller Forthcoming). Other sociologists have argued that learning takes place beyond its explicit sites, such as Reyes (2017) who argues that organizational dynamics create racialized contexts and that racial understanding can be part of a "hidden curriculum."

Another way that medical students informally learn about racism in medical training is through their supervisors. Medical students learn the norms of their environment, and absorb information about what level of racist speech will be tolerated. A 2017 longitudinal study examined the effects of formal and informal experiences of non-African American medical students' attitudes towards African Americans. The researchers found that medical students who reported witnessing their instructors make racist comments or jokes were significantly more willing to express racial bias, highlighting the "powerful influence of normative context on racial attitudes" (Burke et al 2017). Additionally, hospitals and medical settings can also be understood as "white institutional space" (Moore 2008). White institutional space is created when people of color are excluded during the formative period of an organization, and when whites during this era create "institutional logics – norms of operation, organizational structures, curricula, criteria for membership and leadership – which imbed white norms into the fabric of the institution's

structure and culture" (Bracey & Moore 2017). Thus, racist institutional norms become characteristics of the institution which function to mask the racism that plays out within them (Bracey & Moore 2017).

Providers' Insight on Health Disparities

A 2010 study investigated white doctors and nurses' explanations for racial inequality in healthcare (Malat et al). This study looked at healthcare broadly, and found that providers blame patient behaviors for inequality in medical outcomes. More specifically, these providers' beliefs included thinking black patients have less information than white patients, something that was also found within the data I collected. Malat et al. also found that providers insist black patients are hesitant to accept treatment, or are not compliant with physician recommendations, despite the fact that research shows patient refusal is not a significant cause of racial disparities in healthcare, and actually that black patients (more often than white patients) want all possible measures taken to preserve their life (Shepardson et al. 1999 & Degenholtz et al. 2002). Providers were also extremely hesitant to say that provider discrimination was a cause of racial disparities. I find many similar themes, but my research engages with pregnancy as a particular site of racialization due to the specific and long history of the oppression of black women's procreative freedoms in the United States.

Pregnancy as a Racially Salient Event

Pregnancy is an important site to study medical racism not just because of the horrific documented disparities in outcomes for black women and their infants, but also because of the United States' long history of policing, regulating, and committing violence against black

women's reproductive rights and health. Racial disparities in maternal and infant mortality and morbidity can be contextualized as part of long history of "how the denial of Black reproductive autonomy serves the interests of white supremacy" (Roberts 1997). During American slavery, it was in slave owner's economic interest to control – through rape – black women's fertility. Dorothy E. Roberts' 1997 book *Killing the Black Body; Race, Reproduction and the Meaning of Liberty* traces the history of black American women's reproductive lives since slavery. Her work helps us to contextualize the sociological study of racial disparities as deeply connected to this history; "because scientific racism was based on the notion that race is genetic, race was defined as a trait that is inherited, reproductive politics in America inevitably involves racial politics" (Roberts 1997). Boundaries between black and white in the United States were drawn and redrawn as black enslaved women gave birth to their white slave owners' children. The importance of studying these racial disparities comes not only from them being part of a long legacy of horrifying injustices, but also from the need to further understand how bodies are racialized in pregnancy and in childbirth today as a result of that history.

In her 2011 ethnography of a large New York City Hospital, Kiara Bridges justifies her study of pregnancy as a "racially salient event" by explaining that "pregnancy is a focused occasion to interrogate racial processes because it directly implicates the material bodies of women" (Bridges 2011). This is important because, historically and presently, the material body has been understood as the primary sign of racial difference (Bridges 2011). While doctors may work from a schema in which they understand race as biological (Hoberman 2012), as sociologists we understand that race is socially constructed. Because of that knowledge, we are able to see and interrogate how a disparity in health outcomes is connected to what goes on the social world.

It may very well be true, as studies have shown, that the lived experience of racism and of stress over time can create complications in pregnancy.[4] In that case, there might be little providers can do during labor and delivery to eliminate disparities. However, Serena Williams is not the only black woman to report negative or racist experiences in labor and delivery that contribute to complications. Some race scholars have argued that overt racism is no longer the prevailing racial ideology (Bonilla Silva 2018) and in medical settings racism from providers might be more covert, or, as the medical community has taken to calling bias, "implicit." Others have made the argument that there is a particular kind of racism that operates within the realm of childbirth, known as "obstetric racism" (Davis 2018). Anthropologist Dána-Ain Davis defines "obstetric racism" as including neglect, disrespect, causing pain, and engaging in medical abuse through coercion and lack of obtaining informed consent (Davis 2018). She writes, "obstetric racism is a threat to maternal life and neonatal outcomes…Informing women's interpretations of those encounters is a fluency of historically constituted racism, segregation and policing. Obstetric racism emerges specifically in reproductive care and places Black women and their infants at risk" (Davis 2018). Because pregnancy is a racially salient event, I examine providers' racialized ideologies to see how they may influence their work.

Colorblind Racism and the Theory of Racial Ignorance

[4] Another widely cited study about the effects of racism on this racial disparity is a 1997 study of differing birth weight among infants of black women born in the United States, African-born black women, and U.S. born white women (David and Collins 1997). The researchers looked at Illinois birth records from 1980 through 1995 and found that birth-weight patterns were more similar for African-born black women and U.S. born white women and were dramatically higher (and healthier) than that of U.S. born black women. This study was important in that it challenged the genetic concept of race in relation to birthweight by finding that even controlling for socioeconomic status, African-born black women had infants with birth weight more comparable to U.S. born white women. This research is widely understood as suggesting that the lived experience of racism may have an impact on black women and their physical experience of stress, which may contribute to poor outcomes in labor and delivery.

Critical race scholars believe that "racism is ordinary, not aberrational – 'normal science,' the usual way society does business, the common, everyday experience of most people of color in this country. Most would agree that our system of white-over-color ascendancy serves important purposes, both psychic and material, for the dominant group" (Delgado and Stefancic 2012). Race is not a biological phenomenon that can be measured in blood quantum; instead, race is a social category that was created by the dominant group to serve a material purpose (maintaining superiority) for the dominant group. While we may base our understanding of racial categories on phenotypic appearance, they have no genetic reality. That is not to say that race should be treated as if it does not matter – race has real material consequences and racism has a profound impact on the ways that the dominant group, whites, experience unjust enrichment, and the various subordinate groups experience unjust impoverishment through entrenched legal, social, and historical processes (Feagin 2006).

Eduardo Bonilla-Silva's concept of Colorblind Racism challenges assumptions that declining negative attitudes toward people of color indicate a decline in racism. The central frames of colorblind racism are *abstract liberalism* (which frames race-related issues in the language of liberalism – whites can then appear moral while perpetuating inequality), *naturalization* (explains away racialized phenomena by attributing them to human nature)*,* *cultural racism* (blames racialized phenomena on cultural differences instead of on structurally created and reinforced oppression and barriers to advancement)*, and minimization of racism* (simply that discrimination is not a main issue affecting outcomes for people of color) (Bonilla Silva 2018). Other scholars have extended colorblind theory and address racial ignorance as a core process that white people engage in in order "reproduce white domination" (Mueller Forthcoming). Jennifer Mueller shifts from a theory of racial ideology to a theory of racial

ignorance, and argues in her theory of racial ignorance (TRI) that colorblind theory clears the way "for studies that characterize whites as passive, unwitting agents overcome by ideology, rather than possessive defenders of white power, privilege, and wealth" (Mueller Forthcoming). In contrast, TRI "conceptualizes ignorance as a cognitive accomplishment grounded in explicit and tacit practices of knowing and non-knowing" (Mueller Forthcoming). For Mueller, ignorance is an active process, an agreement among whites to "misinterpret…the world they themselves have made" (Mills 1997). Mueller argues that ignorance is the foundation of white thinking, and that the "epistemology of ignorance" is "a way of knowing oriented toward evading, mystifying, and obscuring the reality of racism to produce (mis)understandings useful for domination" (Mueller Forthcoming). Ignorance is valuable to white people because it makes possible the work of domination, both practically and psychologically (Mueller Forthcoming). According to TRI, racial ignorance is the "primary cognitive resource white people need to support the work of achieving racially biased ends" (Mueller Forthcoming). Taken with Moore's (2008) concept of white institutional space, we can understand that ignorance allows white individuals to be perceived and to understand themselves as innocent while still supporting the racial domination they are carrying out through the structure of their white institution.

Moon-Kie Jung's (2015) concept of *symbolic perversity* can also help us to understand how the dominant know about injustice and yet tacitly ignore this knowledge that they have ready access to:

> "Put in terms of race, the dominant, whether they be institutions or individuals, are typically aware of many persistent racial inequalities, beyond those politicized and brought to their attention by subaltern discourses. The dominant possess discursive knowledge of the reality that certain racial category, or categories, of actors systematically fare worse than themselves and others. Much of this knowledge is produced by dominant institutions, like state agencies, research universities, and news media. Yet the dominant's consumption and circulation of this knowledge are censored and structured by an underlying racial logic that implicitly assumes radical difference

> between categories of people and renders the suffering of some incommensurable with and less worthy than the suffering of others. They can and do know about the suffering of their racial others, but this knowledge fails to register or matter – at least not to the same degree as the suffering of the dominant racial category" (Jung 2015).

Studying individuals within an organization is a way to understand more about how a process like racial ignorance or symbolic perversity work at the meso-level. Sociologist Victor Ray has called for a research agenda on racialized organizations, because "once racial structures are in place, a racial ideology—or racism—arises to justify the unequal distribution of resources along racial lines. Racial ideologies then reinforce the underlying cognitive schema" (Ray 2019). However, because we know little about "how the emotions of Whites shape the daily operation and distribution of resources within organizations," more empirical research is needed at the meso level in order to understand how racial inequality is institutionalized (Ray 2019). And so, this study answers – how do the very individuals who work in medical institutions to care for women in pregnancy and childbirth make sense of this problem? Do colorblind racism and racial ignorance play into their explanations of an explicitly racialized problem? If so, how?

Methods

Design

I was interested in talking directly to women's healthcare providers about racial disparities in maternal outcomes because I wanted to know how medical professionals with limited training about race/racism were conceptualizing an explicitly racialized problem. Medical professionals commonly identified the race of their patients without critical engagement about what medical purpose the categorization serves (Bowser 2001, Finucane & Carrese 1990). Because I was interested in understanding the meaning-making process of providers (Holstein &

Gubrium 1995), I conducted 18 qualitative semi-structured interviews with various healthcare providers. I originally sought to interview primarily white providers as white people are the dominant racial group in healthcare.[5]

Data Collection

After obtaining IRB permission, I recruited respondents with the help of a key informant who is an obstetrician-gynecologist (obgyn) at a large NYC Hospital. I emailed respondents and asked if they would like to be part of a study to understand how maternal healthcare providers think about the causes of differential outcomes in maternal mortality. I then used snowball sampling to find other providers throughout the five boroughs. I conducted qualitative semi-structured interviews with ten obgyns, six obgyn-nurses and two practicing midwives in New York City. Interviews were conducted from June 2019-January 2020 in person and over the phone, and were and audio recorded with consent for transcription and data analysis.

Interview questions were grouped into five categories; the provider's training background, how aspects of their work setting constrain or enable their ability to provide care, distinctions and overlap between different maternal care provider's roles, their knowledge of and explanations for racial disparities in maternal care, and their views on research that has revealed racism as a cause of disparities. Providers were asked to share their experiences about training to become medical professionals, what they know about health disparities in maternal/fetal outcomes, how they work with other types of providers, how they understand race and racism, and how they explain these racial disparities. They were also probed to share about particular cases where they felt as though something about race had contributed to a patient's poor

[5] The Association of American Medical Colleges reports that acceptance rates for Black applicants were 34% compared to 44% for other groups in 2016(AAMC 2016), only 5.7% of medical school graduates in 2018 were African American, and only 5.4% were Hispanic or Latino (AAMC 2018).

outcome. I believe respondents were willing to open up to me and share their honest views because of both my identity as a white woman and because the key informant was a relative. To both my white and respondents of color – I was an "insider" in at least one way.

Sample

Originally, I sought to interview primarily white providers, but due to the limits both of studying elite professionals and of snowball sampling, my sample was 44% white, 39% black, and 17% "other" which included people who identified as mixed race and middle eastern. They were also primarily women (89%). Notably, my first round of interviews was with majority white providers, and when I asked these doctors, nurses and midwives if they could connect me with anyone who they thought might be interested in speaking with me about these issues, many connected me with black providers.

Data Analysis

After each interview, I wrote down my thoughts and observations. I then transcribed each interview and wrote an analytic memo. The first round of transcribing and analytic memos helped me to develop my initial hunches. In this initial coding phase, I looked for emerging concepts and codes (Hammersley & Atkinson, 2007; Huberman & Miles, 1994; LeCompte & Schensul, 2010). I noted that providers were discussing obesity, demeanor of patients, pain, and not ultimately knowing the cause of racial disparities, and I then began to code for those themes (Maietta et al 2019). I focused on analyzing by case, and discovering the relationship between quotes and the whole story told by each interview, beginning to note that people's narratives were connected (Maietta et al 2019). After identifying consistent codes, I began a second cycle of coding, which consisted of line-by-line coding looking for the concepts developed in the first

phase. After this cycle, I elucidated the patterns and themes that characterize how these various healthcare providers conceptualize and understand the problem of maternal and infant racial health disparities.

Findings and Discussion

Each provider I interviewed for this study was familiar with the issue of racial disparities in maternal and infant mortality and morbidity. They had either heard about the issue in popular media, at conferences, as part of the professional conversations in their field, or claimed to have learned about it by seeing disparities play out in their own work. These providers spoke of their passion for medicine and of their desire to specifically work in obstetrics because they loved caring for women and were enamored with the magic of childbirth. As one nurse, Patricia[6] put it, "OB is life." Many were deeply upset and concerned about racial disparities in their field and expressed gratitude that I was researching the topic. Most either brought up common potential explanations or had heard of the ones that I asked them about. They could either tell me about specific cases where black patients had bad outcomes in pregnancy and delivery or expressed that they could not identify particular cases because of the frequency of such occurrences. Many believed that socioeconomic status, rather than racism, was a main contributing issue, despite that fact that researchers have shown that racism is a fundamental cause of disparities in socioeconomic status (Phelan et al 2015). Several of the providers of color I spoke with expressed more of a critical knowledge about the racism at play in their profession, but many also mirrored the victim blaming and colorblindness seen in interviews with white providers.

Despite the care and attention these providers expressed about the injustice of racial disparities in maternal mortality and their capacity to identify potential causes related to

[6] All provider names used throughout this paper are pseudonyms.

structural racism, obstetrician-gynecologists, midwives, and obgyn-nurses I interviewed resorted to essentially blaming the victim in their explanations of why black women are facing mortality and morbidity when they come to the hospital to give birth to their children. These victim-blaming "slip-ups" came in the form of reifying genetic differences across races, individual arguments such as higher prevalence of "obesity" among black women, and providers stereotyping women of color in relationship to the patient's pain tolerance. They also explained that black women either fail to speak up in the hospital setting or are too aggressive when they do so. Ultimately, many providers expressed that they did not understand what was causing this problem even after providing me with extensive explanations for potential causes, and expressed that patients should all be treated equally to mitigate this disparity.

It is also important to note that while some of the providers of color I spoke with provided much more nuanced and critical versions of events that can be understood as racist, some did not, or oscillated between thinking critically about the issue and reverting to some of the same conclusions as their white counterparts. There are variations to how people of color see and understand society, but people of color are still socialized into the normative dominant white ideology. This occurs because of the prevalence of the normative white ideology in society – an ideology need only have most members (dominant and subordinate) of the society adjust their views to that ideology (Jackman 1994, Bonilla Silva 2018).

Overwhelmingly the providers I interviewed took no responsibility for their role in this problem, tried to distance themselves from it, and claimed ignorance when it came down to facing what would cause a black woman and a white women of the same socioeconomic status to have a disparate outcome.

Damned If They Do and If They Don't: Speaking Up or Keeping Quiet in Pregnancy and Labor

Many of the providers that I spoke to talked about the need for patients to speak up and take an active part in their medical care as central to how people get good care in a hospital. Many said that patients need to have an advocate in the hospital for this purpose. However, when it came to talking about specific cases where they thought something about the patient's race was impacting care, providers talked about how women of color were not listened to despite speaking up. There is a paradox here – that providers feel women of color are supposed to speak up for themselves to get the best care, but that when they do, they are perceived as either being aggressive or noncompliant with their provider's medical recommendations.

Dr. Samuels, a white obgyn, victim-blamed black women for not speaking up in the hospital and being too deferential. She explained this as a cause for racial disparities. After asking her why she became a doctor, Dr. Samuels proceeded to take me through her career trajectory and to talk about her time working in obgyn-safety. She explained:

> ***"A lot of patients also don't feel empowered to speak up and will sort of accept whatever they're told and kind of leave it at that or not question if they have a question about their therapy.*** *So that in a nutshell I think is what are the main things that I see is a problem with disparities in care is that everyone has to feel part of the process and* ***not be so deferential all the time because no one has all the answers and we all have to participate so…****" – Dr. Samuels*

Dr. Samuels had only been asked why she had become a doctor, but had been briefed on what our interview would be about, when she provided this response. She was immediately defensive about providers' role in causing racial disparities in care before I had even gotten to asking more specific questions. She framed the issue of patients speaking up as being about a lack of empowerment. She placed the blame for a bad outcome on the patient and more specifically on the patient being deferential to the medical provider and "doing whatever they are told." When I asked Dr. Samuels to explain why she thought some patients are more deferential than others,

she said that it may have something to do with their personalities, or the way that they were brought up – an argument that can be understood through the colorblind frame of *cultural racism*. Cultural racism blames racialized phenomena on cultural differences instead of on structurally created and reinforced oppression and barriers to advancement (Bonilla Silva 2018). This is similar to what Malat et al (2010) found in their study of white providers that "recitations of ways that black patients could be to blame for racial inequality in medical treatment fit into the colour-blind ideology that blames behavioural and cultural traits ascribed to blacks rather than whites' behaviour or structural factors."

In contrast to Dr. Samuels' explanation that poor outcomes are the result of women being deferential, another white obgyn, Dr. Welles, tried to justify the frustration providers feel when a patient gets angry and is not being compliant with their medical recommendations. When I asked her to tell me about a time when she thought something about race was impacting her patient's care, she had trouble coming up with one specific case because of how commonly she "noticed" it. She said:

> *"**If a patient is angry, we may feel we're getting frustrated as her care team because she may not be compliant with what we want her to do… then she'll get angry about it more and were like, 'oh she's being a difficult patient.'** Well why is she being a difficult patient? Maybe she has other things going on in her life that make her more resistant to what we're telling her, or you know. **And then sometimes as doctors it's hard, we're human beings right so if someone is being rude to you, sometimes your instinct is to be like rude back, right?**" – Dr. Welles*

While Dr. Welles seems to be trying to offer a possible explanation for why a patient would be resistant to a provider's instructions, she is still placing the blame for the patient's anger on the patient's noncompliance with the doctor's recommendations and on any ensuing frustration or rudeness from the doctor. This conflicts with Dr. Samuels view that women *should* speak up and challenge the doctor's orders.

Another obstetrician, Dr. Tobias, who racially identified as "other" and said that white people see him as a person of color, and black people see him as white, talked about the anger of a black patient when I asked him to tell me about a time when a patient had a bad outcome. Dr. Tobias started by explaining that the adverse event in this case had to do with waiting time and the patient's aggressive demeanor. Dr. Tobias wanted me to understand that this woman was objectively difficult and that while he made the noble choice to engage with her, many others did not. Without him intervening, he explained, on a hospital discharge paper this patient could have been labeled "noncompliant" and the case would not have been further investigated when a poor outcome did occur.

> *"So **I thought this is a patient who is demanding or a lawyer and she's white she would have been seen [sooner] probably I don't know…She made a pediatrician cry, ok with the way she spoke to her. She's going to sue her ass and the f-bomb you name it. It was like she was really…She was angry and she was cursing. And everybody didn't want to talk to her** and if I was not the man who was changed or converted… if I wasn't hanging out with the people I hang out with here - probably I would have been part of those who said ok whatever **call her noncompliant**. No. I insisted on engaging her and I got cursed and I kept engaging until I became her best friend. And I knew she could flip on me in a second but that requires a lot of energy I mean a lot of energy and this is a patient who got transferred from another hospital had a high potential for an adverse event and **with her attitude I'm telling you I would have understood if no one approached her and she could have had that adverse event and we would have said its due to the patients' noncompliance – no problem. On paper and in reality, you look at it objectively you would say you a lot of people tried their best to engage.**" – Dr. Tobias*

Dr. Tobias's story raises the question – who gets to be loud during labor? I had to clarify with Dr. Tobias that this patient was indeed a black woman. He wanted me to understand that because he has been "changed or converted" by being around socially conscious peers who are aware of racial disparities in maternal mortality, he would likely have called this patient "noncompliant" and ceased trying to engage with her, but did not because he did not want her to have an adverse event. Dr. Tobias was seemingly trying to raise the issue that black patients can be easily labeled

as noncompliant which can then cause poor outcomes, but also expressed that he wouldn't have blamed anyone who did so in this case. This is similar to findings in the work of researchers Malat et al (2010) who found that white doctors and nurses blame black patients' noncompliance for differential racial outcomes in health.

When I asked Patricia, a nurse who identifies as "other" or mixed race, to tell me about a time when she thought race or racism impacted a patient's outcome, she told me about an instance involving a black woman whose fetus died. It is notable that Patricia, a woman of color, raised this paradox without victim blaming. She expressed her suspicion that if this patient had complained more, the fetus may not have died:

> *"She was an African American female but she was morbidly obese and for hours she was not being monitored properly, or rather the baby, so sometimes I wonder if that was - if it was a different person if it was a different race* ***if it was somebody that complains more or was verbal more would have been the same outcome****? I think she was overweight I think it was inconvenient for the person taking care of her at the time and I think* ***because it wasn't a person who was loud and demanding she fell through the cracks. That's what I think****." – Patricia (Nurse)*

Patricia questioned whether complaining more would have allowed this patient to receive better care and did not seem to victim blame on account of the patient not being loud or demanding, but instead on the fact that while the patient was a black woman, her weight may have contributed to her outcome. Later, when I asked Patricia what she would say to a well-meaning provider who wants to address the problem of racial disparities in their practice, she seemed caught in the paradox between whether poor outcomes are caused by black women not speaking up, or being too aggressive and loud in labor. She identified that patients are sometimes not treated well because they appear aggressive:

> "***Culturally some people speak aggressive but they're not aggressive****. That's the only way they know how to present themselves." – Patricia (Nurse)*

Patricia also invoked a cultural explanation for why some people speak "aggressive" – though it is notable that she did so while trying to defend patients who are treated poorly as a result.

Ultimately, providers saw black women as being either timid or too aggressive no matter how they emoted in the labor and delivery setting. Without seeing this paradox as problematic, providers were blaming the victim in their explanations by suggesting that the bad outcome is a direct result of the patient's demeanor during their care. These respondents engaged in victim-blaming to explain poor outcomes through creating a paradox in what they saw as acceptable from black women in labor – black women were essentially either too quiet or too loud to survive delivery unscathed. Scholar Dána-Ain Davis provides support for the notion that black women are often blamed for their poor reproductive outcomes in myriad ways. She writes that poor outcomes are typically

> "discussed in terms of what the women do, such as drinking alcohol, smoking, and having less than optimal eating habits that lead to obesity and hypertension (Florido 2014). In other instances, their low earnings or their age is the focus of the blame (Shamus 2016). They make be seen to be at risk based on the presumption that they are 'single,' when in fact they have a partner – but are unmarried. Whatever the circumstance, Black women become wedged between embodying risk and being the targets of intervention" (Davis 2019).

The idea of the "problem patient" has been addressed in medical literature but has historically been divorced from its connections to race. The phenomena of physician feelings affecting treatment decisions become a popular topic in the medical literature of the 1980's, however, this literature does not engage with how race plays into physician's feelings. Instead, medical researchers in the 1980s focused on and engaged with documenting physicians' feelings about "problem patients" (Hoberman 2012). Monitoring "the racial beliefs of physicians was not on the agenda" (Hoberman 2012). Black patients were notably absent from literature about how physician personality can affect patient care. This omission "points to the race-averse attitude on the part of medical authors" to the detriment of the improvement of health outcomes for black

patients (Hoberman 2012). In sociology, too, accounts of medical students labeling and identifying problem patients have been devoid of considerations of race, such as the often cited 1993 study by Howard Becker about how medical students determine what a "crock" is. As a result of this focus on the "problem patient" as a deracialized figure, "Black patients were thus written out of the liberal program to humanize physicians' attitudes toward 'difficult' patients" (Hoberman 2012). The medical profession's disconnection of the "problem patient" label to race prevents the inclusion of addressing racism in solutions for how to address the "problem" patient. And clearly, through maternal provider's responses, we see here that black women are being identified as problem patients whether they be too loud and aggressive, or too quiet. It seems there is no correct demeanor a black woman can have that would satisfy every care provider and thus successfully protect her in labor.

Providers' Stereotypes about Patient Pain

Several providers talked about stereotypes related to pain and about women of color being ignored when they were complaining of pain. Providers talked about how they make assumptions and have stereotypes about race and/or ethnicity and pain that then impact how medical professionals react to a patient who is presenting as being in pain. Most of the providers who mentioned this talked about it as something that they have seen other providers do, and didn't personally want to be associated with this kind of stereotyping.

Sammi, a Black nurse, described this phenomenon as having to do with socioeconomic status, and explained that medical staff assume wealthier white patients to be more susceptible to pain since they are perceived as having had an easier life, whereas "clinic" patients – coded language used to describe patients of color – are expected to take pain better. She reported

repeatedly hearing other providers make assumptions about pain tolerance according to the patients racial or ethnic group:

> *"Yeah so for example we had a patient - I think she was Bengali - and she came in like whooping and hollering and stuff like that and* ***everyone was like 'you know that's how they are.' And it's like - we didn't even check the patient yet!*** *You don't know maybe the patient is fully dilated and well that would be the cause of her pain. But it's just like assumed that usually they are more hysterical. So it doesn't matter what her exam is, it's like, 'yea we already knew she was going to be like that.'* ***But if you get a black woman or a Hispanic woman that's doing all of that whooping and hollering most likely she's fully dilated and that's what's causing her all of this pain because otherwise she wouldn't be in pain as much.*** *" – Sammi (Nurse)*

Despite reporting that she had seen these stereotypes invoked by providers, Sammi wanted me to know that regardless every woman who complains of pain is checked out promptly due to the liability of not doing so. While obviously invoking various racial and ethnic groups, when it comes to perceptions of black women's pain, these stereotypes are part of a medical history of presuming black people to be more tolerant of pain than their white counterparts. Hoberman (2012) writes about black patients' presumed "special toughness" and scholar Dána-Ain Davis (2019) reframes the concept as *obstetric hardiness* which "centers on the ease with which women bear children – reflecting a toughness that is constructed as primitive in nature."

When I asked Dr. Muller, a white doctor, about why racial disparities exist outside of her previous explanation of socioeconomic status, she also turned to talking about assumptions about racial/ethnic groups and pain and about how preconceived notions about pain can impact the care provided to a particular patient.

> *"And if anybody has – if a doctor has some kind of preconceived notion about a person of a certain ethnicity, they may treat them differently.* ***For instance in the labor and delivery room Hispanic women are known to – I mean they have been known in the past to be very you know more vocal when they're in labor or with anything in pain, compared to an Asian woman who literally like could be dying in pain and they're like stoic to a fault so it's like so this colors an obstetricians look so the next time they dealt***

> ***with these situations and then the next person comes in with that ethnicity they're going to have that experience in the back of their head they can't erase that****." – Dr. Muller*

Dr. Muller explained a similar process to the one Sammi described of stereotyping that doctors use when laboring mothers are in pain, yet Dr. Muller did think that these stereotypes cause doctors to treat their patients differently.

Ruthie, another Black nurse, also expressed she had seen this phenomenon, and told me about a particular case where a black patient knew what was happening to her body because she had experienced similar pain when she had a uterine fibroid removed, but was still not listened to despite speaking up and despite nurses speaking up to doctors. Ruthie's example elucidates an example of doctor's not only not listening to a black woman in pain, but using their stereotypes and judgement about the woman's race as a justification for negligence:

> *"**Yeah I've seen it once where someone kept complaining of pain and they kept saying oh it's normal it's this, but never, no matter how the nurse would push for a particular test or can you do this can you do that can we just do a CT scan of her abdomen – oh no its fine it's this it's that – no its not**. And we try to verbalize it and just try to document everything and then come to find out she actually did have a partial obstruction after her surgery. And they did have I want to say maybe like six days later when she was supposed to be discharged, she couldn't be discharged and then they kept slowly working her up where they could have just done everything once and seen it. I've had that on many occasions actually…both black. African American. **And I remember one she had a surgery prior and she said this feels just like when I had the complication when I had the fibroid removed, I had the hematoma and it feels the same way and everybody ignored her.** And then she was post op 13 days and now everybody wants to come in because she's in the hospital and she can't go anywhere. Saying oh you're taking pain meds too often, but she had no background of taking pain meds ever so they thought maybe she was addicted. They were saying all kinds of stuff. And I'm like no. Let's just do a CT scan and when they finally did, she had a hematoma, and now they started all these lines and all these antibiotics late and now she was in the hospital for an extended stay…**They weren't listening to her, they weren't even listening to the nurses**." – Ruthie (Nurse)*

Despite the fact that Sammi believed that these stereotypes do not play out as harmful due to potential liability for not addressing a patient in pain, it is clear through Ruthie's example that

this problematic phenomenon of stereotyping patients and their pain tolerances can cause real harm. Ruthie's patient, a black woman, was stereotyped as addicted to pain medication and suffered as a consequence of that racist presumption. She was not listened to, repeatedly, when in pain, and ended up in the hospital for an extended period of time with a very serious complication.

Racial stereotyping in relation to pain tolerance and ignoring black patients in pain as a result is a dangerous practice. Most upsetting in these reports was the providers' acknowledgement that this was a common practice in their environment. As Burke et al (2017) found in their study of non-African American medical students' attitudes towards African Americans, racist views and norms within the work setting have a "powerful influence of normative context on racial attitudes." An institutional norm that presumes different expressions of pain or different pain tolerances by race or ethnicity is a norm that has the potential to severely harm women of color in the hospital setting.

Victim Blaming and Body Shaming: Obesity and Pregnancy

Several providers brought up "obesity" when I asked them to talk about the racial disparity in maternal mortality rates, without making it explicit that they were associating blackness and obesity. It seemed more like I was supposed to agree that this link was obvious, even though few of these providers engaged with any explanation that there is some kind of over representation of obesity among black women. An emerging body of literature shows that doctors discriminate against fat patients, despite the fact that it is weight stigma and not obesity that cause many of the disease profiles we commonly associate with obesity. The obstetric providers I interviewed bring up obesity to explain a disparity, which essentially blames the

woman for having a preexisting condition when in fact the health outcomes associated with that condition are being caused by the stigma that is coming up in these interviews.

When I asked Jules, a white midwife, about whether she thought emotional support plays a role in pregnancy outcomes, she launched into a story about an "obese" woman who she later revealed to be a black patient after using coded language during her telling of this woman's story.

> *"And the other day actually I don't know if race played into this.* ***But I had a patient the other day who I referred for high risk care because she had a history of high blood pressure in her previous pregnancy and she was very obese. Like body mass over 35 which definitely is associated with some problematic outcomes.*** *And she also had a previous c section… so there were some things going in her pregnancy that made me concerned about her. And I had seen her just a few times but I decided to transfer her to the high-risk clinic. There used to be a more accessible high risk clinic just a few blocks from the center where I work but [Hospital] eliminated that, now I have to send people who live on the lower east side, we're talking like avenue C, and were sending them to the upper west side or the upper east side.* ***And you know some women don't want to travel. So I send her – I make her an appointment to go there and I tell her she needs to go and I told her you know I want you to be careful how you eat …I think you have a risk for diabetes and I think – I did do an early diabetes test and she passed – you're at risk for diabetes I want to make sure you're not taking a lot of soda and juice and I said, what did you eat today? And she said I had fried chicken and blah blah blah and I said it might be better not to eat fried food. And she said what? I'm not gonna stop. And she got upset when I told her what she should be eating. And some people are very sensitive about talking about weight and talking about their diet even though nutritional counseling is something that I try to do with everybody and I hope that I find ways to talk to people that isn't going to offend them but this lady got upset about that…this was like clearly it was a fragmented care that made her fall through the cracks. She had her initial prenatal care at one community clinic and then she wasn't really plugged into the MFM clinic yet, and she was kind of a difficult sort of – kind of a difficult personality, and she was a little abrasive and you have to tip toe around her I learned when I told her not to eat fried chicken*** *like you know" – Jules (Midwife)*

In a response about whether emotional support plays into patient outcomes, Jules explained that this woman had fallen through the "cracks" within the institution even though she was a high-risk patient due to a previous c-section and her obesity – though Jules mentioned she had "passed" her diabetes test. Even while discussing institutional factors that impacted this patient,

Jules was still blaming the patient and racializing this woman as lazy, noncompliant, and difficult. Jules seemed to think that the case she was describing was an example of her giving a patient emotional support.

I asked Dr. Knowles, a black obstetrician, to talk about a time when a patient had a poor outcome. He described a black patient who came in for a scheduled cesarean section delivery, but ended up having to wait all day, without food, for her delivery. The patient ended up with a pulmonary embolism but did survive. When I asked Dr. Knowles to tell me a bit more about the patient, he disclosed:

> *"I just remember it was her third scheduled section* ***she wasn't obese or she was like if anything it was just overweight*** *or class one but it wasn't like very morbidly obese or anything like that…* ***if she was obese then I would think like you know she's higher risk of having like a clot****." – Dr. Knowles*

Dr. Knowles brought up this case and remarked that the patient "wasn't obese" as if that typically is enough of an explanation to justify when a patient does have a poor outcome. Again, it is important to remember that the New York City Department of Health has found that even when accounting for obesity, black women fare worse than white women when it comes to maternal health outcomes (NYC DOH 2016). Obesity is by no means an explanation in itself for a poor patient outcome.

As I began to hear more providers bring up the issue of obesity, I asked Dr. Jones, a white obstetrician, whether she thought obese patients being treated poorly was a contributing factor to the racial disparities in maternal outcomes. She explained that she thinks "implicit bias" around weight is prevalent in the medical community, but justified this by explaining that doctors are only human and essentially that fat bodies are funny:

> *"I would assume that there is probably some implicit bias around weight with providers. I don't know any study that – I trained in the Bronx where I never had a non-obese patient. The average BMI was well over 40, obese means that your BMI is over 30. So we*

> *dealt with it a lot. But then we would have some of these patients who were like in the extreme, over 600, 700lbs, and we medicalized it right –* ***but people make jokes and you lighten the mood and were human beings based on what people look like and how people make us feel*** *and so I'm sure that there has to be some amount of implicit bias I've just never seen the actual research behind it****. I wouldn't be shocked if it ends up showing that people treat obese patients differently****." – Dr. Jones*

Dr. Jones' acknowledgement that providers make jokes about obese patients corroborates many studies that have shown fat people are treated poorly by medical providers (Sabin et al 2012). Presumably, this attitude is linked to societal and medical beliefs that equate fatness as sickness, however many studies have shown that it is the experience of social stigma about fatness that links fat bodies with some poor health outcomes, not weight itself (Phelan et al. 2015).

The argument that obesity is somehow obviously connected to blackness or to poor outcomes for black women is a genetic argument. It assumes that there is something inherently or biologically different and damaged about the obese body. In her research, Dána-Ain Davis spoke with administrators at the March of Dimes, an organization that focuses on the health of premature babies. Davis writes that an administrator she spoke with blamed obesity for high rates of premature babies born to black mothers. She challenged this explanation by saying that the administrator seemed to be attempting to move beyond a biological argument by shifting to more "individual" factors such as "obesity, hypertension, diabetes, and smoking, which serve as proxies for biological causes and, he suggests, occur more often among Black women" (Davis 2019). However, Davis argues that a March of Dimes funded study found "inconsistencies in the effects of obesity on pregnancy, and it is not necessarily related to factors in preterm birth of obese Black women relative to obese white women (Shaw et al. 2014)" (Davis 2019). Davis argues that blaming obesity is simply a way to couch biological arguments in behavioral arguments, to justify a bad birth outcome. We see this in Jules' comments which blame the black patient for her food choices, despite the fact that Jules is also bringing up and yet ignoring

structural constraints and her own acknowledgement that this patient does not in fact have diabetes.

The linking of blackness and obesity is not unique to this setting. Sabrina Strings (2019) has argued in her book, *Fearing the Black Body: The Racial Origins of Fatphobia,* that phobia and repulsion about fatness and societal preference for thinness have not historically been about health and wellbeing. They have, instead, "been one way the body has been used to craft and legitimate race, sex, and class hierarchies" (Strings 2019). She argues that "that two critical historical developments contributed to a fetish for svelteness and a phobia about fatness: the rise of the transatlantic slave trade and the spread of Protestantism. Racial scientific rhetoric about slavery linked fatness to 'greedy' Africans. And religious discourse suggested that overeating was ungodly" (Strings 2019). It is clear that providers judge the individual choices of fat patients, assume they are more likely to have poor health outcomes, and find their bodies comical. Coupled with this kind of victim-blaming, shaming, and assumed rhetoric around obesity as inherently unhealthy, being obese and being black place a woman in a precarious position when receiving medical care for pregnancy.

Not Knowing "Why" – the Willful Ignorance of Providers

After spending up to an entire hour speaking with me about all of the various possible explanations for this racial disparity and sharing their knowledge about systems that constrain provider choices, implicit bias, socioeconomic disparities, and explicit racial prejudice and discrimination, many providers still concluded that the did not understand why this disparity continues to exist sometimes in the same breath as explicitly naming implicit bias or racism. Strikingly, this came up several times when the provider brought up the case of Serena Williams without being prompted, as her case has been very publicized in the news media.

Dr. Samuels, a white obstetrician, shared theories she had heard about intergenerational trauma and the toll of a lifetime of lived racism on the body's stress responses, and yet concluded in the same breath that she did not know what the problem was.

> *"***I think there's more questions than answers I don't really think I don't know the – I don't really have a theory as to what the problem is…***I don't think we really know other than it's hard to fix something when you don't know what's causing it right? So we also can't fix something that we don't – we have no control over what happened two or three generations ago we can only deal with what we have now." – Dr. Samuels*

Dr. Samuels simultaneously acknowledges generations of oppression, and yet still maintains that she does not know what the problem is. This switch from knowing to not knowing is a clear example of Mueller's theory of racial ignorance. Mueller calls the epistemology of ignorance "a hardy means to resist antiracist critique and evade the kinds of critical race knowledge that would have moral and practical implications" (Mueller Forthcoming). To own the knowledge that there have been generations of racism and ongoing racism within society and the medical profession would implicate Dr. Samuels as both a white woman and as a white doctor working in a white institutional space. Here, her ignorance functions to protect her own innocence and to clear her from any culpability.

Similarly, Dr. Tobias was enraged talking about the Serena Williams case expressed that he did not understand why the doctors caring for Ms. Williams wouldn't have listened to her:

> *"You have a patient who is black and educated who tells you I'm having pulmonary embolism and no one is listening!* ***Why wouldn't you listen?!*** *Any* ***regular*** *patient tells you I have a pulmonary embolism you're going to do the CT scan even if I know you don't have it because you just said it to me. So why would you have – Williams yeah.* ***I don't understand that episode.*** *It could be that they're cautious they don't want to submit her to the CT scan it could be because I had a VIP [Very Important Person] once and I was like oh should I do a CT scan – not a big VIP like a local VIP ok so should I do a CT scan, should I not, maybe she has a PE, we ended up not doing it. She could have had a PE and died and I would have been like – well the doctor didn't do a CT scan! But people don't see this…****That what I would like to investigate is the why. You know and they're not all racist out there they are not all racists.*** *When you're a doctor or a nurse you know it's very rare, they come to help people. So, there's something that we are*

> *missing in intervening in that window.* ***And I don't know what it is. I just don't know. I don't think we know." – Dr. Tobias***

Dr. Tobias is enraged about the injustice of Serena Williams not being given a CT scan, without recognizing that this was a racist event. He jumps to needing to know the "why" – and then in a cognitive jump to racism that should be the knowledge necessary to help him answer his own question – defends other doctors and nurses as not racist and returns to his position that "we" are ignorant about why this is happening to black patients.

Meredith, a white midwife, invoked the Serena Williams case when I asked about black women of high socioeconomic status having poor outcomes, and despite giving the explanation of implicit bias, also reverted to saying she didn't have the answer.

> ***"And that's where I guess the implicit bias piece goes on*** *where for instance when Serena Williams telling everyone that something was wrong and nobody listened****. I don't have the answer to that – why****." – Meredith (Midwife)*

When I then asked Meredith to clarify why a white woman would have a better outcome even when socioeconomic status was the same, she went back on her previous explanations about racism, and indicated that more research needs to be done to understand the problem.

> *"That I can't answer.* ***I don't know****. I guess I'm just talking about the differences in socioeconomic status as well as the racial differences****. I can't necessarily answer why a black woman of the same status as a white woman would be more at risk but they are.*** *The research shows that they are. Something to keep working on." – Meredith (Midwife)*

Despite her previous answer about implicit bias – which may be a softened way to talk about racism but nonetheless shows some understanding and knowledge about what causes poor outcomes for black women – Meredith reverted to claiming she does not know what causes the problem.

It bears mentioning that the media coverage of Serena Williams' birth experience has been framed, by many people of color, as an example of and a face to the statistics that show the

crisis of black women's reproductive health and freedom in the United States. Mueller, in her theory of racial ignorance, reminds us of the work of the concept of *willful hermeneutical ignorance* (Pohlhaus 2012) – the "the tendency for dominant groups to dismiss the intellectual resources and insights marginalized people develop by virtue of their experience" (Mueller Forthcoming). This ignorance is not the absence of knowledge, it represents a decision to *actively ignore* the knowledge that is clear before these providers' eyes.

For Mueller, ignorance is a "twin pursuit: [it] maintain[s] white power, privilege, and wealth alongside a 'lifelong white moral identity" (Mueller 2020). Healthcare workers, in particular, have a stake in being perceived as having a moral identity. Jung's concept of symbolic perversity also helps to explain this phenomenon. Jung writes:

> "Contrary to the prevailing liberal notion that the dominant, like all people, would act justly if they knew about this or that injustice, I underscore the ideas that the dominant, *know* plenty and that the knowledge is not hidden away in the buried recesses of their unconscious or some arcane archive. Rather they tacitly ignore this knowledge that they produce, have ready access to, and consume. This deeply patterned ignorance, a depraved indifference, follows a racial logic that devalues the suffering, indeed the lives, of certain categories of people" (Jung 2015).

As many of these providers are engaged in department wide or hospital wide efforts to reduce racial disparities in maternal mortality, this willful ignorance and devaluing of the suffering of black women is a threat to the lives of their black patients.

"I treat all of my patients the same!"

When it came to talking about solutions to this problem, providers spoke about attempting to make their practice equal, without thinking instead about what may be necessary for their care to be equitable. Many providers, after talking about the inequities black women face both in society and within the healthcare system still maintained that it was important to

treat all of their patients equally, and did not consider that addressing this disparity may require differential treatment that actually acknowledges that black women are having worse outcomes and therefore would seek to actively insure black women who come in are given increased attention or care.

Dr. Samuels, a white obstetrician, emphasized that this disparity could be eliminated if hospitals focused on providing excellent care to all patients equally despite race or type of insurance or where they live.

> *"We have no control over what happened two or three generations ago we can only deal with what we have now so by all we can do and it seems sort of feeble is* ***provide really excellent care to all of our patients the same****. And a lot of what we do at least in the [hospital] health system is when I took this job the my task was to align first of all align all the clinics and second of all make sure that the clinic practice is a line with the private practice so you can't tell the difference* ***if you're blindfolded you can't tell if this a clinic patient or private patient.*** *Is this patient from [Hospital] East or [Hospital] West you can't tell.* ***Everyone is treated the same****." – Dr. Samuels*

Dr. Samuels is acknowledging some kind of effect of the past two or three generations, but does not extend that understanding to a solution that would acknowledge the different history for different patients, instead opting for a colorblind solution that treats all patients the same.

Patricia, a mixed-race nurse, said that the advice she would give to a well-meaning white provider who wanted to help to reduce this disparity would be to treat all of their patients equally and to ignore race.

> *"Treat every patient like they're your mother, your sister, your niece, somebody you care about. Don't care about their religion,* ***don't look at the color of their skin****, don't listen to the words they say because I'll surely some people speak aggressive but they're not aggressive that's the only way they know how to present themselves." – Patricia (Nurse)*

Again here, Patricia is acknowledging that there is a problem with providers perceiving certain patients as aggressive, but her advice is still to treat everyone equally.

Sammi, a black nurse, talked about the importance of treating all of her patients the same, but then described the ways she intentionally treats them differently in order to make sure they have access to needed information. It was clear she wanted to convince me that doing so did not mean she gave anyone preferential treatment, and that she understood there was some importance to maintaining the party line that all patients be treated the same.

> ***"I try not to look at race at all I mean I treat all of my patients the same****. But I do know that just in general I do know that sometimes the African Americans, the Hispanics, even sometimes the Asians they don't have as much information so naturally like that's my job to give them the information. Because I can't assume like hey um this patient knows this, they already learned it. Even with the private patients like I can't assume that you already discussed this with your doctor. So I have my whole sequence of like how my admission goes and based on your background we are going to talk about all that stuff things that could possibly happen during labor, that could lead to a c section or maybe not lead to a c section so I do think that –* ***I do that naturally with all patients no matter what their race is, however with the patients of color I am a little more conscious that I guess because were the same race that maybe they're treated a little bit differently?*** *So I do make sure that I advocate for them but I will do that with any patient so." – Sammi (nurse)*

Sammi seemed to think the "right" answer was that everyone should be treated equally, and tried to use that language to couch her answer that she does in fact know black patients are treated differently and that she tries to be conscious of that and to make sure her patients of color have the necessary information. She even sees herself as an advocate for those patients. Sammi clearly did not want me to think that that kind of attention would only be given toward black patients, and reiterated that she will do that "with any patient."

These providers are going back on any previous acknowledgment of various kinds of racism in society and within the hospital that affect their patient's outcomes, and reverting to a colorblind solution that assumes all of their patients to be on a level playing field. This rhetoric exemplifies Eduardo Bonilla Silva's colorblind frame *abstract liberalism* – which holds that white people can appear reasonable and even moral by invoking the language of liberalism and

equality to explain or justify racial inequality (Bonilla-Silva 2018). In this case, providers are using the principle of equality as a solution to a problem that is about inequity.

Conclusion

This research asked how maternal healthcare providers conceptualize racial disparities in maternal care, and ultimately found that despite providers concern for and knowledge of how racism affects the lives of their patients outside of the hospital, that knowledge does not translate to anti-racism within the care setting. When I asked providers about what causes these disparities, they blamed black women for either being too loud or not speaking up during labor and employed colorblind cultural racism arguments. Providers shared that stereotypes about race and pain tolerance are rampant in their field. They also reified genetic arguments about race through linking blackness and obesity, and making assumptions about inevitable outcomes for "obese" black mothers. Ultimately these providers feigned ignorance, and claimed that solutions should be colorblind.

Future research should further explore the role of emotional support in labor and involve interviewing doulas. The providers that I have spoken to thus far have strong opinions about doulas that expose a tension between maternal healthcare providers who work in hospitals with the doula activists that are working to increase access to doulas for black women in order to increase emotional support and thus hopefully improve outcomes for black women in childbirth.

Ultimately in this study, providers expressed myriad beliefs about cases where black women have had poor outcomes, and then ultimately claim ignorance about what the main problem is, particularly for women who have a higher socioeconomic status. This victim blaming is particularly problematic because most widescale solutions are coming directly from providers. Placing blame on causes like obesity that can be individualized, focusing on race

neutral solutions like equal treatment, and continuing to ignore knowledge put forth by black women about racism occurring will not allow providers to come up with solutions that tackle the true problems at play. Blame-shifting also prevents providers from investigating the ways they participate in the creation and perpetuation of disparate outcomes.

Finally, these providers need to have the courage to own the knowledge that they do have about this problem as being the result of racism in various forms. Jung (2015) reminds us:

> "…Sven Lindquist (1992:2) states, 'You already know enough. So do I. It is not knowledge we lack. What is missing is the courage to understand what we know and draw conclusions.' True, but what is also lacking and precedes courage is recognition of the conditions that warrant courage. For the dominant, the moment of choice between bravery and cowardice often never comes: they know not what they know, for they care not what they know" (Jung 2015).

Maternal healthcare providers must cease blaming their black patients for poor outcomes, and have the courage to claim their knowledge about these racial disparities and draw conclusions that are color-conscious rather than color-blind. This shift is imperative if we are to see a desperately needed improvement in outcomes for black mothers.

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APPENDIX – Interview Schedule

Principal Investigator: Cara Cancelmo
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Title of Study: Providers Insight on Health Disparities Interviews

Orienting Paragraph:

Thank you for taking the time to speak with me today. I would like to learn about your experiences as an (OBGYN/DOULA/MIDWIFE/NURSE). You are likely aware that there are grave racial disparities in maternal and fetal mortality and morbidity, particularly in New York City. I am interested in learning about what you know about this problem and how you came to know about this problem. This is an informal conversation, so please feel free to share whatever comes up for you as we are talking. This problem of racial disparities in maternal and fetal health is a complicated issue with many confounding explanations - I am simply interested in learning about how you as a care provider of pregnant women think about and make sense of this issue.

Questions:

1. Training Background
    a. Can you tell me a bit about your training to become an obgyn/midwife/doula?
    b. Did your training include formal instruction about race or social determinants of health?
    c. Did conversations about racial disparities or racism come up informally during your training?

2. Constraining/Enabling of the work setting
    a. Can you think of a time when it felt like racism/race was impacting your patient's health or access to care?
    b. If you could redesign your work environment to help reduce this disparity, what would you change?
    c. As medical settings are rapidly evolving, how do you see institutional change playing a role in this issue?
    d. How do you think emotional support from care providers plays into the outcomes for pregnant women?

3. Provider Roles
    a. Have you ever worked with a doula/midwife/obgyn? What are those experiences like?

b. As an obgyn/midwife/doula, how do you think the other care providers think of your role?
c. Do you think that doulas are able to provide something to pregnant women that obgyns are not?
d. Is there tension between OBGYNs and doulas? Why do you think that is?
e. What aspects of the roles of doulas/obgyns/midwives overlap? What aspects are separate?

4. Racial Disparities
    a. How did you become aware of the racial disparities in maternal and infant morbidity and mortality?
    b. What does race mean to you?
    c. What does racism mean to you?
    d. Do you see this problem as related to racism? Why or why not?
    e. Are you aware of professional conversations happening in your field about this issue? What kinds of conversations are happening?
    f. What do you think - from your stance as a(n) obgyn/midwife/doula - causes this disparity?
    g. What do you personally think causes this problem?
    h. If you are comfortable sharing, can you think of a time when a black patient had a bad outcome? Do you think race/racism played a role in that outcome? Why/why not?
    i. Do you think your race plays into the relationships you have with your patients or the care you are able to give them?
    j. How does knowing about this problem inform or contribute to your daily work?
    k. Are you aware of any solutions being posed to deal with this problem, whether in your workplace or around the city? What do you think of those plans?

5. Breaching Questions/Specific Interventions
    a. (If they have been focusing on socioeconomic explanations) Research shows that these racial disparities still exist when we control for socioeconomic status. Can you talk about why that might be?
    b. One famous study explains that the lived experience of racism takes a toll on the body and can cause poor outcomes for black mothers and babies. Do you think there is anything care providers can do to combat this during pregnancy/delivery care?
    c. Studies have shown that the continuous emotional support provided by a doula can reduce birth complications. Do you think that access to doulas is a viable solution to this problem? How accessible are doulas to black women in NYC?
    d. Studies have shown that many white doctors still believe genetic fallacies about race, including believing their black patients have a higher threshold for pain than white patients. What do you think can be done to combat this?