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“Disbelieving Black Women to Death”; the “Double Jeopardy”: Racism and Sexism Affects Black Women’s Access to and Quality of Care During Pregnancy, Birth, and Postpartum

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“Disbelieving Black Women to Death”; the “Double Jeopardy”: Racism and Sexism Affects
Black Women’s Access to and Quality of Care During Pregnancy, Birth, and Postpartum

University Honors Program Thesis

University of Nebraska at Omaha

Submitted by

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Spring 2020

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UNIVERSITY OF NEBRASKA AT OMAHAHONORS THESIS/PROJECT/CREATIVE ACTIVITY ABSTRACT

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ABSTRACT OF THESIS:

This paper explores possible reasons why Black women in the United States experience a higher maternal mortality rate than their white counterparts. Using books, articles, journals, documentaries, personal experiences and stories of Black women and mothers, I argue that barriers from the societal to the individual level create health and medical disparities for Black mothers in pregnancy, during delivery, and the postpartum period. The paper concludes with a multifaceted solution and call to action.

Keywords: Black, maternal mortality, healthcare, barriers to healthcare, obstetrics, childbirth, bias, discrimination, racism, sexism

Introduction

Angela Pie, a Black¹ woman who worked in the child welfare profession for over twenty years, was unaware of the horrific statistics of the maternal mortality rate in Black women until it became her reality. She was a mother of three healthy boys when she became pregnant with a fourth child. As someone who had experienced many miscarriages, Pie was aware and sensitive to the symptoms and concerns associated with a miscarriage. Pie had spotting within the first trimester and was told not to worry by her OB-GYN. She made it to her second trimester with good reports of the baby's growth. However, Pie suffered a drop in her iron and platelets and was told that she could suffer a brain aneurysm at any moment. She was instructed to be on bed rest with scheduled platelet transfusions. Her questions on her condition were left unanswered and her concerns were left unattended. The probability that this mother would live past delivery was slim to none. Within the limited time of her pregnancy, she had to prepare herself to leave her husband, three children, and newborn while also preparing her children to live a life without their mother. All the while, Pie experienced extreme fatigue and illness. During the delivery, the physicians performed a spinal tap without real consent and refused to give Pie oxygen when she was short of breath. They refused to treat any other symptoms Pie faced including continual nausea and vomiting. All the odds were against Pie and somehow, she lived. Pie is using her second chance to bring awareness and improve maternal outcomes for Black women and all women in the United States; she notes, "We deserve to enjoy our pregnancies - not plan for our funerals. We deserve to live. We deserve better..." (Pie, 2018, p. 901).

¹ Throughout this paper, "Black" will be used instead of "African American" because not all Black people are African Americans (NABJ, 2019). The usage of "Black" instead of "African American" provides and ensures inclusivity of everyone within the African diaspora, geographically and culturally (Jeffers, 2019). "African American" and "Black" may be used interchangeably depending on what the author or source has used.

High maternal mortality rates are an important issue in the United States and should precipitate greater concern. Despite ranking first with the highest monetary investment in hospital-based maternity care than any other country, the U.S. is among the worst developed countries for pregnancy-related death prevention (Martin & Montagne, 2017b). Though the maternal mortality rates in the United States are relatively low from a global perspective, they are rising in some areas, especially for Black women. This is not surprising given that the Black population have historically been denied opportunities for proper healthcare. What has been provided is either of diminished quality or markedly exploitative. This lack of equity is a matter of life and death – particularly for Black women. In general, Black women receive less attention and lower quality healthcare; this inequity is particularly apparent among pregnant Black women who are three to four times more likely to die from pregnancy-related complications than white women (CDC, 2019a). Moreover, this statistic is independent of parity, age, or education and sixty percent of these deaths could have been prevented (CDC, 2019a). Despite medical advancement, the ratio between the rates of Black and white maternal mortality have not declined in over 25 years.

Maternal mortality rates of Black mothers is a multifaceted issue. No single statistic clearly identifies why the statistics differ dramatically between white mothers and Black mothers. Thus, to assess the high rates of maternal mortality rates, it is necessary to assess the barriers constructed by racism. Assessing race-related impediments to equitable healthcare for Black women may help identify injustices caused by racist stereotypes and (un)conscious biases within the patient-physician relationship. The harsh reality of historical mistreatment of Black people in the U.S. healthcare system, alongside current healthcare statistics, clearly demonstrates that Black women are in grave danger. They are endangered by the common childbirth practices

of today and the lack of accessible prenatal care options. These practices are rooted in the history of obstetrics - which as part of the history of the U.S. is profoundly influenced by the forces of patriarchal priority and racism.

History of Obstetrics

Women were the earliest birth attendants. Ancient mythology and artistic depictions identify women as the earliest practitioners of midwifery within historic groups. Women caring for women, in tune to the natural tendencies of the body, and knowingly patient in appropriate timing is the earliest model. Prehistoric figures and ancient Egyptian drawings showcase women giving birth in a sitting or squatting position – a position that better utilizes musculature and gravity to ease the process of delivery which was commonly used throughout the world.

However, in 1663, Francois Mauriceau triggered a methodological shift in Europe pushing patriarchal influences upon birthing practices into the birthing room. Mauriceau attended the childbirth of one of Louis XIV's mistresses with the King and introduced the practice of women lying in bed to give birth instead of the aforementioned positions. This was not a medical innovation, but rather a way to give the King a "view" of the childbirth, something he found titillating and erotic (Drife, 2002, p. 312). Thus, the practice of men entering the delivery room occurred for power reasons, not for the wellbeing of the mother and child. The use of forceps during the birthing process began as a way for male physicians to speed up the birth through intervention instead of letting the mother's body follow its own rhythm (Curl & DiFranco, 2014, p. 208). This intervention comes with significant risk prioritizing the baby over the mother and potentially causing long-term or permanent health issues for both the mother and baby (Curl & DiFranco, 2014, p. 208). When medical textbooks educating men and male physicians about childbirth were published in Europe in the 1500s, male comfort and supposed superiority gave

rise to competitive tensions between physician and midwives – a patriarchal construct that remains despite the gender of the midwife/physician (Drife, 2002, p. 311). Still, because of the association with high status and power, women turned to physicians with promises of safer, less painful labor through the use of forceps, and later drugs and anesthesia (Dye, 1980, pp. 101-102).

Widely published information on childbirth, the extension of the delivery process into an “official” medical field, and the development of new technologies led to more advanced and “modern” practices. Some of these practices have led to unintended (both beneficial and life-threatening) consequences. For instance, puerperal fever is caused by uterine infection following childbirth. The fever affects women approximately three days after childbirth and may rapidly progress to death from sepsis within a few days (Hallett, 2005, p. 1). Until the mid-1800s, puerperal fever was transmitted through surgeons who worked on wounds and then called to care for a mother without washing his hands in between patients (Carr, 2000). Thus, they carried bacteria from working on a wound and into the open wound of a womb (Carr, 2000). Washing hands or any form of sterilization was not a practice at this time, but puerperal fever motivated Ignaz Semmelweis, a Hungarian physician in Austria in the 1840s, to start experiments on antisepsis (Zoltán, 2019). Semmelweis was known as the “savior of mothers” because the simple act of washing one's hands drastically reduced the number of women dying (Zoltán, 2019). Many American physicians were unconvinced and ignorant of the importance of antisepsis and the practice did not become routine until the end of the 19th century (Dye, 1980, p. 103).

A little over 150 years ago, women bore children without anesthesia. The first effective anesthesia was developed by James Young Simpson and Crawford W. Long. However, its use in childbirth in the 1840s was widely debated. Some believed the Bible suggested God had made it so women should suffer during childbirth. But others believed it provided a new freedom to

women who routinely underwent the agony of childbirth and anesthesia was eventually praised (Eschner, 2017). It is the development of antisepsis and anesthesia that laid the groundwork for Caesarean sections. When C-sections were introduced in the early 1800s, the life of the mother was prioritized during C-sections because once the obstetrician was summoned, the baby was presumably already dead (Drife, 2002, p. 311).

Until the late 18th century, birth was exclusively a women's affair in the U.S. and was considered to be more of a social event. Because medicine was exclusively a men's occupation, the transition from social to medical views of deliveries was synonymous with the transition of woman-controlled birth experiences to a man-controlled one. This transition occurred gradually between the late 18th century and into the early 20th century. Physicians (men) between the 18th and 19th centuries described midwives (women) as "ignorant and dangerously incompetent." However, midwives of the time were knowledgeable on the stages of labor, recognized and managed difficulties throughout delivery, and used mechanical and pharmacological means to alleviate pain and speed labor (Dye, 1980, p. 104). By the 1920s, the transition into the medical model of childbirth was complete and the medical profession controlled birth management nationally.

Obstetrics Now

With a resurgence of interest in ancient methods in the 21st century, both beneficial and detrimental obstetric practices of the past have become popular. For example, it is thought that giving birth in a sitting or squatting position is more beneficial than the supine position because the baby receives more oxygen as there is less risk of compression on a major blood vessel (Wolfrum, 2016). Sitting or squatting allows the pull of gravity upon the infant to guide them through the birthing canal; these positions both reduce maternal fatigue and increase efficiency.

However, women usually give birth in the supine position – likely due to the comfort of the physician. As the research on birthing positions has supported ancient practices, mothers have increasingly been encouraged to not only sit more upright during delivery, but to move around throughout the process. Though the resurgence of this ancient methodology has improved the wellbeing of women during childbirth, there are other practices that raise concerns for safety, such as unsupervised or untrained home births or strange inducement methods. Ultimately, the voices of women during the childbirth process are receiving greater attention possibly linked to the Feminist Movement and resurgence of midwives in the United States.

The current prenatal care system is a derivative of the model used in the late 1800s that focused on recognition and prompt treatment of complications rather than promotion of health and prevention. In fact, the reduction of maternal and infant mortality is strongly associated with the provision of early and continuous prenatal care (Maloni et al., 1996, p. 18). Women receiving no prenatal care are three to four times more likely to have a pregnancy-related death than women who receive prenatal care (*Maternal Health in the United States*, 2018). Approximately 25% of women do not receive the recommended number of prenatal visits; this number rises to 32% among the Black population (*Maternal Health in the United States*, 2018). However, financial, social, and individual barriers often prevent women from receiving proper prenatal care. Women of lower socioeconomic levels tend to have less access to good nutrition and healthcare and are likely to have higher stress levels. These women of low socioeconomic status are at the greatest need for prenatal care but may not seek it because they simply cannot afford it in terms of time and money (Maloni et al., 1996, p. 19). Women report being unable to make the recommended prenatal visits because of conflict with work schedules, school schedules, transportation availability, and finances (Anderson & Bulatao, 2004). Physician appointments

are generally only offered during daytime hours; clinics may be difficult to reach, and the cost of the services are all barriers to receiving care (Maloni et al., 1996, p. 21). Each of these barriers alone is enough to make it impossible to make the appointments, but health care providers are more likely to place judgment on the “failure” of the patients to seek care rather than working toward a solution (Maloni et al., 1996, p. 22) and this may be especially true for low socioeconomic status Black women.

History of the Black Population in the Healthcare System

The years of neglect of the health of Black Americans starts at the beginning of the slave trade and continues in the clear and evident neglect of Black health issues nationally today. Africans were captured, shipped, sold, and enslaved; they were forced into involuntary sterilization and exploitative medical research; and segregated (officially and unofficially) to areas where healthcare is largely inaccessible.

Mortality rates in Africa during slave “round-ups” and marches to the coast were as high as fifty percent (Byrd & Clayton, 1992, p. 193). The Africans that made it to the United States to be enslaved were overworked and overexposed to the elements. Slaveholders only provided them with the bare minimum resources for survival. Poor nutrition, inadequate clothing, insufficient housing, and overall poor sanitation caused high mortality rates among those enslaved (Byrd & Clayton, 1992, p. 193). From the start of slavery in 1616 to its abolition with the 13th Amendment in 1865, physicians rarely attended to the health and survival of slaves. Additionally, slaveholders enforced slave breeding and enslaved women were often raped. These atrocities led to even more traumatic injuries, obstetrical complications, and gynecologic diseases for the slave women (Byrd & Clayton, 1992, p. 194).

Beginning in the mid-18th century, the pattern of exploitation of Black lives also extended into academia. Physicians and medical students started using Black persons for training and as experimental subjects. The expansion of the medical field and new “sciences” intensified the views of racial inferiority, further justifying slavery as “scientifically” appropriate. Medical schools and journals displayed unnecessary surgeries, vulgar representations of nudity and genitals, starvation, and burnings performed on slaves in the name of advancing medical knowledge (Byrd & Clayton, 1992, p. 194).

By the early 1900s, science began disproving claims of racial inferiority, but that did not end the medical disparities between white and Black pregnant women. As early as 1907, hysterectomies were performed on Black women with neither their knowledge nor their consent. Between 1930 and 1970, North Carolina alone sterilized over 7,600 women (Krase, 2014). These nonconsensual hysterectomies were “jokingly” called “Mississippi appendectomies” by physicians and were most certainly motivated by racist ideologies (Byrd & Clayton, 1992, p. 196). Nonconsensual experiments were not limited to Black women, but these exploitative procedures continued well into the 20th century, perhaps the most infamous of these are the Tuskegee syphilis experiments.

The Tuskegee syphilis experiments had a profound effect on the United States’ healthcare system through its betrayal of the Black population. In 1932, the Public Health Service and the Tuskegee Institute began the “Tuskegee Study of Untreated Syphilis in the Negro Male” to observe the long-term effects of syphilis (CDC, 2015). Six hundred men were initially recruited, 399 men with syphilis and a control group of 201 men without syphilis (CDC, 2015). Researchers told the Black men that they were being treated for several ailments, termed as “bad blood,” and in exchange, would receive free medical exams and medicine for diseases other than

syphilis, transportation, meals, and burial insurance (CDC, 2015). By 1947, penicillin was the recommended and effective treatment for syphilis, but only placebos of aspirin and mineral supplements were given to the men (Nix, 2017). In order to track the full progression of syphilis, the researchers provided no effective care as the men died, went blind, insane, or experienced other severe health problems due to the untreated syphilis (Nix, 2017). In July of 1972, a journalist published a story about the Tuskegee Study and the public was mortified and outraged. A federal government advisory panel concluded that the study was unjustified. The experiments were shut down because it was exposed by the media, not because the researchers or anyone involved with the Public Health Service or the Tuskegee Institute thought it was unethical. The study was supposed to last six months but lasted for forty years (CDC, 2015). In 1973, Congress held hearings on the Tuskegee experiments and decided upon financial settlements for the surviving participants and heirs of those who had died (Nix, 2017). New guidelines were issued to protect human subjects in government-funded research projects. The legacy of Tuskegee is a deep mistrust of public health officials and the healthcare system in U.S. Black populations (Nix, 2017). This mistrust has contributed substantially to the underrepresentation of minorities in clinical trials (Brooks, 2006).

The Civil Rights Movement in the 1960s paved the way for better health care for Black Americans. Medicare and Medicaid brought integration to hospitals, however, these programs excluded people not meeting certain age, employment, or income requirements (Interlandi, 2019). Full equality and fairness in the healthcare system has not yet been attained – nor does it appear to be nearing completion.

In addition to barriers at the societal level, there is damage occurring at the individual health level for Black populations. In 1992, Arline Geronimus theorized the idea of

“weathering,” that over time, the toxic stress of dealing with discrimination leads to poorer health outcomes. The toxic stress of racism led to increased cortisol levels and inflammation and these increased levels in turn caused premature aging. There is no doubt that the impact of toxic stress negatively affects the well-being of Black women and their infants throughout pregnancy and delivery. A study of historical injustices directed at Black people found a strong association between premature mortality rates of African Americans and Jim Crow laws –potential linkages include lack of access to adequate care, excess exposure to environmental hazards, economic deprivation, and the psychological toll of living in racism each and every day (Krieger, 2014, p. 502). Historian of science at Harvard University, Evelynn Hammonds notes, “There has never been any period in American history where the health of Blacks was equal to that of whites... Disparity is built into the system” (Interlandi, 2019). Jenna Wortham, a reporter and staff writer for The New York Times explains the toll of racism on her health as a Black woman:

All the rage and mourning and angst works to exhaust you; it eats you alive with its relentlessness. These slayings obey no humane logic. They force you to reconcile your own helplessness in the face of such brutal injustice, and the terrifying reality that it could happen to you, or someone you hold dear (Wortham, 2016).

The trauma that Black Americans experience from their everyday lives plays a large role in their health.

Maternal Mortality Rates in Black Women

From cradle to grave, Black women can expect lower quality care and a higher percentage of negative health outcomes than white women (Stallings, 2018). As reported above, Black women are three to four times more likely to die from pregnancy-related complications than white women (CDC, 2019a). A national study showed that Black women were two to three times more likely to die from five common medical complications (preeclampsia, eclampsia,

abruptio placentae, placenta previa, and postpartum hemorrhage) than white women who had the same condition (Tucker et al., 2007, p. 247). Seventy-five percent of Black women give birth at hospitals that predominantly serve Black patients. Unfortunately, such hospitals provide lower quality maternal care with higher rates of maternal complications for elective deliveries, non-elective C-sections, and maternal mortality (“Black Women's Maternal Health,” 2018). In fact, Black women who delivered at high Black-serving hospitals have the highest risk of poor outcomes (Howell et al., 2016). These same women are unlikely to obtain health care elsewhere and are thus forced to endure statistically life-threatening care. Thus, inequitable care and inaccessible options have an effect throughout the entirety of the pregnancy, from prenatal care, regular check-ups, and in delivery.

The repercussions of health disparities among Black mothers echoes into the next generation. Although the overall infant mortality rate in the U.S. has decreased, the disparity between the infant mortality rate of Black and white babies has increased (Hogue & Bremner, 2005, p. 47). In 2017, the infant mortality rate per 1,000 live births was 10.9 for Black infants and 4.9 for white infants — Black populations have *2.2 times* the infant mortality rate as white populations. The majority of Black infant deaths are related to preterm delivery. In 2017, Black women were approximately 50% more likely to have a premature baby compared to white women (CDC, 2019b). Preterm delivery is linked to Geronimus’s concept of “weathering” and can be explained by the mother’s elevated stress levels and even exposure to racism-associated stress (Hogue & Bremner, 2005, p. 49).

Harvard T.H. Chan School of Public Health’s Dr. Ana Langer reports, “It’s basically a public health and human rights emergency because it’s been estimated that a significant portion of these deaths could be prevented” (American Heart Association News, 2019). These rates and

statistics should give rise to national concern, but there are obstacles within the medical world and healthcare system – both at a general and an individual level – that must be addressed.

Barriers to Health Caused by Racism

Racism is not only apparent in the past and present of the healthcare system; it also causes significant disadvantages in almost every aspect of life influencing health. These disadvantages restrict Black Americans from receiving adequate healthcare and are all interconnected. Housing and environment, income and unemployment, education, transportation, access to nutritional food, trauma of racism, disproportionate incarceration, and the limited availability of opportunities all play a role in the overall quality of life, health, and wellbeing. On average, African Americans have the highest poverty rate and workers that earn poverty-level wages are disproportionately women, Black, and between the ages of 18 and 25 (Economic Policy Institute, 2011). Due to the restriction of education and opportunities, these statistics are unsurprising.

According to *What Drives the Cycle of Poverty* provided by the Stand Together Foundation in 2017, the five primary factors of poverty are chronic unemployment, personal debt, educational failure, addiction and trauma, and the breakdown of the family. The vicious cycle of poverty clearly affects quality of life, including access to healthcare. With poverty comes vulnerability to further poverty and ill health; this vulnerability then leads to disability and the cycle continues. The deficits in economic, social, and cultural rights, not only have a personal affect, but a political impact as well. The disadvantages experienced by Black persons leads to the cycle of 1) reduced participation in political decision-making, 2) denial of civil and political rights, 3) social and cultural exclusion, and 4) stigma leading to the additional denial of opportunities for economic, social, and human development.

A girl born into a poor family may experience hunger and malnutrition, that results in stunted development and poor health including infections, lack of energy, and behavioral issues, that leads to severe disadvantages in education. This, in turn, impedes development of healthy self-esteem and feelings of confidence, which limits opportunities for work and a sense of control. Educational deficits and lack of confidence contributes to insufficient income, limits housing options, and diminishes the ability to access sufficient/quality healthcare during a pregnancy. Poor or little health care leads to a life-threatening delivery, that requires additional time off work, that ends with unemployment; and the poverty cycle continues. From their seemingly unending life trauma, those stuck in the poverty cycle are more likely to employ poor coping skills, like using drugs and alcohol, which only contributes to the continuation of the cycle. Additionally, high childbirth rates, sick elderly, and more dependents only reinforce the cycle. The poverty cycle is nearly impossible to break and often pulls back or entraps those that have “made it out.”

With low income comes an inability to pay costs for appointments, scans, and procedures; it may also impede attending these appointments, scans, and procedures due to a lack of transportation, inability to leave early or take a day off work, forego the lost income for time off, or find safe and affordable child care. Within communities of poverty, it is rare to find a geographically close or public transit accessible Women’s Center or Clinic. Additionally, Black neighborhoods are less likely to have a local primary care physician (Stallings, 2018). David R Williams, a Harvard professor of Public Health, Sociology, and African American Studies states, “In the United States, your zip code is a stronger predictor of your health than your genetic code.” Along with the lack of nearby clinics, there are issues with consistent primary care physician appointments which leads to no recommendations for screening – especially for

prenatal and postpartum care. Lower educational levels may contribute to hesitation of asking questions about medical terms, clarification about scans, results, and procedures. For any patient, a physician's communication of bad news may not be delivered well and the patient's shock may overwhelm the ability to ask questions for clarification and comprehension. This may be further exacerbated by the mistrust generated by mistreatment of the Black population in the United States' healthcare history which can also contribute to a lack of understanding or fear of confrontation of authority. Additionally, the intersection of racism and sexism further restrict Black women from receiving adequate healthcare. A question of equitably accessible and quality care arises: are there additional obstacles – after the barriers created by racism, poverty, and prevalent historical practice are addressed – when the physician enters the exam room where the patient, a Black pregnant woman, awaits?

Patient-Physician Relationship

“The simple fact that you have to ask that question is a problem,” says Charles Johnson, a Black widowed husband who lost his healthy Black wife and unborn child during an emergency surgery after being disregarded by their physician and healthcare providers (“Love, Marriage, Children and Heartbreak: A Family's Tragic Delivery Room Experience,” 2018). Receiving the best possible results within the American healthcare system is a task in and of itself. All patients and/or advocates must be proactive, well-informed, assertive, and sometimes aggressive in dealing with healthcare professionals and insurance companies. However, when Black women are “proactive, well-informed, assertive, and sometimes aggressive,” they are often perceived as stereotypical tropes; this stereotyping can put Black women at an even higher risk of being overlooked, dismissed, and/or harshly judged by medical staff. It is difficult to scientifically prove that Black women are being discounted, dismissed, and denied treatment, but literature

shows at minimum, unconscious bias is occurring. Many studies show that healthcare providers exhibit implicit – unconscious or unintentional – bias against members of marginalized groups, usually resulting in differences in treatment. Minorities often receive inequitable specialty care, pain management, mental health services, etc. (Ryn & Fu, 2003, p. 249). Many Black women intuitively feel that they are not receiving the care they deserve; many have a nagging feeling, a gut reaction that something is not right about the treatment they receive (Anwar, 2019). The intersections of being a woman and Black results in “Double Jeopardy;” this leaves Black women questioning if they were dismissed because of their race or gender or because they have a clean bill of health.

Stereotyping is a major factor in how Black women are treated. The negative stereotypes of Black women include the “angry Black woman,” “mammy,” “welfare queen,” and the “prostitute” (Sacks, 2017, p. 60). Historically, Black people were stereotyped as lazy and lacking intelligence as early as the 17th century, but it continues into the 21st century (*Popular and Pervasive Stereotypes of African Americans*, 2019). When a Black woman states her opinion, she is seen as the “angry Black woman.” A Black woman may be considered a welfare queen if she seems “well-off” but is using government assistance. If a Black woman is sexually active, she may be assumed to be a “prostitute.” Black patients are considered lazy if they do not follow up or take proper care of themselves. Some physicians may be taken aback and genuinely surprised when a Black patient is able to ask informed questions about their health disproving their unconscious or conscious bias; “I think a lot of people get surprised when you finally start talking to them and they realize that—that you are intelligent, you are articulate, you work hard to communicate accurately” responded Chris, a 59 year old Black woman with a doctorate in divinity, when asked how she is treated at her physician’s office (Sacks, 2017, pp. 64-65).

These stereotypes, unbacked by any science or data, may also influence pain management of patients. Racial bias in pain perception is associated with racial bias in pain treatment recommendation. This means that a physician who dismisses a Black patient's pain (due to the false ideas of racist stereotypes) will continue to dismiss the patient throughout their treatment (Hoffman et al., 2016), thereby conditioning Black patients to underestimate their own pain (Wortham, 2016). A study done at the University of Virginia found that a significant number of medical students and residents held "wildly erroneous" beliefs about biological differences between Black and white people, including the less sensitive nerve endings in Black people or the thickness of their skin (Wortham, 2016). A textbook used in nursing schools around the U.S. was pulled only two years ago for prejudiced (and false) statements including, "Hispanics may believe that pain is a form of punishment and that suffering must be endured if they are to enter heaven," "[African Americans] believe that suffering and pain are inevitable," and "[Native Americans] may pick a sacred number when asked to rate pain on a numerical scale." Physicians and healthcare professionals are making judgement calls rooted in racial stereotypes (Wortham, 2016).

Dr. Langer reports "Basically, Black women are undervalued... They are not monitored as carefully as white women are. When they do present with symptoms, they are often dismissed" (American Heart Association News, 2019). Being dismissed, ignored, and chastised on multiple occasions through their everyday lives and in doctor's appointments causes many Black women to dread going to appointments. Karen Winkfield, MD, PhD, a radiation oncologist and associate director for Cancer Health Equity in North Carolina, notes that not all issues are based on finances or access to care, but rather on how the patient feels about the physician, "The question is whether people feel welcome and listened to" (Stallings, 2018).

Alexandra Moffett-Bateau, an Assistant Professor at the John Jay College of Criminal Justice, recounts and reflects on her own experiences as a Black woman seeking medical care, “It was just this belief that I was making things up, that what I was saying wasn’t real, that I must be seeking drugs or selling the drugs... And so, what happens is you start to develop a ton of fear around going to the doctor” (Kreisinger, 2018). Patients and people in general are less likely to engage in a healthy, honest, and open conversation about their health when their physician and/or a physician(s) in their past have dismissed their symptoms and their very being as a human – inherently valuable and worthy of care.

The style of dress, verbal skills, scientific knowledge, educational credentials, etc. can determine how successful – or unsuccessful – the patient-physician interaction will be. Many Black women acknowledge the prevalence of stereotypes and the importance of adapting their regular behavior to mitigate discrimination. Research done by Tina Sacks at UC Berkeley was based on in-depth interviews of 19 middle-class women and two focus groups explored stereotyping and bias in the healthcare system. One of Sacks’ research participants stated, "In my own mind I try to avoid being stereotyped by doing certain things..." (Sacks, 2017, p. 59). The first impression of how Black women talk or dress may completely reverse the way a physician interacts with the patient. Some Black women "dress up" to go to their appointment. Some realize their level of education or educational persona impacts how they are received and treated. Another one of Sack's participants notes, "I think that they first look at me as being inferior because of my gender. I think they look at me being even more inferior because of my race ... I think they also get surprised when you demonstrate that you are also a person" (Sacks, 2017, p. 65).

However, a “good first impression” does not always reverse the way physicians see their Black woman patients. It is harmful when physicians assume poverty and center the conversation around financial issues. This assumption shifts the focus from the data that relates to the physical and mental health of Black Americans to money (Meadows-Fernandez, 2018). Black Americans of all socioeconomic and educational levels need physicians to prioritize data surrounding bodily health (before including societal and environmental factors) to ensure that all medical components are addressed. An intentional effort to prioritize medical data – reported by the patient and through testing – is necessary because medical data can be shrouded by a physician’s interpretation of the person, outside of socioeconomic and educational levels. For example, even well-known and successful Black celebrities are not immune to the danger of implicit racism within the medical system. Tina Sacks, an assistant professor of Social Welfare at UC Berkeley notes:

When you look at inequalities in healthcare, you see a lot of studies tying the problems to race and poverty, but there’s not a lot about educated, insured black women who are not poor. Yet infant mortality rates for black women with a college degree are higher than those for white women with just a high school education (Anwar, 2019).

Serena Williams suffered a pulmonary embolism after delivering her first child by C-section (Fuller, 2018). She had previously suffered from a pulmonary embolism in 2011 and was acutely aware of the danger during and after birth (Fuller, 2018). Williams felt her symptoms and demanded to be given the necessary care after the healthcare staff dismissed her (Fuller, 2018). Her pre-existing condition left her at a greater risk, yet the medical staff only responded when she insisted (Fuller, 2018). Unfortunately, not all patients have the education, nor weight of voice, to demand care. Serena Williams’ story and her advocacy in speaking to the public about the mortality rates of Black mothers empowered other Black women to share their stories of how

often they feel dismissed, ignored, and even chastised during doctor's appointments. Though Williams' testimony made the space for conversations to begin, collecting data and finding the number of Black women who have and continue to experience this sort of treatment still eludes the medical world. Perhaps because there are too many women who will never have the opportunity to share their story as they have died from complications that could have easily been diagnosed, treated, and cured. But, the stories of survivors call out the ways in which the healthcare system has diminished their quality of life.

Patrisse Cullors, one of the co-founders of the Black Lives Matter Movement, had an emergency C-section in 2016 and states the surgeon "never explained what he was doing to me." She was in pain and found no relief with the pain medication and nothing bettered the situation until her mother "scream[ed] at the doctors to give me the proper pain meds" (Martin & Montagne, 2017a).

Shalon Irving, a Black woman who dedicated her professional life researching and fighting against how structural inequality, trauma, and violence make people sick, died of postpartum complications (Martin & Montagne, 2017a). Irving fought to eradicate disparities in the healthcare system and still fell victim to the exact thing she was trying to eradicate. A friend of Irving's, Raegan McDonald-Mosley, the chief medical director for Planned Parenthood Federation of America, stated, "It tells you that you can't educate your way out of this problem. You can't health care-access your way out of this problem. There's something inherently wrong with the system that's not valuing the lives of black women equally to white women" (Martin & Montagne, 2017a).

What Now?

Healthcare, and in this study, particularly healthcare for pregnant Black women and their infants is a multifaceted issue. With this multifaceted issue comes a multifaceted solution. To fully improve maternal health outcomes, there must be open and honest conversations about policy change and training on conscious and unconscious racial and ethnic bias within the healthcare system. However, other social changes must also occur if maternal health is going to substantially improve. Increasing the minimum wage and raising incomes in poorer communities will help provide clean, safe, and affordable housing for all. This, alongside better government funding, to improve the quality of education; improve, expand, and ensure reliable public transportation; and increase the availability of accessible, equitably affordable, healthy food. Each of these are clear solutions to relieving layers of toxic stress and improving the health and wellbeing of all citizens, not just Black mothers.

In the “land of the free,” access to healthcare free of discrimination should be a priority; all citizens, healthcare professionals, and policymakers should care about health and wellbeing as they are two things that allow people to experience freedom. Public policy and medical practice should focus on eradicating cultural biases and discrimination in both medical education and existing practice, increasing provider diversity in maternal care, and holding physicians and hospitals accountable for failing to provide unbiased, high-quality, and evidence-based care (“Black Women's Maternal Health,” 2018).

A particular challenge to address is that some Black women face a “coverage gap.” They earn too much to qualify for Medicaid but make too little to pay for their own comprehensive insurance. As a result, these women lack access to health care despite their clear efforts to work hard and provide for their families. Although a controversial topic, the U.S. needs policies that

expand and maintain access to health care for all – especially those within the “coverage gap.” Countries including Switzerland, Great Britain, Japan, Taiwan, and Germany treat healthcare as a human right successfully (Palfreman, 2008). The public and our elected officials need to push for an assessment of the United States’ healthcare system because good healthcare should not be a privilege, but a basic human right.

Another obstacle to improving maternal mortality rates in Black women is not all states are required to gather and report information on race, ethnicity, income, and health insurance status in maternal mortality statistics (*Maternal Health in the United States*, 2018). In 2010, only twenty-three states had a full or partial policy that established review boards for maternal mortality (*Maternal Health in the United States*, 2018). This data is critical for recognizing and understanding these disparities. Implementing a nationwide requirement for data collection will ensure more research to better identify interventions and ways to prevent maternal mortality rates among women of color.

John Oliver, a comedian and commentator, notes that not all physicians are racist or sexist, but acknowledges that there are problems of bias:

“[P]eople have biases and doctors are people. And they may have come up in a system that intentionally, or not, has often discounted the experiences of a major portion of the population. And their biases, explicit or implicit, have life or death consequences” (“Bias in Medicine: Last Week Tonight with John Oliver,” 2019).

Physicians and medical staff need bias training. They need to be trained to not only see the patient as a collection of signs, symptoms, and history of illnesses, but also understand the social environment that leads patients to poor health. The prioritization of data to ensure that the medical issues are addressed still needs to be balanced with the intersection of social and societal environmental concerns. These sets of data do not lie; patient centered care needs to carefully and attentively address both the medical symptoms and the humanness of the patient. There is a

distinct disparity between the quality of care among people of color and women because of racism and sexism. The rate of pregnancy-related deaths is appalling, particularly when considering Black women are three to four times more likely to die from pregnancy-related complications than white women in the wealthiest nation in the world. In light of these disparities and the intersectional way in which they interact, it is necessary for medical staff to ensure patient-centered care that is responsive to the needs and inquiries of all women, especially women of color. Blaming patients for their health problems will never be the solution, it is clear that Black women hesitate to seek medical care with their historical distrust of healthcare institutions and are less likely to return after bad experiences with a physician. But, approaching the patient and trying to understand the patient's symptoms, life story, and the events that influenced their current medical situation will help build comfort and trust. Although, patient-physician time is limited, physicians should be better educated and trained to actively listen to their patients, provide clear and understandable explanations, and take time to answer all of the patient's questions.

Black women, no matter their education or socioeconomic environment, should not be left scared and afraid during pregnancy or delivery because physicians have failed to communicate. Black women, no matter their social status or renown, should not have to demand care for a documented pre-existing condition. Black women, no matter their political involvement, should not have to die during childbirth when they have spent their lives fighting for fair and just medical practices. As Angela Pie stated, "We deserve to enjoy our pregnancies - not plan for our funerals. We deserve to live. We deserve better..." (Pie, 2018, p. 901).

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