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Intersectionality and Maternal Mortality: African-American Women and Healthcare Bias

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Essay completed in partial fulfillment of the requirements for graduation with Global Honors, University of Washington, Tacoma

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Introduction

When Serena Williams, the famous tennis player, gave birth to her first child in September of 2017, everything seemed to go perfectly (Haskell, 2018). Williams was in fantastic physical shape at the time of giving birth, having competed at professional tennis meets early on in her pregnancy, and having had excellent prenatal care. While she required a C-section to deliver her daughter, Alexis Olympia, immediately after surgery everything seemed to be fine. However, when she experienced shortness of breath the day after birth, before being released from the hospital, she knew that something was horribly wrong. Williams had a history of blood clots, and thus she knew the signs of a pulmonary embolism. However, when she attempted to tell the nurse she was having a medical emergency, her pleas were not taken seriously. The nurse completely disregarded her. Williams had to insist on the doctor running tests, at which point blood clots were found in her lungs, followed shortly thereafter by a hematoma in her abdomen at the site of the C-section. She proceeded to have two more surgeries in the next six days before finally being allowed to leave the hospital. This case caught a great deal of attention as Serena Williams had every indicator of having a healthy pregnancy and delivery. She had the advantages of power and wealth, yet when she went to what was undoubtedly a high-income-area hospital she was nearly denied the medical care that ultimately saved her life.

Williams' story is thought-provoking for its unfortunate normality. Thousands of women each year die, or nearly die, of post-pregnancy complications. This worldwide epidemic is prevalent within the United States as well, as it has a higher maternal mortality rate than almost every other developed country in the world. With the enormous amount of money the United States pours into healthcare, and the technological innovation involved, it is surprising that the

maternal mortality rate is so high. And unfortunately, black women have an extremely high rate of death after pregnancy that is far above the general population. There are many contributing reasons for this, such as the historical role of sexism and racism in the American healthcare system and healthcare provider implicit bias, but ultimately these women are being oppressed from many different sides. The maternal mortality rate of black women in the United States is an important case study as to why the physical effects of intersectional oppression needs to be factored into the health determinants in the healthcare system, and this lack of awareness is a major reason as to why the maternal mortality rate in the United States greatly exceeds international goals.

Maternal Mortality

Maternal mortality is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes" (WHO, n.d.). Additionally, there are also 'near misses', or where women had significant complications that nearly lead to their death. The most likely causes of death for women after giving birth are preventable: "cardiovascular conditions [which account for] (15.5%) [of deaths] followed by other medical conditions often reflecting pre-existing illnesses (14.5%), infection (12.7%), hemorrhage (11.4%), and cardiomyopathy (11.0%)" (Creanga, Syverson, Seed & Callaghan, 2017). Worldwide, there has been an enormous reduction in maternal mortality: "[i]t is estimated that, between 1990 and 2008, 147 countries experienced a decline in maternal mortality ratio, 90 of which showed a decline of 40% or more. In 2 countries there was no change, and in the remaining 23 countries, including the United States, the maternal mortality ratio actually increased" (APHA, 2011). In many impoverished countries, the deaths

of pregnant women and new mothers might have easily explainable causes such as a lack of hygiene or access to proper medical care, but this is not the situation in the United States. All the easy explanations—a lack of resources or insufficient access to medical care—are nowhere to be found. The reason for this death rate is not one of medical lack. Unfortunately, the statistics only get worse.

The maternal mortality rate of the United States has increased significantly over the past three decades, from 7.2 deaths per 100,000 live births in 1987, to 18.0 in 2014 (CDC, 2018). In 2017 there were a reported 17.0 deaths per 100,000 live births (Creanga, Syverson, Seed & Callaghan, 2017). In comparison, Greece, Iceland, Poland, and Finland all have only 3.0 deaths per every 100,000 live births (CIA, 2015). While there are significant distinctions between the healthcare processes of these countries and the United States, the numerical differences in deaths are staggering. In the same study, it was found that the United States is ranked 46th in the world for maternal mortality (CIA, 2015). Approximately 700 women die from pregnancy and birth complications in the United States every year, and 60% of these deaths are preventable (CDC, 2019). Of these deaths, 31% occur during pregnancy, 36% occur at birth or within the week after birth, and 33% occur between one week and one year postpartum (CDC, 2019). Women's lives are continually in danger from the time they become pregnant to a year after they give birth. Even more strikingly, "non-Hispanic black women hav[e] a 3.4 times higher mortality ratio than non-Hispanic white women" (Creanga, Syverson, Seed & Callaghan, 2017). This is an astoundingly high mortality ratio, and one that deserves attention. In a developed country where women are still at serious risk for pregnancy and birth complications, black women are especially vulnerable.

The World Health Organization and the United Nations have set goals in order to assist countries in ensuring that their maternal mortality rate is reduced. Millennium Development Goal #5, established by the United Nations in 2000, was to reduce maternal mortality by 75% between 1990 and 2015 (WHO, 1990); when this was not achieved, the 2030 Agenda for Sustainable Development gave a goal of eliminating all preventable maternal mortality deaths before 2030 (UN, 2015). Additionally, these organizations set several guidelines to assist countries in lowering their maternal mortality rate. It is not the intent of this paper to analyze all of these guidelines and how they are upheld or abandoned, but it is important to address two in particular that the United States is violating. These are "addressing inequalities in access to and quality of reproductive, maternal, and newborn health care services," and "ensuring accountability in order to improve quality of care and equity" (WHO, 2017). These two issues are vital when addressing black women's maternal mortality rate in the United States, as black women lack access to quality, comprehensive medical care, and face a system that allows doctors' implicit biases to make judgements that produce said lack of access.

The most astounding fact about this seeming epidemic of deaths is that "most deaths are preventable, no matter when they occur" (CDC, 2019). Another source indicates that approximately half of all maternal deaths and 30-40% of near-misses in the United States are preventable (APHA, 2011). The causes of death are treatable as long as women receive quality medical care in time. Indeed, as a past president of the International Federation of Obstetricians and Gynecologists states, "Women are not dying because of untreatable diseases. They are dying because societies have yet to make the decision that their lives are worth saving" (Fathalla, 2006). The issue is not in the technological capability for doctors to save women's lives; rather, it is in their willingness to do so, and the priorities undermining their care for them.

Unfortunately, black women are more likely to die because of the oppression they face in society based upon the intersections of their social identities, and a lack of value placed upon their lives within the healthcare system.

Theoretical Framework

Sexism greatly shapes black women's lives. There is a long history of bias in the healthcare system, as historically women have not been respected to understand their bodies, and thus their physical ailments have been disregarded. This is shown through the historical usage of 'hysteria' to medicalize sexism: by believing that women are emotional, less rational, and feel pain more readily, the ability to place a medical diagnosis based upon this perceived weakness was key to their complaints being ignored. Unfortunately, this line of thinking has continued into the present day, as there is considerable discrimination in the medical system built on gender (Hamberg, 2008). Physicians tend to be biased against their female patients and take their concerns less seriously, and this means that women struggle to have their medical concerns understood and treated with appropriate significance.

In the modern medical system, men have been used almost exclusively as the test subjects of medical study, to the exclusion of women (Mazure, 2005). The reasons for this were based in sexist thought, as women's bodies were considered to be too variable to be used as case studies, or too fragile because of potential reproductive health risks. Their bodies were assumed to work the same way as men's, with no gender differences between symptoms of disease. However, this proved to be deadly, as the diagnostic procedure for many diseases, such as cardiovascular disease, were based upon male symptoms (Mazure, 2005), leading to many women being misdiagnosed and having a substantially higher death rate. This compounds with

racial prejudice in the case of black women, as they are then fighting a two-front war to have their medical complaints taken seriously, even when they are potentially deadly.

Racism is also extraordinarily influential in the lives of black women, but in the United States it is often considered a taboo subject to discuss the effects of racism. The over-arching philosophy used throughout American society is the idea of being 'color-blind', or that racial prejudice is individual, rather than institutional and held up by all societal organizations, and that by ignoring racial issues we can eliminate them (Wise, 2010). This leads to the suggestion that the United States is a 'postracial' society, and as such issues stemming from racial oppression can be safely ignored as they are assumed to no longer exist. This philosophy rejects both the lived experiences of people of color and the data showing widespread bias in the United States. The issue with a color-blind approach to racism is that acting to treat all people as equal regardless of their skin tone does not improve the quality of life for people of color, and in fact ensures the continuance of the dominance of white people in American society (Bonilla-Silva, 2010). By denying that racism is systemic—affecting everything from access to medical care to generational wealth—people of color are denied services and privileges that white people hold as normal. It intensifies the gaps between people of color and white people and can actually increase racial prejudice and oppression (Wise, 2010). In order to eliminate racism, its systematic elements must be first acknowledged openly (hooks, 2003).

To truly address racism at a societal level, a more substantial theory must be employed. Derrick Bell, a black man and Alan Freeman, a white man (Ladson-Billings, 1998), address the shortfalls of color-blind racism within their framework of Critical Race Theory. It states that racism is widespread in American society, both historically and presently. It does more than simply give a perspective on institutional racism and reveals how our society at large and the

political structure of the United States is shaped by racism (Gillborn, 2008). This includes the larger structures of the United States, such as the education and healthcare systems. Additionally, it holds that all white people are implicated in white supremacy (Gillborn, 2008). By participating in the system that institutionally oppresses people of color, rather than working in opposition to it, white people are upholding this system. Acknowledging that everyone in American society is shaped by racist behaviors, and that individuals need to actively choose to break free of these learned beliefs, is essential to understanding the discrimination that black women encounter on a daily basis.

But simply looking at both the racism and sexism that black women face is not enough, as it is the way that these two forms of oppression are interlinked that make addressing this crisis so complex. This intersectionality is key to understanding the reasons behind these deaths. Intersectional Feminism, a subsection of third-wave feminism, is focused on 'intersectionality'. This term was first coined by Kimberle Crenshaw in her 1989 work "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Policies." She argued that if we only look at discrimination with 'single-axis analysis'—that is, taking into account only one type of discrimination against one identity, such as gender, race, or class—we are not seeing the full perspective of someone's societal experience (Crenshaw, 1989). She argues that "Because the intersectional experience is greater than the sum of racism and sexism, any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated" (Crenshaw, 1989). Other authors agree that racism is systematic, and that the intersections of social identity need to be acknowledged in order to understand their lived experiences (The Combahee River Collective, 1986; Patricia Hill Collins, 1993). This

subordination, which is greater in its intersection between systems of oppression than simply adding together black women's experiences with sexism and racism, is key to acknowledging the issue, because they tend to be trivialized within their individual groups (Campbell, 2009).

The intersections of systems of oppression need to be acknowledged in order to get a holistic perspective of black women's lives, as they tend to be marginalized even within efforts that seek to aid them (Crenshaw, 1993). When women are targeted as a group, white women become the focus, and when programs are created to assist the African-American community, black men are targeted. The intersectional needs of black women tend to be put into one category or another, but because of their minoritized status, when an intervention is given, they are often sidelined. In order to give an intervention that will truly assist black women, this intersectional perspective is essential (Nsiah-Jefferson, 2009).

These two theories combine into an intersectional theory that is referred to as Critical Race Feminism. A subsection of this theory, Black Feminist Theory, focuses strictly on the effects of societal oppression on black women in the United States and how that affects their lives (The Combahee River Collective, 1986). It takes the concept of racism in the United States from Critical Race Theory, with the framework of systematic oppression, and combines it with the focus on social positionality—in particular race, gender and class—from Intersectional Feminism. Doing this reveals the broad spectrum of social positions African-American women find themselves in, and the oppression that our society forces upon these women is also multifaceted. This combination of factors shapes their often-negative relationship with the American political system, and the structures it creates, such as healthcare (The Combahee River Collective, 1986). Critical Race Theory emphasizes the importance of individual experiences and sharing these experiences (Ladson-Billings, 1998) in order to understand the larger issue of

oppression. Thus, it is essential to focus on the stories and experiences of black women. In order to truly understand the way that these women live and why their access to medical care is often restricted, we must look at all of these factors in combination.

History of Discrimination

Within the medical setting both women and people of color have been historically discriminated against. As with sexism, racism was medicalized into a trend of finding physical diagnoses that would 'prove' the racial inferiority of people of color, and black men and women in particular. Indeed, "Medicine has historically promoted a racial construction of disease that in turn perpetuates a biological construction of race" (Roberts, 2011). This is clear when looking at the history of medical study of racial difference. In the 1870s and 1880s, right after the abolition of slavery, there was a major push to justify the detainment of African-Americans back into the slavery system by their so-called 'inferior bodies'. This line of research, deeply entrenched in racist thinking, argued that because of the supposed differences in the bodies of African Americans, compared against white people, they were best suited for physical labor and domestic work. A massive amount of effort was put into justifying the political stance of slavery through medicine, and this was shaped by the ideology of racism. Unfortunately, this situation is not purely historical. Many justifications have been made over the years in order to find a biological basis for racial separation, particularly in reference to disease and structural differences (Roberts, 2011), which would perpetuate societal discrimination.

Today, racism in the medical setting takes a different face: that of racially-based differences in care by medical doctors. While many healthcare professionals claim to take a colorblind approach, which can lead to greater healthcare inequities (Wise, 2010), many other doctors actively treat patients differently based upon their presumed race. For instance, there

have been studies finding that black patients are given less pain medication in ERs than white patients when diagnosed with painful injuries, or that Asian patients are given less anesthesia during surgery (Roberts, 2011), based upon healthcare professionals putting their patients into racial categories—usually without asking the patient themselves what their ethnic background is—and working from medical stereotypes. These stereotypes do not hold up under scientific scrutiny: few differences in the body have been found to be universally distinct across racial lines, and there is little medical evidence for these assumptions. Despite this, gender and race bias can have a significant impact on how patients are treated, even when the symptoms that patients present are otherwise identical (Hall and Fields, 2012). The most astonishing part is that these doctors usually do not consider themselves to have any racial bias: typically, this widespread belief is used with no ill will, but can lead to incorrect patient diagnosis and unneeded suffering, while the doctors themselves believe these attitudes are medically beneficial (Roberts, 2011).

Black Women's Responses Towards Healthcare

Due to this history of bias and the institutionalization of racial differences in medicine, often compounded by personal poor experiences in medical settings, black women are less likely to trust a medical doctor and tend to focus more on holistic wellness and keeping themselves healthy (Campbell, 2009). Their attitudes towards healthcare tends to be suspicious, and they will delay medical treatment for a longer time. For instance, black women have a substantially higher chance of dying from breast cancer (Cohen, 2009), and part of this is because they wait longer to go in for treatment. This is unfortunate but vital to understand, as it provides an example of a difference in attitude created through historical societal discrimination producing a physical effect: by the time black women go in for treatment, their cancer tends to be at a more

advanced stage, and they are more likely to die because of it. Research has shown that perceived racism from a healthcare provider means that African Americans are less likely to trust these providers (Benkert et al., 2006), and this can mean delaying or avoiding care in order to avoid the stress or bias they believe goes alongside it.

This combination of factors, having both sexist and racist bias against them, means that black women have a particularly difficult social positionality to access quality medical care. Black people are significantly more likely to die prematurely in the United States (Williams, 2016), and while that is an issue of racial bias, it is compounded by the sexist bias against black women. This is demonstrated through their significantly elevated maternal mortality rate over white women: while white women are singularly burdened by sexism, black women are multiply-burdened (Crenshaw, 1989). There is no one straightforward way these women are oppressed; rather, we must take into account the multiple pathways that lead to their lived experiences of discrimination. A great deal of research has taken into account either racial or sexist bias, but to truly understand the issue of black women's maternal mortality, it is essential that both are factored together.

This is not to say that black women have not themselves made strides towards ensuring their access to medical care. Black-women-lead organizations, such as the National Black Women's Health Project lead by Byllye Y. Avery, have been working on community-led self-help projects to support black women through prenatal care (Avery, 1994). Another organization, the Black Women's Health Imperative, was founded in 1983 and has a defined focus to increase the number of healthy black women in the United States from 9.5 million to 12.5 million by 2020 (BWHI, n.d.), doing research on healthy black women in order to learn from previous success and running programs to improve these women's health. Black Women

for Wellness, a California-based organization, emphasizes the importance of holistic health, and works to increase access to health services for black women (Black Women for Wellness, 2019). All three of these organizations are examples of how black women have been taking active roles in their healthcare experience and are using their agency to increase their access to and quality of healthcare. As black women intimately understand the difficulties of living under interlocking systems of oppression, it is not surprising that the organizations they create advocate a mixture of methods that address their concerns. However, more must be done from a systematic standpoint, and maternal mortality is particularly sensitive to the intersectional oppression that is experienced by black women.

Race-Related Health Issues

Maternal mortality is greatly impacted by intersectional oppression, and sexism and racism are particularly powerfully shown through the birthing process. Systematic review of many reports has determined that women of any ethnicity are more likely than men to experience bias in their interactions with healthcare providers and how their ailments are treated (Hall et. al, 2015), and this sexism is amplified in a female-specific area. Much like with breast cancer, birth is a female process, and thus the sexist beliefs about women's inabilities to handle pain or voice concerns for their physical states are being used to make significant judgement calls about their care. The medical experience of healthcare providers is considered to almost universally overrule women's individual experiences, as can be seen in the case of Serena Williams. When she spoke up about a potential medical complication, her voice was disregarded by a healthcare professional, and it was only when she became insistent and demanded further testing that her potentially-deadly complication was discovered. Her healthcare providers made a judgement call about her physical health, and had she not spoken up, that disregard would have been lethal.

But there are more factors in the birth and post-birth-complications process for women of color that make them especially vulnerable to being disregarded. To neglect black women's different experiences from racial and gender-based oppression when addressing the issue of elevated maternal mortality rates among black women is to ignore the root of their issues (Nsiah-Jefferson, 2009). Black women go into pregnancy with an increased chance of complications due to their place in society causing them an increased level of stress (Hall and Fields, 2012). This stress is particularly harmful when pregnant or giving birth, as these life phases are especially sensitive to heightened stress levels and can easily cause medical complications to worsen. One of the most common reasons for a maternal death is the pregnancy aggravating a prior health condition, and these health conditions are more likely to be severe with already-heightened stress levels before pregnancy.

Constant negative interactions, such as those produced by racially-based micro-aggressions, can cause stress levels—such as the stress hormone cortisol—in the body to increase semi-permanently (Hall and Fields, 2012). This would therefore cause the body to essentially go on alert and become overtaxed, which produces a variety of negative health implications, such as hypertension and depression (Hall and Fields, 2012). Many—if not most—black women in the United States go into pregnancy with already-heightened cortisol levels and chronic stress, which makes them more likely to have health complications later in the pregnancy or after birth. Healthcare providers can also worsen this, by themselves producing more stress towards their patient through biased interactions or failing to note the increased stress-load the body is bearing and thereby giving inadequate, non-holistic care. Once again, this sociological effect of racism causes physical effects, which lead to black women being more likely to have pregnancy complications further down the line.

Healthcare Provider Implicit Bias

But while black women experience many additional physical effects that can produce supplementary pregnancy complications, the most important factor in their lack of access to quality medical care is healthcare professionals' implicit bias against them. The same racist and sexist bias that is woven throughout American society deeply influences healthcare professionals, as much as individual doctors and nurses may protest being biased. An Institute of Medicine field literature review, which looked at hundreds of studies, revealed that statistically, across the nation "Minorities are less likely than whites to receive needed services, including clinically necessary procedures" (2002). This can be connected with the tendency for medical professionals to racially stereotype patients and delay or give sub-standard care to them without considering themselves biased. This bias has a powerful impact on people of color's quality of life and medical care, and yet it is often ignored when addressing differences in care. Indeed, this Institute of Medicine report was initially attempted to be suppressed, with government organizations demanding an edited copy released without any reference to institutional bias, before the report was leaked in its original form by IOM employees and ultimately released as-is (Roberts, 2011). Even as a scientific study proved that healthcare professionals are implicitly biased against people of color, the backlash was so significant the results were nearly buried. Unfortunately, this refusal to acknowledge the institutional components of oppression is very common.

This implicit bias is even more powerful against women of color. As they are doubly-burdened and prejudiced against for being black women, it is not surprising that this bias is more evident. Women in high- and medium-black-serving hospitals die at a higher rate than those at low-black-serving hospitals, and black women who delivered their babies at high-black-serving

hospitals are most likely to have a poor birth outcome (Howell et al., 2015). This shows how doctors are likely to treat black women differently than white women, even within the same hospital, and this leads to their death rate being substantially higher. Additionally, patients of color are more likely to be kept waiting for assessment and treatment than white patients, and doctors spend more time with white patients than patients of color (Hall et. al, 2015). This means that the post-birth complications that are time-sensitive, such as hemorrhaging, can be deadly at a higher rate for black women than for white women. This bias, which keeps doctors from addressing the needs of women of color as quickly as they do for white women, can be fatal very rapidly. When a woman is internally hemorrhaging, a five-minute wait might make all the difference between life and death, and black women are more likely to be kept waiting.

Tragically, this happened to a black woman named Kira Johnson in 2016 (Helm, 2018). Kira had a healthy pregnancy with extensive prenatal care, but after giving birth to a healthy baby boy, she began bleeding extensively. Her husband Charles brought her bleeding to the nurse's attention, and the hospital staff ordered a CT scan. However, despite her husband's numerous reminders to the staff, it took over seven hours for the doctors to finally perform an internal exam, and a CT scan was never performed. By the time she was examined, Kira had hemorrhaged three liters of blood into her stomach, and her heart stopped less than twenty minutes after the examination began. All medical reports indicate that Kira had no pre-existing medical concerns, and that had she been examined sooner her death could have been avoided entirely. This tragic death was completely avoidable had doctors not delayed her care and is exactly the reason the intersectional bias against black women can be deadly.

Recommendations

What can be done to prevent this bias? There has been a great deal of research done to investigate the effects of race and implicit bias in healthcare, but few studies have looked into bias related to other facets of social identity (Hall et. al, 2015). These intersectionalities of forms of oppression are a place where bias has not been researched, but the evidence is clear that this bias exists and is strengthened within the intersections. Additionally, evidence-based research on how to reduce a healthcare provider's implicit bias is essentially absent (Hall et al, 2015). While this lack of research means that there is not a specific methodology to recommend in order to reduce bias, it also means that there is room to suggest options for growth. More research needs to be done on whether it is possible to reduce bias by forcing healthcare professionals to actively consider their own biases and incorporate anti-bias techniques into their daily patient care methods.

As has been shown, the United States has failed to uphold the World Health Organization's goals for how a healthcare system should be run in order to best prevent maternal mortality. There is no system in place to ensure accountability at a hospital or individual doctor level to see why black women are dying at such an elevated rate, and the social inequities that create an imbalance in healthcare quality and prevent black women from having proper ease of access to medical care—the same as white people experience—are left completely unaddressed. By addressing these guidelines, and incorporating several strategies, the American healthcare system can fall more into step with what it should be doing in order to save women's lives at their most vulnerable point. Many of the guidelines that WHO provides require a sensitivity to the social positionality of patients as it applies to healthcare outcomes. This is true of other nations as well: women in positions of oppression in societies throughout the world can be better

understood when a detailed understanding of the intersections of racism and sexism are incorporated into the healthcare system.

Ultimately in the United States, much of the research boils down to one question: are the underlying differences in black women's health outcomes due to their societal positionality being addressed by their doctors in their healthcare strategies? The research indicates that there is a significant impact on black women's health based on their place in society: it causes them to be put into situations that increases both their overall life stress and the discrimination against them in medical settings. There is much to be learned from the efforts done by organizations run for and by black women, and these can be used to ensure that black women's concerns are given appropriate emphasis in the medical system. Strategies that they utilize to advocate for their own can be respectfully used in larger methodologies, such as understanding the ways that oppression may make it difficult for black women to access prenatal care, in order to ensure their optimum health outcomes. The physical effects of discrimination, which negatively impact their overall health, are direct results of societal oppression and must be incorporated into the overall picture of maternal mortality.

Additionally, while generalized research can indicate better methodologies for incorporating social determinants of health into the treatment of black women during pregnancy, at birth, and when experiencing post-birth complications, healthcare providers' implicit bias must also be directly addressed. The Institute of Medicine report states that "Healthcare providers should be made aware of racial and ethnic disparities in healthcare, and the fact that these disparities exist, often despite providers' best intentions" (2002), and this needs to be done on a patient-by-patient basis, as well as within the training of healthcare providers. There needs to be distinct training in the curriculum for healthcare providers of all types, whether it be

doctors, nurses, physicians' assistants or other providers, to assist them in identifying the very fact that they hold biases based on gender (Govender and Penn-Kekana, 2007) and race. Training can be done continuously throughout their education to help them see the biases that they have been taught throughout their lives and prevent it from affecting their judgement. Hospital-based training programs can be run, in addition to the supplemental educational events being done on other topics, and this can help providers become conscious of their biases and consider the ways they affect their judgement of patients every day.

Additionally, a practically implementable system must be put into place so that healthcare providers keep their implicit biases from affecting the quality of care for patients. When patients come in for care, doctors need to focus on the patient's family history, symptoms, and personal health background, not their gender or assumed race. Physicians who have come to realize their own biases have had success in actively controlling their thought processes and changing how they address patients (Cohan, 2019). In the case of maternal health, doctors need to recognize the increased likelihood of complications for black women without stereotyping them as having a particular set of symptoms because of their race, and disregarding sexist ideologies by taking their complaints seriously.

An excellent method that both recognizes the social determinants of health and prevents medical bias would be to create a checklist of likely symptoms for patients that is based on their social positionality and the health effects that they are more likely to experience. A healthcare professional using this checklist asks the patient what they consider to be their racial and ethnic background and based upon this information a set of symptoms that the patient is further at risk for can be provided to the healthcare provider. This does not medically stereotype patients, as their likelihood for disease is not based upon the provider's assumptions of their physical

characteristics or presumed differences, but it still accounts for the higher rate of death and complications for women of color. Additionally, it is not healthcare providers who are making the judgements of what racial category any individual woman falls into, but rather the woman herself, thus eliminating the potential for racially-based stereotyping or placing assumptions upon the women. This would allow for women of color's health concerns to be addressed rapidly, as doctors and other healthcare professionals can specifically look out for complications. However, should a black woman have a healthy pregnancy, no intervening treatment need be done, as the symptoms are being actively searched for without being assumed to exist. This respects the women's autonomy and right to consent to treatment while still ensuring that women of color are receiving additional care for the societal-bias-induced strain their bodies often undergo.

Additionally, this methodology also allows for doctors to be constantly checking their own implicit biases and seeing how it affects their treatment of their patients. With the knowledge that the physical differences between people across societally-constructed racial lines are extremely minor, but that there are physical differences based upon societal treatment of people, physicians can be constantly checking their own views of patients. This forces healthcare professionals to be constantly reevaluating their own assumptions about patients, which will hopefully lead to all patients—regardless of racial background—being treated with similar strategies and testing regiments, thereby improving black women's healthcare outcomes.

This methodology follows the accountability and inequality goals of WHO, by providing a specific mechanism by which the social inequities—which manifest as physical stress and biased medical care—are addressed, and by providing a system by which doctors are held accountable for considering their own biased views. Should a doctor actively discriminate

against a patient, there is a guideline by which this can be tracked. If a woman of color is presenting symptoms of a birth complication and is not given the appropriate medical treatment, it is documented. Additionally, more research will provide additional methods by which these complications can be addressed, leading to better survival rates.

If we are to ensure that the hundreds of deaths of women in the United States are prevented, we must push forward. In a world where thousands upon thousands of women die of health complications that cannot be easily prevented, it is a travesty that those that can be are being ignored. The United Nations and the World Health Organization has made it a priority, but as a developed country, the United States has the ability to make changes without outside intervention in order to prevent these deaths. If the United States is to successfully eliminate all preventable maternal mortality deaths in the next eleven years, by the 2030 goal, putting into place a system that would advocate for black women is one of the first steps to changing our healthcare system. We owe black women the respect and equal medical treatment they deserve, one saved life at a time.

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