The Danger of Being Black and Pregnant in America: Exploring the Intersection of Racism and Sexism in Maternal Care

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With the continuing rise of education and technology in the United States, it is assumed that this would be reflected in positive health outcomes; however, this is not the case. Take maternal mortality rate (MMR) for instance, which can be used as a determinant of overall health in a country. Maternal mortality is defined by the Centers for Disease Control and Prevention (2019) as "the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication; a chain of events initiated by pregnancy; or the aggravation of an unrelated condition by the physiologic effects of pregnancy" (para. 5). The maternal mortality rate is measured by the number of maternal deaths per 100,000 live deaths. As of 2018, the CDC reports that the United States had a MMR of 17.4 deaths per 100,000 live deaths -- meaning over 600 women died giving birth -- the highest numbers among developed countries. In addition, MMRs have decreased in most developed nations excluding the United States, in which they have been increasing over time. According to the Centers for Disease Control and Prevention (2019), the pregnancy-related mortality rate (PRMR) "for black women with at least a college degree was 5.2 times that of their white counterparts" (para. 6). These numbers display the obvious racial disparity when it comes to maternal health outcomes.

The issue of increasing maternal mortality rates resurfaced in 2018 when celebrities Serena Williams and Beyoncé Knowles-Carter experienced almost fatal pregnancy complications. Knowles-Carter was diagnosed with preeclampsia, while Williams experienced pulmonary embolism. Both instances resulted in the women having to get an emergency Caesarean section. To make matters worse, Williams recalls that she was "not taken seriously" when the hospital nurse to whom she reported her concerns assumed that "Williams's medication

might have been confusing her" (Chiu, 2018, para. 21). It is astonishing to think that women at this level of socioeconomic status are still experiencing near misses in the hospital setting. Some researchers attribute this phenomenon to the fact that "doctors largely disregard or discount complaints of pain by black patients more frequently than they do for white patients" (para. 18) that "stemmed from people's long-held beliefs about biological differences between black and white people" (Chiu, 2018, para. 20). Knowles-Carter and Williams voicing their stories sheds light on providers' lack of responsiveness when it comes to maternal care during pregnancy and childbirth.

The issue has garnered the federal government's attention and The Preventing Maternal Deaths Act was recently passed as a law in December of 2018. The goal of this legislation is to analyze the underlying causes regarding the high pregnancy-related deaths in the U.S. A specific component states that maternal mortality review committees would be established for states to get a better understanding of data and come up with potential solutions/best practices to aid in the decrease of maternal deaths (Congress.gov, 2018).

There are textbooks that still say that women experience differential experiences of pain in childbirth because of race (USC Annenberg, 2019). A study was conducted and showed that some medical students thought that Black people didn't experience pain in the same way that other races do (USC Annenberg, 2019), clearly demonstrating racial bias in some healthcare providers. Some of these myths date back to the 19th century, when gynecology was in its beginning stages. James Marion Sims, known as the "father of modern gynecology," conducted much of his research on enslaved Black women "under the racist notion that black people did not feel pain" (Holland, 2017, para. 5). It is essential to make providers and doctors in training aware

of these histories, provide context for how this type of thinking can bring harm to their future patients, and remove inequities from medical textbooks.

This thesis will examine the implicit bias that negatively impacts obstetrics provider communication with their maternal patients. I have gathered literature regarding the history of obstetrics and gynecology care for Black women. I will compare this information with more recent publicly available first-person accounts of women of color, including videos and blogs, in which women describe their personal experiences with their obstetrician or hospital staff during pregnancy and childbirth. By analyzing first person accounts, I will be able to better understand how these women perceive their doctors and their care. I will also consider the communication practices that may occur between hospital physicians and midwives or doulas.

Literature Review

Ethics In Health Care

In Western culture, we typically turn to medical physicians and specialists when we are ill or in need of certain medical procedures. We put our trust in these individuals who have been trained rigorously in science and anatomy for years. We expect to receive treatment in an ethical manner to return to our healthy state. Health care communication ethics "protects and promotes" quality care "in meeting moments of robust health, normal difficulties, the tragic, and the inevitable" (Arnett, Fritz, & Bell, 2009, p. 191). This means that providers must tend to their patients whether they are healthy, in dire condition, and everything in between. If we consider the Hippocratic Oath for instance, which is taken by physicians as a promise to provide ethical care no matter what the circumstance. For the purpose of this study, the key components of health care communication ethics that will be discussed are care and responsiveness. Arnett, Fritz, and Bell (2009) define care as "a human answer to the call of the Other, a willingness to

meet and attend to someone other than oneself" (p. 192). When caring for patients, physicians should be selfless. They must be active listeners and provide their fullest attention to be able to respond appropriately for each individual patient. Responsiveness is how "we engage others and ourselves in times of health-related need" (Arnett, Fritz, & Bell, 2009, p. 193). This concept takes into account a number of aspects of health events: how patients decide to deal with a health concern, how a provider communicates and treats patients, how health care teams communicate with one another, how patients and/or providers decide to deal with certain health concerns after a lived experience. It's a never-ending cycle of responses influenced by the results of previous interactions.

Physicians should care for their patients and respond to each specific patient accordingly; however, this is not the case. In a 2016 TED talk by Dorothy Roberts, doctors "use race" – a socially constructed category – "as a shortcut" when providing care. In the hopes of providing efficient care, providers use generalizations about groups to speed up their decision-making in diagnosis and treatment. If this method is being used with the social construct of race, the same could potentially be happening in terms of gender as well. Due to the staggering data presented above regarding maternal morbidity, it seems that physicians are not taking heed to responsiveness in their practice. I seek to understand why this phenomenon exists through the lens of muted group theory.

Women's Voices Are Muted

Muted group theory will be used as the framework for my research. As the name suggests, this theory looks at how the voices of marginalized groups are excluded from important conversations. According to Kramarae (2005), "Accepted language practices have been constructed primarily by men in order to express their experiences" (p. 55). Because men used

their own realities to define social norms in terms of communication, the realities of women were excluded. Another important component of muted group theory is that "women are more constrained than are men in what they can say, when, and with what results" (Kramarae, 2005, p. 55). Because men set the stage for language and communication, there is a translational gap that exists between men and women. Women must first comprehend men and translate their own language to match that of the dominant male. In addition, men's communication is more widely accepted as superior thought simply because they created the language. Women's "speech is disrespected by those in dominant positions; their knowledge is not considered sufficient for public decision-making or policy making process of that culture" (Kramarae, 2005, p. 55). The thoughts and ideas women share are frequently represented via the man's viewpoint. This is problematic in our society, especially in healthcare, because men do not understand the realities of women therefore their concerns are often missed or overlooked. Muted group theory can be used to understand "many kinds of human hierarchies and domination" (Kramarae, 2005, p. 60). Race can be viewed through the same framework; Whites are dominant over Blacks in that they define culture and language. The intersection of gender and race for Black women is dangerous.

Intersection Of Gender and Race

Muted group theory was initially used to understand women as a marginalized group, but it can also be used in terms of race – specifically for the Black population. In my research, I consider Black women who are marginalized based on gender and race, and how the intersection of these identities impacts the way they are treated in the realm of health care. Due to the double jeopardy hypothesis, Black women are socially "discriminated against both as women and as minorities," which is why it is important to examine their care through both lenses (Berdahl & Moore, 2006, p. 427). We must listen to the lived experiences of Black women because they

often “experience dual or multiple oppression” allowing them to “identify patterns that are difficult for those immersed in the culture to discern” (Allen, 1996, p. 258). They offer a perspective that is not of the dominant White male which is necessary for real improvement in various social aspects of society.

In a 2008 study, Moody, Dorries, and Blackwell found that national media outlets use framing to mute the voices of missing Black women. “Coverage of missing White women is more prominent” while “the same tactics are lacking in the coverage of missing Black women” (p. 18). News media outlets use more techniques to describe the missing White women and their stories in detail, which allows the audience to connect more with White women than Black women. These separate styles of coverage “affects views about the inherent value of people, which is transmitted to the public” (Moody, Dorries, & Blackwell, 2008, p. 2). The amount of coverage can be seen as an indication of how valued individuals are in this society. Through this study we see Black women are muted in the media which influences the way that society sees – or does not see – almost invisible Black women. According to the U.S. Department of Health and Human Services, Health Resources and Services Administration, and National Center for Health Workforce Analysis (2017) this underrepresentation of Black women spills into the world of health as well.

Underrepresentation of Black Women in Health Care

Due to systemic inequity, there are many socioeconomic disparities that exist between dominant and marginalized groups. According to Lavizzo-Mourey and Williams (2016), “Health builds from where we live, learn, work and play” (para. 13). If we think about this from the perspective of gender and income, we know that women only make $0.81 to every dollar a man makes (PayScale, 2020). This gap is even higher with the inclusion of race; black women make

$0.75 to every dollar a white man makes. Money is linked to power in Western cultures. Our health is determined by all the aspects listed above, which require wealth for the best. This wage gap paired with health disparities that exist for the Black population is problematic. Not only is health influenced by these factors, but opportunities for general success are impacted as well – resulting in the underrepresentation of Black women in positions of power.

In a 2017 study of the OB/GYN workforce, the American Congress of Obstetricians and Gynecologists, found that half of all OB/GYNs were women while only about 11% were African Americans. The voices of Black women obstetric professionals are muted because of existing "marginalizing differences" (Kramarae, 2005, p. 55). In addition, there is a maternal healthcare shortage in the U.S. which further decreased responsiveness for mothers across our country. As discussed previously, the realities of muted groups are overlooked simply because they do not "fit into" the social norms of the dominant group. Due to the small number of Black women in obstetrics and gynecology, Black women who are pregnant may find it difficult to find a provider to whom they can relate which can reinforce care issues of responsiveness. According to Wiltshire, Allison, Brown, and Elder (2018), patients are more likely to develop trust and be more satisfied with care when their physician is of the same race and gender as them. The maternal care provider shortage, a factor outside of the Black woman patient's control, has the potential to eliminate their response options in terms of the provider they choose to see.

Provider Bias Impacts Care

In a 2019 study, Giving Voice to Mothers, Vedam, Stoll, Taiwo, Rubashkin, Cheyney, Strauss, McLemore, Cadena, Nethery, Rushton, Schummers, Declercq, and the GVtM-US Steering Council found that implicit bias by healthcare providers links to disparities in access to and quality of care. For instance, Black women were twice as likely as White women to report

that a health care provider ignored them, refused their request for help, or failed to respond to requests for help in a reasonable amount of time. Black women's voices are muted, which impacts provider responsiveness during pregnancy care, but why? Ferguson and Candib (2002) conducted a study of physicians, their patient perceptions, and how that might influence care. They found that physicians are "less likely to have a positive perception of African Americans on a number of issues" (p. 357). Physicians assumed that African Americans were less physically fit, and more likely to use drugs than patients of another race. One of the most eye-opening findings was that physicians found it unlikely that they could be friends with their African American patients. All these perceptions were ranked worse when low social class was added into the mix. In addition, "physicians rated African Americans as less intelligent and less educated than Caucasians" (Ferguson & Candib, 2002, p. 357). The results of this study show that Blacks are already being judged and seen as less than before they even enter a doctor's office for care.

Contrary to this image that has been painted by the previous study mentioned, many attribute a sense of strength and resilience to the Black woman, often overlooking their vulnerabilities. This can have life-threatening effects especially in terms of the maternal mortality/morbidity disparity that is the focus of this study. For instance, sixty percent of maternal deaths are preventable because physicians are trained and have the technology to handle the two most common causes of maternal mortality – cardiomyopathy and hemorrhage (USC Annenberg, 2019). In looking at the communication practices of Black women, Davis (2015) found that "Black women regulate strength in themselves and one another" which "enables refuge from and collective resistance against larger oppressive forces, as well as validation and celebration of a distinctive Black woman identity" (p. 20). Black women find

community and a sense of belonging in each other. They understand that they are a marginalized group and use this as fuel to better support other Black women.

RQ1: What are some common themes that exist in the personal accounts of Black women who have suffered from pregnancy-related complications?

RQ2: Is there a component missing from the training and/or documents that OB/GYNs use to address pregnancy-related complications?

Method

A content analysis of the narratives of Black women who suffered from pregnancy complications was the focus on this research. Through coding these narratives, I looked at the concept of provider responsiveness via the perspective of Black women specifically, giving a voice to those who have been muted. In addition, I completed a textual analysis of the types of training documents and toolkits that currently exist in the field of obstetrics and how they may affect quality of care for Black women specifically. The concept of health and responsiveness was used in my study to understand how these health outcomes influence provider and patient decision-making.

Sample and Data Collection

I collected publicly available first-person accounts from Black women regarding pregnancy-related complications they have experienced. These narratives came from NATAL, which specifically focuses on the voices of Black women and their unique pregnancy experiences. NATAL is a podcast docuseries about having a baby while Black. At the time of my research, this series contained the stories of nine women – Alexius, Brittany, Cecilia, Marilyn, Mikah, Myeshia, Shellie, Trish, and Yvonne. Being a part of this series, the individuals involved identify as Black women. Listening to their stories allowed me to hear their voices as opposed to

them being translated through a reporter or interviewer. These intimate accounts revealed themes about their experiences including specific complications and their interactions within the healthcare system throughout their pregnancy and thus answering RQ1.

In addition, I collected publicly accessible national medical guidance for OB/GYNs. First, I examined the Council on Resident Education in Obstetrics and Gynecology's (CREOG) *Educational Objectives: Core Curriculum in Obstetrics and Gynecology*. This document sets the framework for OB/GYN residents across the country and the competencies they must meet throughout their training. Second, I examined two Committee Opinions from the American College of Obstetricians and Gynecologists (ACOG), *Effective Patient-Physician Communication* and *Racial and Ethnic Disparities in Obstetrics and Gynecology*. Committee Opinions are meant to serve as evidence-based best practice guidelines for various topics. They are periodically updated by committees of medical professionals to reflect any new scientific research that is released. Third, I examined the Alliance for Innovation on Maternal Health (AIM) patient safety bundle titled *Reduction of Peripartum Racial/Ethnic Disparities.* Patient safety bundles are typically used to follow a specific protocol once complications arise. For this portion of research, I specifically focused on documents that directly address maternal care, communication, and physician-patient relationship. Being able to see these resources helped me to answer RQ2 by understanding if the information included – or not included – could have an impact on physicians' care of Black women patients.

Data Analysis

In regard to the first-person accounts, I used thematic analysis to look for themes in the women's experiences communicated through the NATAL podcast. Specifically, I followed Braun and Clarke's (2006) six-step process for thematic analysis. First, I listened to each unique

experience once. I located transcripts of the narratives on NATAL's website. I also used this stage to begin taking my own mental notes on each experience. Second, I looked for initial codes by highlighting quotes that stood out to me and typing out "what is interesting about them" (p. 88) in the margins. I identified any patterns that exist within the data, especially similar interactions that occurred in more than one of the narratives. I did this by listing out the most prominent interactions and adjectives used for each woman separately, but all on one document. Third, I highlighted codes in various colors to group like codes with somewhat of a theme and decipher between codes that brought about different themes. This helped me to visually see and understand how each of the codes were interrelated. From there, I was able to name a vague theme for each. Fourth, I reviewed themes for validity in relation to their data and the data set as a whole. Then, I broke down what each theme means and gave them names that were even more specific and/or appropriate.

I performed a very similar process for the medical documents discussed previously. First, I read through each document once. I used this stage to copy and paste passages that stood out to me the most onto a new document and began taking notes in the margins. At this point, I followed the identical method used in steps two through five above to find common themes that existed in the medical guidance documents.

Challenges and Opportunities

Completing a thematic analysis of the accounts of Black women went well. There were nine narratives to review which provided an array of experiences. However, there were still a few challenges and limitations of my research method. The sample data that used was not representative of the nation's population of Black women. With only nine narratives, I was not able to capture the diversity within the population group (i.e. social status, geographic location,

etc.). Another challenge was that women may not be as likely to disclose in-depth details about their pregnancy-related experiences due to the intimate nature of the topic. I collected qualitative data which means that data saturation was an issue since there is no set limit to the number of themes defined.

This research regarding maternal care for Black women has the potential to influence future researchers in their studies of pregnancy-related disparities. This research also offers the opportunity to: 1) raise Black women's awareness to influence their responsiveness when seeking maternal care, 2) inform legislators and medical pedagogists – especially dominant White males – that certain policies and regulations need to be updated, and 3) and create a dialogue between the vulnerable population of Black women and their medical professionals.

Findings and Interpretation

To address RQ1 regarding common themes that exist in maternal care of Black women, I listened to nine personal accounts from the NATAL podcast. I immediately noticed a pattern in the arrangement of each account and the layout they followed highlighting the stages of pregnancy: prenatal, labor and delivery, and postpartum and reflection. I decided to use these overarching patterns to organize the themes found amongst the narratives. I noticed that each phase of pregnancy contains recurring themes, and most themes overlap into multiple phases. The five themes identified (positive staff, uninformed, advocacy, negative staff, and lack of agency) will be defined and discussed below:

Positive Staff

The Positive Staff theme addresses any positive interactions mothers had with clinical staff throughout their pregnancy. Positivity was a theme that emerged across eight of the nine narratives. The group used words such as warm, friendly, and supportive to describe the

clinicians involved in their care. The ability to have open conversations with providers during prenatal care was touched on often. For instance, Myeshia recalls feelings of reassurance after talking with her physician very early on about her family history of preeclampsia. In another case, being able to call the doctor's office frequently to ask questions about the pregnancy process put Cecilia at ease: "I felt really comfortable in their hands." Having this sense of comfort and security with staff is crucial in the development of the doctor-patient relationship. Mikah says that venting about their violent home life during prenatal visits led to positive outcomes: "They [medical staff] got me in touch with a social worker." From that point, Mikah moved into a women's shelter where they were able to learn from the other mothers. Something that stood out in terms of labor and delivery was the concept of representation. Cecilia mentioned having a Black nurse who continuously checked on her after giving birth. She described her experience with this particular individual with whom she could identify with as "very beautiful and affirming." She felt seen.

In three of these eight Positive Staff narratives, the mothers chose to use a midwife and/or doula throughout their birthing process, as opposed to an OB/GYN. In their cases, their positive interactions involved a midwife or doula. The women in these narratives appreciated the longer length of appointments as well as the purposeful inclusion of their partners in the birthing process. Most importantly, a certain level of comfort was apparent in their experiences. Brittany describes what she felt after an initial phone call with a local midwife: "A connection that I was looking for that was missing. And it's so simple. It's just listening." Alexius recalls how her home birth delivery team was able to put her at ease: "They secured my space, they secured my sanity and my peace." Although positive experiences existed in a majority of the narratives, there was a significant amount of unpleasant interactions as well.

Uninformed

The Uninformed theme addresses moments in which mothers felt unprepared due to a lack of awareness or appropriate resources. Four out of nine of the narratives included codes that suggested they were uninformed at some point during the birthing process. Mikah says of their prenatal care staff, “They weren’t trying to educate me.” They felt as if more resources could have been provided regarding what to expect. It is important for individuals to understand symptoms to look for to know when an emergency doctor’s visit is needed. Yvonne says, “No one ever told me about the signs of miscarriage.” In terms of the postpartum stage, Shellie and Marilyn both mention that they suffered from postpartum depression unknowingly. They weren’t aware of the severity of their symptoms and no one ever recommended therapy. In their moments of uncertainty, some women had someone intervene and advocate on their behalf.

Advocacy

The Advocacy theme addresses any interactions in which the pregnant mother, a family member, or any party outside of the delivery team had to stand up for the pregnant mother. Five out of the nine narratives included instances of the birthing mother or someone supporting her had to address clinical staff due to their behaviors. These situations were especially present during the labor and delivery stage. Shellie says, “I remember they were having some conversation about another patient who had died in delivery.” Her partner had to be the one to call them out and end it. In Yvonne’s case, front desk staff asked her to be seated and continue waiting after experiencing dizziness due to miscarrying in the restroom. Her mother stood up for her and let staff know that their dismissiveness was unacceptable. Additionally, Brittany took matters into her own hands when she continued to feel as if physicians in the clinical setting were not listening to her during prenatal care. She went through trial and error until she landed

on a doula with which she felt comfortable enough proceeding. Most of the advocacy that took place in these examples were mostly reactive due to negative experiences with providers.

Negative Staff

The Negative Staff theme addresses any negative interactions mothers had with clinical staff throughout their pregnancy. Six of the nine narratives included some unpleasant interaction with clinical staff. Some common words used to describe the physicians and nurses in these situations include cold, rude, and even careless. Brittany discusses her prenatal care: “She was just less than enthused. I just felt like it was very mechanical.” She even brought up multiple instances in which the OB/GYN would interrupt her while she was trying to speak. Mikah says, “I kind of felt like a burden to them” when recalling her experience at prenatal visits. Pain tolerance in different for everyone and in a few instances, clinical staff disregarded this. Marilyn’s physician did not wait for pain medication to take effect before manually removing her placenta, which was described as an excruciatingly painful procedure in more than one narrative. Myeshia shares her experience with a nurse who was shocked by the amount of pain she was in: “Like it seemed to surprise her so much that I’d be crying because I’m in pain.” This lack of sensitivity trickled into the postpartum stage as well. Shellie says, “I don’t ever remember being asked how I was doing. Everything was baby focused, baby centered.” Overall, it seems as though neonatal care was sometimes prioritized over maternal care in these particular events.

Lack of Agency

The Lack of Agency theme addresses the interactions in which mothers felt as though they didn’t have a say in the matter. In these moments they mentioned giving into the recommendations of clinical staff due to the limited time they had to make a decision.

Although many birthing parents create birth plans prior to labor and delivery, things don't always necessarily go as planned. There are some cases in which split decisions must be made that have the potential to affect the health of mother and/or baby. When faced with these situations, Cecilia says, "You're just kind of like, well, I'll just do what the doctor says because you're so scared about making a bad decision." While her husband was at work, Marilyn was alone when complications arose with her twins and she had to choose between the two babies. As one of the youngest birthing parents included in this study, Mikah mentioned being administered birth control immediately after giving birth and said, "It was not really talked about. It was kind of just told to me." Feeling as though they had to along with what clinical staff recommended was common for the individuals in this particular theme.

To address RQ2 regarding the competencies expected of OB/GYNs, I examined four medical guidance documents. I noticed that each document identified aspects of care that have been proven to lead to positive outcomes with maternal patients, so I decided to focus on this as the overarching topic to guide my themes. The four common themes identified (emotional intelligence, attentive listening, partnership, and advocacy) will be defined and discussed below:

Emotional Intelligence

The Emotional Intelligence theme addresses physicians' emotional traits or characteristics as key to successful outcomes. This theme was present in all four of the documents. Some adjectives used to describe interpersonal and communication skills essential for physicians include compassion, respect, positivity, and appreciation. Specifically, when reviewing the Studer Group's AIDET (Acknowledge, Introduce, Duration, Explanation, Thank You) communication tool, ACOG's *Effective Patient-Physician Communication* Committee Opinion states the importance of "showing appreciation to the patient for her cooperation." The

formation of an emotional bond with the patient seemed to be a resounding topic amongst this data. On a deeper level, each document mentioned that physicians must work through some internal reflection to determine their own personal biases. CREOG's *Educational Objectives: Core Curriculum in Obstetrics and Gynecology* suggests this competency in the Professionalism section of the document: "Develop awareness of implicit biases that may affect patient care." When physicians are emotionally mature, they have the ability to give the patient their undivided attention, especially through listening.

Attentive Listening

The Attentive Listening theme addresses the use of care and responsiveness when listening to patients. This theme was present in all four of the documents. Patient-centered interviewing seemed to be one of the best methods for physicians to use to practice attentive listening to their patients. ACOG's *Effective Patient-Physician Communication* Committee Opinion suggests a five-step process for patient-centered interviewing which involves removing "barriers to communication" and obtaining "additional data from nonverbal sources." Another component of the Attentive Listening theme is responsiveness. Physicians must not only be able to respond in a timely manner, but the key is to respond to patients effectively. ACOG's *Effective Patient-Physician Communication* Committee Opinion highlights flexibility: "Understand your personal style and recognize when it may not be working with a given patient." Physicians should be able to monitor their own patient outcomes and tailor their actions periodically to put their patients at ease. Solutions for clinicians included quality improvement activities specifically focused on these racial disparities. The AIM *Reduction of Peripartum Racial/Ethnic Disparities* Patient Safety Bundle states the importance of establishing "a mechanism for patients, families,

and staff to report inequitable care and episodes of miscommunication or disrespect." Attentive listening allows physicians to build a stronger relationship with their patients.

Partnership

The Partnership theme addresses physician and patient working together to come to a consensus in terms of treatment plans. This theme was present in three of the four documents. CREOG's *Educational Objectives: Core Curriculum in Obstetrics and Gynecology* and ACOG's *Effective Patient-Physician Communication* Committee Opinion both specifically cite the term "counsel" to describe how physicians should interact with their patients, especially regarding plans for treatment. It is suggested that the physician and patient work together as a team, in which the physician shares "relevant risk and benefit information on all reasonable treatment alternatives," while the patient shares "all relevant personal information that might make one treatment more or less tolerable than others." ACOG's *Effective Patient-Physician Communication* Committee Opinion defines this as shared-decision making. This specific term shows up in the remaining two documents included in this theme as well. Partnership

Advocacy

The Advocacy theme addresses physicians being advocates for their patients, from individual patient care to national public policy for women's health. This theme was present in all four of the documents. ACOG's *Effective Patient-Physician Communication* Committee Opinion suggests that physicians "advocate for sustainable practice models that increase the duration of visits." Longer appointments allow the physician to address all patient concerns and therefore forming a stronger bond. Continuing along this concept of relationship building, AIM *Reduction of Peripartum Racial/Ethnic Disparities* Patient Safety Bundle encourages health

systems to "engage diverse patient, family, and community advocates" who can be the representative voices in the efforts towards an equitable health care space.

Discussion

The Muted Group theory suggests that social hierarchies exist in which some groups are dominant over others (Kramarae 2005). In the case of Black birthing mothers, they are left to face this daunting intersectionality of race and gender throughout their pregnancies. As seen through the Negative Staff, Advocacy, and Lack of Agency themes, the mothers included in this study were often ignored, didn't feel cared for, or felt forced into a certain plan of action. While the race of physicians involved in these particular situations were not mentioned, there were instances in which the mother identified their negative experience being with a male physician. According to ACOG's (2018) *Racial and Ethnic Disparities in Obstetrics and Gynecology* Committee Opinion, "Studies suggest that race and language concordance between patients and practitioners may improve communication and outcomes." While this study did not show adequate support for ACOG's claim, mothers did express excitement and a stronger sense of connection when there was a Black woman involved in their care during pregnancy. This feeling of belonging and familiarity proves to be an important aspect of the physician-patient relationship. ACOG, CREOG, and AIM stress this in their medical guidance documents.

The Core Curriculum, Committee Opinions, and Patient Safety Bundle examined in this study contained positive, patient-centered themes, even mentions of physicians' reflection regarding personal biases. Apparently, there is a disconnect between these guidelines and the experiences women faced in the NATAL narratives. It is important to note that these documents serve as a national framework rather than mandated requirement, as resources vary from state to state. In an effort to combat this unlevel playing field, AIM was developed to consult with state

departments and determine best practices for their particular OB/GYN facilities. The issue here is that it is an opt-in solution. States must subscribe to the AIM community in order to receive the necessary interaction needed to humanize the materials. As of September 2019, only twenty-six states were utilizing AIM initiatives (American College of Obstetrics and Gynecology). If states do not opt-in, they can still access the bundles; however, it is up to the state and their various facilities to determine efficient implementation.

Theoretical Implications

This research brings up the need to shine a light on the double jeopardy hypothesis within health care communication ethics. Physicians are a key subject in health care communication ethics; they are expected to respond to patients with care whether their illness is minor or chronic. Since care is about the act of being selfless, personal biases should not get in the way of that. This is where the double jeopardy hypothesis could lend its concept of individuals suffering from multiple oppressions, highlighting the importance of cultural acceptance on all levels in care.

In addition, Muted Group theory could be further evolved by incorporating concepts from intersectionality. Muted Group theory only examines one group versus another, as opposed to the combination of social factors that have a major impact on the way an individual interacts with others and vice versa. This would allow us to see others as multifaceted human beings who are not to be defined by one particular element of their identity.

Practical Implications

Educational organizations responsible for training OB/GYN residents must ensure that the element of humanization is incorporated into training programs. Studying written documents regarding health through the lens of racial disparities is not enough. Written information can

come off as procedural, and therefore has the potential to transfer to patient care. In an effort to avoid this, states should opt into AIM, through which professionals can consult with practices regarding best practices tailored to their specific needs and resources available.

The inclusion of Black women in these improvement efforts where they are located would be another great way to bring about change in terms of the maternal health disparity. Another solution would be to improve the representation of Black women in the OB/GYN field. States and medical universities must implement strategic efforts to recruit this population.

Lastly, health care professionals must be more open about communicating all options for birthing mothers, including the risks and benefits of each. This gives patients the ability to weigh their options and ask questions if needed. The doctor-patient relationship should be a partnership in which the patient is able to make their own decisions regarding their body, under the consultation with a medical professional. Creating an atmosphere of comfort for the patient is essential to understand their true concerns and levels of tolerance.

Conclusions, Limitations, and Future Research

This research benefits Black mothers by raising their awareness regarding the alarming disparity. In addition, through the medical guidance documents they will understand the specific physician competencies and how they should expect to be treated in the clinical setting. This way, if any interactions do not meet those expectations, they will know that advocacy is necessary. In terms of physician training, this research will benefit state departments in knowing the benefits of opting into the AIM community to improve maternal care. More broadly, this research will shed a light on the dangers of being Black and pregnant in America, a developed country, for individuals who may not be aware of the disparities. They will benefit by being able to spread the word to loved ones, and possibly start some self-reflection regarding any biases

they may have. The U.S. has only just begun their journey to reducing pregnancy complications and maternal deaths. It will take physician selflessness, and the inclusion of mothers in the decision-making process regarding their own bodies, to improve maternal health outcomes in this country.

Limitations

One limitation of this study is the number of narratives collected. There were only nine narratives analyzed, and the subjects were not representative of the U.S. population. The participants' birth places were not disclosed in every situation so it could not be inferred that Black women suffer similar injustices across the nation. In the same vein, to be Black woman is not monolithic. The narratives are unique to the individuals involved and cannot be generalized amongst the population. These were all Black mothers which leaves out women of other races who could have been a control group.

Another was the amount and nature of medical guidance documents included. There are many organizations that exist to develop curriculum and standards for physicians besides those discussed. All data for this section were PDF files, which does not speak to the more interactive resources that may exist in other formats such as in-person courses, workshops, or webinars.

Future Research

It is with great hope that this research will advance academic conversation in terms of maternal health. The collection of more nonbinary narratives to be more representative of the nation's population would be a start, especially in terms of gender and sexuality inclusivity. All narratives can reveal themes regarding care that could influence quality improvement, while also giving voice to those who are not heard. There were only a couple narratives that included a homosexual couple and a transgender man as the subjects in this study.

Future studies should also take into account the discrepancy in health care quality from state to state. Focusing on one state – gathering narratives and medical practices – could allow for individualized community-based quality improvement efforts.

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