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Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing

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ABSTRACT

In this article, I analyze the birth stories of Black women living in the United States. Their birth stories describe various forms of racism during medical encounters while they were pregnant or during labor and delivery. In the global women's health arena, the issues raised are viewed as obstetric violence. However, obstetric racism—as both an occurrence and analytic—best captures the particularities of Black women's reproductive care during the pre- and post-natal period. Obstetric racism is a threat to positive birth outcomes. I argue that birth workers including midwives and doulas, mediate obstetric racism and stratified reproductive outcomes.

KEYWORDS

United States; Black women; labor and delivery; medical encounters; obstetric racism; pregnancy

One night in early 2018, Josie, a white doula I interviewed, sent me a text because she was distraught. She had witnessed her client, Michelle, a Black woman receiving Medicaid, being treated very badly during her labor and birth. Josie described that after Michelle was admitted to the hospital, she experienced being controlled by medical staff and was given Pitocin, the synthetic version of Oxytocin which is the body's naturally produced hormone to induce contractions. A nurse told Michelle that her cervix was about five centimeters dilated, which justified the Pitocin, although Josie, an experienced doula and midwife in training, believed Michelle was probably closer to 8 cm dilated. According to Josie, the medical staff seemed to want to deny Michelle a birthing experience similar to one that another client of Josie's was able to have. Hospital staff told Michelle that only one person would be allowed in the room with her, and that she would have to choose between her mother and Josie. "She chose me," Josie said. But a week earlier, Josie told me, she had been at the same hospital with a white woman who had private insurance and six people in her room (Davis 2018).

In the labor and delivery room, Josie said Michelle felt the urge to push, but the nurses and the doctor told her to stop: they said there was cord prolapse, which is when the baby's head is very high in the birth canal and the umbilical cord has descended. But Michelle's water had not broken yet, so it was unlikely there was a cord prolapse. Michelle eventually gave birth and although she did not experience a lot of bleeding, Josie was shocked when the doctor announced that Michelle had clots. Then, according to Josie, the doctor aggressively "went in" to remove the clots. In addition to being violent, aggressive entry after a birth can cause infection. Michelle was screaming, "Stop! Stop!" After the birth, Michelle's son ended up in the NICU due to a congenital bowel defect. Josie said the doctors made Michelle feel that the defect was her fault because she had delivered "too quickly." Obviously, a congenital problem is not the result of birth. Josie described what she had witnessed as obstetric rape (Davis 2018).

Because her son was admitted to the NICU, Michelle was one of the Black women in the United States burdened by an adverse birth outcome. According to Stacey D. Stewart, president of The March of Dimes—the international organization that seeks to decrease infant mortality and birth

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defects — in 2016 the preterm birth rate among Black women was 49 percent higher than the rate of all other women (March of Dimes 2017). These disparities are indicative of stratified reproduction in that the inequalities of race, as well as class, gender, culture, and status, produce differential reproductive outcomes (Colen 1995). The differential outcomes that burdened Michelle produced, what I call, *obstetric racism*.

Obstetric racism lies at the intersection of obstetric violence and medical racism. Obstetric violence is a form of gender-based violence experienced by people giving birth who are subjected to acts of violence that result in their being subordinated *because* they are obstetric patients. The term suggests that institutional violence and violence against women coalesces during pregnancy, childbirth, and postpartum (Women's Global Network for Reproductive Rights 2017). Obstetric violence includes dehumanizing treatment and medical abuse such as birth rape, or violations experienced during childbearing. It expresses the explicitly harmful consequences caused by medical professionals when they exert reproductive dominance over women in countries such as Mexico and Argentina (Dixon 2015; Elmir et al. 2010; Vacaflor 2016). In the US, some scholars view obstetric violence as phenomenon experienced by particular women. For example, middle-class white women are "more exposed to the effects of medicalization and technology" due to healthcare access (Shabat 2015:232). Others examine the limits and legal possibilities of using the framework in the US in relation to human rights (Borges 2018; Diaz-Tello 2016).

While obstetric violence is a potent analytic to understand how abuse is experienced at any time during maternal healthcare processes, it does not adequately take into account the contours of racism that materialize during Black women's medical encounters. Drawing from Gilmore (2007), I define racism as the institutionally and state sanctioned practices that make particularly designated groups of people vulnerable to harm and premature death. The history of medical racism in the US deeply influences Black women's medical encounters, and these encounters have been detrimental. Obstetric racism, I argue, is a threat to positive outcomes for obstetric patients.

Medical racism occurs when the patient's race influences medical professionals' perceptions, treatments and/or diagnostic decisions, placing the patient at risk. Histories of medical experimentation on African Americans shows the profound disregard that the medical profession has displayed for Black lives, treating people as "clinical material" (Hoberman 2012; Washington 2006). For example, Black patients have been subjected to racially stratified diagnoses resulting in the denial of pain medication, based on the belief that they withstand pain better than other demarcated groups (Fabien 2017; Hoffman et al. 2016).

Negative ideas about Black women, such as them being licentious, reveal a gendered dimension of medical racism (Hoberman 2012). Medical racism is woven into the historical narrative of reproduction, gynecological, and obstetric practices in which Black women's bodies have been valued as "medical superbodies" (Cooper Owens 2017:77). A "superbody" is worthy enough for labor and experimentation—such as gynecological experiments to address vesicovaginal fistula—but the woman herself is not worthy of being treated humanely. There are numerous examples of reproductive abuse suffered by Black girls and women. The abuses range from capitalizing on Black women's reproduction to sustain the slave economy and the use of enslaved women in the development of gynecology (Berry 2017; Cooper Owens 2017) to the case of the Relf sisters, ages 12 and 14. In the case of the Relf sisters, doctors sterilized the two poor young Black girls who lived in Alabama, without permission. Another example of reproductive abuse was the unauthorized use of the carcinogenic birth control drug Depo Provera on 4700 Black women (Washington 2006). A different form of reproductive abuse was the denigration of Black women's role as midwives in the nineteenth and twentieth centuries as obstetric medicine became the established intervention to address parturition (Wilkie 2003).

The term obstetric racism is an extension of racial stratification and is registered both from the historically constituted stigmatization of Black women and from their recollections of interactions with physicians, nurses, and other medical professionals during and after pregnancy. Obstetric

racism is a threat to maternal life and neonatal outcomes. It includes, but is not limited to, critical lapses in diagnosis; being neglectful, dismissive, or disrespectful; causing pain; and engaging in medical abuse through coercion to perform procedures or performing procedures without consent. Informing women's interpretations of those encounters is a fluency of historically constituted racism, segregation and policing. Obstetric racism emerges specifically in reproductive care and places Black women and their infants at risk.

In this article, I elevate Black women's interpretation of their interactions with medical staff when accessing prenatal care and during labor and birth, and in doing so, I point to the harm caused by obstetric racism. This article is based upon research showing that some Black women and birth workers viewed pre- and post-natal medical encounters in terms of racism regardless of whether women had public or private insurance. Women and birth workers recounted the ways in which racism haunted Black women's pregnancies, labors, and deliveries. Based on their narratives, I argue that the reproductive practices and procedures that some women described exemplify obstetric racism. First, I situate this discussion in the context of the literature on adverse birth outcomes, an anthropology of reproduction, and the subset of scholarship that explores the anthropology of race and reproduction in the US. Second, I describe the methodological approach of the study. Third, I present three case studies of Black women's medical encounters during their pregnancies to elucidate the concept of obstetric racism. Finally, I explore the role of birth workers who seek to intervene and where possible reduce the medicalization of birth and decrease women's obstetric racist encounters.

Reproduction, race, and racism

Race and class often cloud our understanding of pernicious birth outcomes in the United States. In other words, researchers are often likely to frame adverse births in term of being Black (or non-white), having a low income, low educational attainment, and risk behaviors such as smoking and alcohol consumption (Centers for Disease Control 2017; Florio 2014). Another framework suggests that Black women's reproductive capacity wears down over time. Known as the "weathering hypothesis," this framework posits that an overall early deterioration of health—from an accumulation of various aspects of disadvantage, contributes to prematurity and low birth weight (Geronimus 1996). Other scholars suggest that genetics contributes to Black women's risk for poor birth outcomes (Amini et al. 1994). However, several researchers argue that overcommitting to genetic explanations underemphasizes socio-economic causes and that disparities are a biological expression of race relations (Krieger 2003; Non and Gravlee 2016).

Complicating the dominance of the socio-economic basis of negative birth results is research showing that Black women with the highest levels of educational attainment have worse birth outcomes than do white women with the lowest levels of educational attainment (New York City Department of Health and Mental Hygiene 2016; Schoendorf et al. 1992). Consequently, it is reasonable to view racism as a mediating factor in exploring Black women's reproductive outcomes. Stated differently, race is not genetic or biological, but racism can contribute to such health issues as high blood pressure or elevated cortisol levels (Richman and Jonassaint 2008).

Heeding Ginsburg and Rapp's call to place reproduction at the center of social theory (Ginsburg and Rapp 1995), feminist scholars have taken up the project of theorizing reproduction—from considerations of how the fetus has been elevated over the mother (Casper 1998) to cultural analyses of reproductive technology (Franklin 2013). Feminist inquiry has also centered on the increased use of reproductive technology, which has resulted in important critiques and explorations of transnational reproduction (Deomampo 2016; Twine 2011). Other scholars have examined stratified reproduction to illuminate how inequalities are instantiated in social reproduction processes and the role that racism plays in social and biological reproductive outcomes (Colen 1995; Mullings 1995).

Informed by this feminist scholarship, in this article I am concerned with the overlapping issues of reproduction and racism. I draw from Roberts (1997) analysis that shows the ways in which racist history, policy, and practices have disrupted and controlled Black women's reproduction since enslavement. More recently, Mullings and Wali (2001) theorize the relationship between racism and reproduction shedding light on the impact of racism and the structural constraints Black women face with regard to housing, income, caregiving, among other issues, all of which increase the likelihood of mortality and morbidity. Gutíerrez (2008) reveals how racial anxieties inform nativist rhetoric that position women of Mexican origin as hyperfertile: rhetoric that led to coercive sterilization in the 1970s. Bridges (2011) takes up the institutionally sanctioned procedures that result in racializing pregnant women who are recipients of Medicaid, the public health insurance for low-income people. To varying degrees, these studies attend to the cultural aspects of birth outcomes in relation to race and racism.

One of the first studies examining the biological consequences of racism on birth outcomes was reported in 2000 (Collins et al. 2000), and was followed by other studies showing that psychological stress associated with racism may increase the risk of preterm delivery (Rich-Edwards et al. 2001). Intersectional analyses of class, racism, and gender subordination have been an important focus in understanding African American women's reproduction (Lane 2008; Mullings and Wali 2001). While poor and low-income Black women are frequently the subject of adverse birth outcomes, the problem plagues Black women across class (see for example, Paisley-Cleveland 2013). Because this article focuses on Black women who possess college degrees and/or have middle to high incomes, I caution against using the trope of poverty, which is often an ill-fitting proxy for behavior to explain adverse birth outcomes. I suggest that the experience and recollection by women, about medical encounters can be a central site of understanding medical practices to reveal obstetric racism and raise fundamental questions about the obstetric care which Black women receive regardless of class status.

Methodology

Part of a larger project that began in 2011, this article is based on research investigating race and reproductive injustice (Davis 2019). Specifically, I examine pregnancy, prematurity, labor, and birthing among Black women who have secured educational attainment and/or professional status. During the research, I interviewed and conducted oral histories with nearly 50 people including mothers and fathers, and birth workers—that is midwives, doulas (who do not provide medical assistance but rather offer support), and reproductive justice advocates. Medical professionals such as neonatologists, neonatal nurses, labor and delivery nurses, and administrators who work or had worked at the March of Dimes, were also interviewed.

I collected birth stories, a form of oral history, from 17 parents – 14 mothers and three fathers. Two mothers were Filipina and one was white; all other parents identified as Black. Parents resided all across the country, and their state of residence at the time of the interview was not necessarily where their children were born. Except in five instances, parents initiated contact with me through introductions made by people aware that I was interviewing parents whose children had been admitted to a Neonatal Intensive Care Unit (NICU). In three cases, parents did not discuss premature birth or admission to a NICU, but instead, they wanted to describe incidences they had with medical professionals. I spoke with parents both in person and on the phone, with conversations lasting between 90 minutes to two hours. In several instances, there were two to four follow up conversations. Because their children had already been born and survived (except in one case), parent's recollections were rich, punctuated by sighs of anxiety and relief, silences, quivering voices, and tears.

There was no specific geography of racism or prematurity, and so the research was not a geographically bounded endeavor. However, there were two sites of ethnographic observation:

NICUs and birth worker trainings and workshops. I conducted ethnographic observations at four different NICUs—each one in a different state: New York, Connecticut, Minnesota, and Louisiana.

The second ethnographic site took place at doula training programs, workshops, gatherings, and conferences in New York and Washington, DC. I also completed training as a doula during research project.

These engagements were essential to understanding racisms' articulation over time and space. For example, the location of interviews and observations varied. Parents shared stories of children who were born between seven months and 35 years earlier than when the interviews took place allowing me to show that the phenomenon of obstetric racism has been persistent. Although women described varying degrees and forms of racism over that time, the inclusion of birth workers in this project who seek to ameliorate the racial disparities of Black women's birth outcomes, suggests that the problem is not intractable.

Obstetric racism

I take a Black feminist approach to examining reproduction, which affirms positioning race and gender at the forefront of knowledge production. Knowledge is produced through narratives in which participants reflect upon the experience (Collins 2000). Black feminist theorizing situates women's stories as evidence and the source of theory because the intersection of race, gender, class, and sexuality are often expressed in the most complex ways in Black women's lives. From their lived experience, we can examine obstetric racism, as an analytic framework, that threatens the health and well-being of Black women.

Case 1. "I sought out care"

In 2008, Yvette Santana, a Black woman working as an administrator, was 40 years old. Yvette was married but she and her husband Carlos lived in two different states – she in North Carolina and he in Washington, DC. When they discovered Yvette was pregnant with twins, the couple were delighted that, after having two myomectomies, i.e. the surgical removal of fibroids, she had conceived through In Vitro Fertilization (IVF).

Yvette's OB/GYN was a white male, high-risk pregnancy specialist. Although Yvette says she expressed anxiety about her pregnancy to her physician, he told her she was not high-risk because she did not have diabetes or high blood pressure. Yvette believed differently and wanted the doctor to treat her with greater concern. Not only did her physician downplay the complications that her pregnancy posed, but when Yvette implored him to take her more seriously he neglected to do so. Yvette sounded shocked as she told me that the doctor asked if she was trying to "make herself high-risk," suggesting that she was a hypochondriac. Based on Yvette's interpretation, the doctor was holding her responsible for her own wellness through some mysterious power of will.

At a later point in her pregnancy, Yvette planned a trip to Washington DC to see her husband and meet with a new OB/GYN who agreed her pregnancy could be problematic. The week she was to travel, Yvette did not feel well. Keeping a prenatal visit with her North Carolina doctor, Yvette wanted to ascertain if making the trip was advisable. The doctor's response, according to Yvette, was that there was no problem. After boarding the plane, she still did not feel well and upon landing, Yvette immediately went to an Emergency Room (ER). ER staff did not believe that anything was wrong, but several hours later, Yvette gave birth to twins when she was just 26 weeks pregnant. Each baby weighed less than two pounds—making them very low birth weight. Both were admitted to the NICU, where, Yvette told me, NICU staff commented on the strength of Black babies, and assured her they would be fine. But after almost one month, one of the twins died from a hospital based infection (Davis 2019).

During our conversation, Yvette linked her experience to racism. First, she recalled that medical professionals often blame negative birth outcomes on Black women. "They think we do not seek out

prenatal care and that is the reason we end up having premature births with infants being admitted to the NICU. But I sought out care," Yvette remarked. Although some research has pointed to delayed entry for prenatal care as a factor in birth outcomes, Yvette reasoned that she and other Black women challenged that perception. Not only did she seek out prenatal care, but she also advocated on her own behalf to secure the kind of prenatal care she believed was important in her situation; other women interviewed also made this some point in relation to their experiences. Yvette voiced disbelief as she remembered that her doctor neglected to address her high-risk pregnancy, which she attributed to racism. She said she sought good care, and had a high-risk specialist, but he told her she was not high-risk based on the *absence* of presumably racialized health factors.

Recently, several articles have raised alarm about the fact that medical personnel do not listen to Black women sufficiently when they register concerns about their health. This is exactly what happened to tennis star, Serena Williams, whose initial requests for postpartum attention went unattended (Gay 2018). Medical staff neglected to take her concerns about her health seriously.

Yvette also viewed the comment by a NICU staff member, that racialized the strength and survival of Black infants, as an indication that, had she and her children been white, they would have been viewed as fragile and treated differently. She suggested that neglect and racist stereotypes factored into the babies' treatment. While hospital based infections was not one of the factors examined, a recent Stanford University study did find Black infants in the NICU received qualitatively inferior care compared with other infants (Profit et al. 2017).

Yvette was aware that blame follows Black women based on the belief that they do not seek out prenatal care. Certainly, healthcare is not always accessible but inaccessibility can be compounded by past negative experiences, which are also barriers to receiving care. For instance, a key finding in the study, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care*, was that discrimination is an impediment to accessing care (Center for Reproductive Rights 2014).

Then there is Yvette's interpretation of her treatment and that of her children. In the first instance, Yvette points out the racist rationale her doctor used to dismiss concerns about the risks her pregnancy posed—that she did not possess the "markers" of being Black, such as having high blood pressure or diabetes. This was, disturbingly, not only a lapse on the doctor's part but also a reductive understanding of the risk to Black infant and maternal health. Racism allows medical professionals to interpret the absence of a presumably race-specific health risk as justification to deem a person as having no risk. In the second instance we can ask in what ways, directly or indirectly, can the doctor be held accountable for the premature birth of her twins and the death of one? The doctors' unwillingness to register Yvette's self-reported concerns is indicative of how structurally embedded racism can prevent medical professionals from listening to their patients (Tello 2017). The physician's dismissal of Yvette's apprehensions was not only negligent, but also an example of obstetric racism because, according to her, he viewed her health status as related to race, generating an interpretive fallacy that precluded greater care with Yvette's potential medical situation.

Case 2. "I wanted a peaceful birth"

Prior to being a stay-at-home mom when her son, Junior, who was born in 2016, Crystal Rainey was an hourly wage employee at a social services agency that serviced autistic children; where, she said, she was "putting her psychology degree to good use." After chatting for a while, I asked 28-year-old Crystal to tell me her birth story. Crystal began by saying she was well aware that when people meet her, they think they have met a teenager. The relevance of this remark became clear, later. Crystal described the factors that influenced how she wanted to give birth: because Black people are subjected to policing, Crystal expressed fear that she might lose her child or husband to violence. Also, Crystal's knowledge about Black women's negative experience with the medical system contributed to her researching different birthing options.

She had decided on an alternative birth, specifically a homebirth. However, her husband was nervous about her not having the baby at a hospital, so they settled on having a doula and a delivery at a birthing center. With her doula, Adowa, Crystal created a birth plan that did not include Pitocin nor a C-section. Crystal wanted immediate skin-to-skin contact after the baby's birth and to breastfeed, which most professionals suggest begin within one to four hours after birth. Crystal was determined "to have a peaceful birth," which would symbolize the kind of relationship she and her child might have (Davis 2019).

When Crystal went into labor at 40 weeks, she called Adowa and then went to The Birthing Center. Shortly after her arrival the birth center staff transferred Crystal to the Emergency Room of a local public hospital before Adowa arrived. Crystal had meconium stained fluid and staff at the birth center were worried about the baby having meconium aspiration, which is when a newborn inhales their first stool. Crystal said that the Emergency Room was chaotic and that it looked like an apocalypse. For example, there were people with gunshot wounds and there was blood everywhere. She was glad to finally be assigned a room. There, Crystal met the Black female obstetrician who was to attend to her birth, who Crystal described as "nasty." Crystal mentioned that she had a birth plan and that her doula would be arriving shortly, but in response, the obstetrician replied: "It [the birth plan] won't be honored." Crystal did not know nor was she told that the plan had to be suspended because of the threat of meconium aspiration, which can result in fetal distress and lead to an emergency C-section. Unaware of these consequences and without the presence of her doula to mediate interaction with the obstetrician—who most surely would have been helpful in explaining the situation—Crystal pushed back and kept insisting that they stick with the birth plan and her doula arrived too late to advocate for her. Everything Crystal did not want to happen, happened. She recalled, "It was the typical stuff that a hospital does that I had wanted to avoid." Crystal received Pitocin; she had an epidural, and then a C-section.

When Junior, named after his father, was born, Crystal saw him briefly. Then the hospital staff whisked him to the NICU because, they said, meconium was present in the amniotic fluid. Crystal later discovered that Junior had not inhaled the meconium. In Crystal's opinion, the hospital kept him in the NICU for five days as punishment to her for making demands about her birth plan. Crystal felt that the doctors viewed her as "just another young Black girl who could be ignored," and they kept her son in the NICU because she had insisted to have some say in her birthing. "Maybe I am wrong," Crystal said. But her husband and her doula shared her suspicion. Through a barely audible voice, she recounted:

> It was like he [Junior] was in jail. The NICU was far from where I was, I had just had a C-section and I had to walk to a different floor to see him. The doors were heavy and it was hard because I did not have abdominal muscles. I also wanted to breastfeed on demand. I would go up there, but they would send me away and tell me to come back. But it was hard to move.

In the days following Junior's birth, Crystal inquired why her son was in the NICU. The first day a resident dismissively told Crystal, "Because we have to monitor him." On the second day she asked a different resident, and he said he was unsure but would check Junior's file which included a lung scan. After the resident told Crystal that Junior's lungs looked typical for a healthy baby, she said,: "So, if he looks like a typical newborn, why is he still in here?" Crystal also asked NICU personnel why Junior was on an IV. A NICU staff member said that Junior was not receiving enough fluids from her breastfeeding. "Thank God, I had attended all of the childbirth classes because I asked them 'Can't you measure if he is getting liquids through his diaper? If he is peeing, then we know he is getting liquids.'" According to Crystal, after this comment, the medical staff responded, "Oh, yeah, you're right."

Crystal's experience further illustrates the obstetric racism paradigm. We can begin with her concern that she looked young and could be subjected to stereotypical ideas that circulate about single Black pregnant teenagers. The legacy of the "pathological" Black family is a narrative many Black women can recite and their reproductive "misbehavior" has a sordid history alongside Daniel

Patrick Moynihan's 1965 report on the "disorganized" Negro Family (Solinger 2007). The seeming lack of information Crystal received, her awareness of the negative representations that circulate about young Black women, and the ways she felt disrespected, and treated with hostility, colluded to produce obstetric racism.

Finally, Crystal sensed that Junior's stay in the NICU was longer than necessary as a penalty for her being forthright about the kind of birth she wanted, as confirmed by both her husband and her doula. In light of Crystal's earlier comments about the policing of Black life, it is not surprising that she viewed her son's stay in the NICU equivalent to being in jail. Whether or not the hospital was punishing Crystal by keeping Junior in the NICU, the experience of being separated from her son, was a reminder of the tenuousness of Black familial bonds. Those bonds have been and continue to be shredded by institutional interference such as foster care and medical systems (Roberts 2002; Silver 2015). Moreover, Crystal's anticipation of the violence her child will face as a Black person, aligns with the ways that Black people navigate risk through a deep and embodied understanding of structural inequality.

Case 3. "I can read between the lines. It was racism"

Jessica Carter grew up in the Midwest although her parents are from West Africa. Jessica, who is in her 30 s, has one son, age six, whose name is Adante. In 2011, Jessica had recently completed college and was offered a job in Atlanta, Georgia as a project manager for a utility company. She became pregnant and although she knew very little about birth work, or birthing, Jessica says she conducted research and along with input from family and friends, decided she wanted limited medical interventions during her labor and birth. Unable to secure the services of a Black midwife and doula for a homebirth, Jessica ultimately chose a midwifery practice that had five or six midwives, all of whom she "loved" except for one, a white midwife named Linda.

Each time Jessica met with Linda for check-ups, Linda expressed surprise that Jessica had such a good job. This led Jessica to state that, "Linda was racist." When I asked why she thought this was so, Jessica said, "Look. I grew up as Black woman in America and I know what those kinds of comments mean. I can read between the lines. It was racism." According to Jessica, the unspoken words trailing Linda's inquiries was that Jessica had a good job "for a Black person." Jessica was forced to negotiate Linda's constant surprise that Jessica was highly educated and well-employed, interactions which led to distrust. Jessica hoped that a different midwife would be on call when she went into labor.

Because Jessica wanted to minimize medical interventions, she labored at home for as long as possible with her doula and her husband's support. When she felt it was time to deliver Jessica called the midwifery practice to check in. Linda was on call and in Jessica's opinion, Linda was inattentive. As her contractions started coming more regularly, Jessica called Linda again. Linda asked the doula to check Jessica's cervix to see how dilated she was, although this is not approved practice for doulas: they are *not* supposed to perform medical exams.

Jessica went to the hospital and continued to labor for 10 hours. Linda was not present during the earlier stages but showed up near the end. Jessica felt abandoned, left in the hands of the hospital's medical staff who undermined her autonomy to give birth the way she envisioned. Medical staff attached Jessica to a fetal monitor, which limited her mobility, and she was given Pitocin: "None of this was what I wanted. And when Linda finally did show up, she was barely doing the job she was supposed to do," that is, to help Jessica manage her labor and delivery. The final straw came after the vaginal delivery, when Jessica sustained a second-degree tear. Linda proceeded to stitch Jessica without the use of numbing medication: a practice which I think is reminiscent of nineteenth century gynecological abuse by physician Dr. J. Marion Sims, who subjected enslaved women to painful experiments without numbing medication in the interest, allegedly, of "advancing" gynecological procedure (Cooper Owens 2017).

Layers of obstetric racism constitute Jessica's birth story. Jessica was frustrated with Linda's preoccupation with her employment status, which she viewed as an expression of "presumed

incompetence." Presumed incompetence is when the dominant society assumes that members of a minoritized group could not possibly achieve success (Gutíerrezy Muhs et al. 2012). Such disbelief, articulated as surprise and wonderment at the accomplishments of the person of color, is a passive form of aggressive disrespect or micro-aggression. Linda's near abandonment of managing Jessica's labor and delivery could be attributed to Jessica being viewed as too assertive, resulting in medical providers closing rank on a patient. Conversations with two nurses and one doula, all of whom were white, revealed that medical professionals are sometimes aggravated by patients or family members who challenge their authority. Additionally, "there is an extra layer of aggravation [among medical professionals] if the person challenging is Black. I have seen that everywhere I have worked," said Lee who has been a nurse and nurse administrator for 30 years. "In my mind," she continued, "I can hear them thinking that the patient is stupid. That is disrespectful and it is racism." Josie, the 30-year-old doula who shared Michelle's story with me, said that in her experience, when Black women express wanting to have control over their births, "some nurses and doctors, regardless of the medical professionals' race, punish Black moms. It is like they don't deserve to have the kind of birth they want." Beyond being disrespectful, Jessica included in her list of Linda's violations abdicating her responsibility by asking a doula to conduct a physical exam, therefore placing the doula at risk of losing her certification; and being absent during the initial stages of Jessica's labor, which left Jessica vulnerable to the medicalization processes that she had tried to avoid. Tethered to technology and medicalization, Jessica maintained that all of the procedures she underwent were conducted without her consent. These incidences—presumed incompetence, disrespect, interventions without consent, and painful procedures—were all, in Jessica's view, racially motivated and examples, therefore, of obstetric racism.

Disrupting obstetric racism

Rarely, if ever, have Black women's reproductive lives been respected. In terms of pregnancy and birth outcomes, medical care is most certainly affected by race (Grant 2016). Resuming the role that Black women have historically held as midwives—after having been forced into exile in the nineteenth and twentieth centuries as obstetric medicine became established (Wilkie 2003), doula and midwifery care are flourishing (Cruz 2015). Among those interviewed, doulas and midwives especially seek to disrupt the technological and medicalized dominance of pregnancy, labor, and birthing care (Rothman 2015). Their work reflects a reproductive justice approach, which means they support and strive to help women maintain personal bodily autonomy, chose to have or not have children, and parent in safe and sustainable communities (Ross and Solinger 2017). It also includes participating in planning a birth on one's own terms.

Birth workers in this study were fully aware of racially disparate outcomes due, for example, to induction and C-section delivery rates (Amnesty International 2010; Roth and Henley 2012). And most birth workers interviewed view these disparities *as a result of racism* and the medicalization of birthing, which is differentially choreographed on Black women's bodies. Resisting the disempowering medicalization of birth, midwives and doulas said they provided care to help reduce premature births, and to reduce infant and maternal mortality and morbidity.

Rukiya, a 35-year-old Black woman from North Carolina, started a grassroots organization to support women of color who cannot afford doula services. Trained as a doula and a midwifery assistant, Rukiya also has her own private doula practice. She said: "[Black women] have been doing this [assisting with births] for generations. It is important to continue that tradition." Although she serves all women, Rukiya prioritizes Black women, and forms trusting relationships to help them feel safe during pregnancy, labor, and birthing. She focuses all of her attention on her clients, because she is responsible only to them since her caring and assistance is not mediated through hospitals or incentivized by profit. Rukiya pointed out that "women need someone with them who has their back, someone who cares." For instance, it is crucial to understand that if a woman has been raped, that experience influences the treatment they should receive during the birthing process.

While some birth workers offer emotional support based on knowing each pregnant person's life circumstances, midwives offer a standard of care and skillfully assist in labor (O'Uhuru 2013; Rothman 2015). Along with doulas, they know techniques to help ease the pain of a contraction. Their knowledge also includes knowing what positions are best to help "ease a baby out" (Rothman 2015:16) and how turn a breech baby. The midwives I interviewed recognize the benefits of waiting for a woman to give birth on her body's time and are wary of using interventions too quickly unless there is a risk (e.g. meconium staining). I saw the temporal conflict between hospital staff and midwifery knowledge at one hospital in Minnesota. Idalia was in labor, and an obstetrician came in to inquire if the mother should be given Pitocin to speed up labor. Jill, the midwife who I was assisting, said: "no, let's just be patient, let's give her body time." Twice more the obstetrician came in to pressure a decision, but Jill was steadfast in her belief that Idalia just needed time. An hour later, Idalia gave birth, without intervention, to a beautiful baby girl.

Most midwives believe that positive reproductive outcomes involve providing people with information so they feel empowered to make decisions. Nubia is one of those midwives. Nubia is a 39-year-old Black doula and a certified midwife. She and I have co-led childbirth education classes in New York, in a community that is dominated by one hospital that many women and birth workers consider to be a hostile environment for giving birth. Our goal is to share knowledge so that women and their families understand what happens during pregnancy and birth.

Faced with the problem of addressing Black women's birth outcomes and how Black women are treated by medical professionals, Nubia notes that addressing racism begins with clients being armed with information to make informed decisions about continuing or ending a relationship with a provider. Nubia says: "I always let them know they do not have to continue to go to that person. I open their eyes…I get people to investigate the hospital, to ask questions. For example, does the hospital have a high or low vaginal birth rate after C-section (VBAC rate)? Does the hospital have midwives? Will there be constant fetal monitoring?" The answers to these questions point to if a hospital and a woman's OB/GYN view and respect the autonomy and rights of people who give birth. Further, the answers to these questions, are often scaled in relation to race.

Nubia and other midwives who I interviewed teach women to listen to their bodies and serve as an advocate for women: "I go with my clients to prenatal visits so they can be supported in asking questions to ensure that their concerns are addressed," said Nubia. This kind of care focused on prevention *throughout* the pregnancy results in better outcomes (Kozhimannil et al. 2016). Rukiya and Nubia are among the birth workers who have worked with mothers across class and race, providing what they call, holistic attention, and care. Cultivating skills to assist throughout a pregnancy, labor, and birthing are fundamental aspects of birth work and addressing adverse birth outcomes. Additionally, listening to clients and understanding the complexities of their home life, their past, and experiences that can influence a pregnancy can minimize the likelihood of obstetric racism that so often accompanies highly medicalized births.

Conclusion

US-based Black women's descriptions of medical encounters during prenatal care, labor, and birthing illustrate how their interactions constitute obstetric racism, and force us to consider the callousness with which some Black women are treated. The context in which women interpret those experiences is the result of being knowledgeable subjects who have lived their lives in a country where the legacies of racism, evidenced by the racial capitalism of enslavement, segregation, and medical experimentation, influence their understanding of the treatment they receive. Black women's stories mark the ways racism hovers over and disrupts their pregnancies, labors, births, and postnatal encounters. Neglect, lack of information, dismissiveness, disrespect, and interventions without explanation, permeate their maternal care and coalesce into obstetric racism.

Obstetric racism is not new, but rather, it is entangled with histories that shadow contemporary expressions of medical racism deployed on Black women's bodies. The way that Black women have been

demonized, stereotyped, violated, and policed in the past, is consistent with contemporary medical interactions and operate as reminders of that past. Even nurses and birth advocates point out that Black mothers experience racism because they are disciplined by medical practitioners. The violence of obstetric racism is that it ignores the collective risk that anti-black racism exerts on the lives of Black women and their families. Whereas the medical establishment does not readily admit the structurally embedded risks that Black patients face, by contrast, birth workers who begin their relationships with clients who want prenatal care, understand those risks, and attempt to ameliorate them.

The reproductive experiences of Black women like Michelle, Yvette, Crystal, and Jessica highlight key examples of obstetric racism—from what Josie described as Michelle's experience of birth rape in Florida, to the doctors' unwillingness to address Yvette's concern about the multiple risks that probably led to premature birth in North Carolina. From Crystal feeling dismissed, disrespected, and undergoing procedures that she did not want and were not explained to her in New York, to Jessica's report of a midwife and medical professionals in Georgia who overrode her desire to have a minimally medicalized birth. It did not matter where these women lived or what year they delivered: obstetric racism constituted their medical encounters. Their stories echo those of many Black women whose birth outcomes are at crisis levels. And while the cases presented here illustrate the potential harm that Black women experience, birth workers like Rukiya and Nubia seek to interrupt the practices of medicalized care that do not necessarily serve Black women's interests.

Although obstetric racism draws attention to Black women's interactions with medical professionals who wield power that exacerbates their reproductive vulnerabilities, it is useful in other contexts to clarify the experiences of people with similar histories of reproductive injustice. For example, like US-born Black women, Indigenous women in Bolivia have long standing birth outcomes and prenatal care experiences that are explicitly connected to being racialized. There are reports of doctors referring to indigeneity as a risk factor that influences maternal-infant life (Morales 2018). Obstetric racism is an important framework for analyzing the reproductive exploitation of Native, Puerto Rican, and Mexican women. For instance, Native women's reproductive pasts have included involuntary sterilization by the federally funded Indian Health Service (Volscho 2010). Puerto Rican and Mexican women have also been exploited through sterilization abuses (Lopez 1993). While obstetric racism takes into account the feelings and perceptions, of racism in reproduction, it most profoundly points to the ways that patient care can end up being violent.

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