Reclaiming Our Power: Black Women Resisting Medicalized Birthing

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by

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This project explores Black women's reclamation of power, autonomy, and consent outside of the medical system during and after pregnancy. Through the use of midwives and doulas, Black women throughout the United States have started to return to traditional methods of birthing as a result of the rising U.S. maternal mortality rate, and the increasing racial disparity in birth outcomes. Reclaiming power, autonomy, and consent, are important factors in dismantling the systemic and historic racism ingrained within the modern U.S. medical system. This project examines the historical medicalization of birth as an entryway point for this discussion. Starting with a discussion of U.S. slavery and moving into the present, this project investigates the history of gynecology and the rise and fall of midwifery in the United States. As part of my investigation, I conducted interviews with midwives and doulas in the Texas area about the new rise of midwifery. Ultimately, the main objectives of this project are: 1) Analyze the medicalization of birthing in the United States 2); Explore how midwives and doulas empower Black women through birth work and the midwifery model of care; and 3) Address the importance of patient power, autonomy, and consent within and outside of the medical system.

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Introduction

Why I Write

I stand nervously in a crowded elevator amongst a well-dressed group of soon-to-be medical students. As a part of the medical school interview process, we are in the midst of touring the hospital affiliated with the school. This hospital welcomed 242,640 emergency patients visits and 12,583 births in 2018, and attempted to save the life of the 35th president in 1963. Recently renovated, the building boasts state-of-the-art technology, modern architecture, energy efficiency, and some of the best medical training in the country. The elevator comes to a slow, cool stop. Fourth year medical students relay some facts about the hospital while guiding us to a waiting area that overlooks the downtown city skyline.

Looking down, I see the moving line of cars adjacent to the entrance of the hospital. Returning my attention to the student tour guides, I take in my surroundings. The abrupt end to the carpet of the waiting area brings about the beginning to the bleached, speckled linoleum leading to the swinging double doors of the hospital maternity ward. Through these double doors the stench of antiseptic and ethanol permeate, the walls shine with a jaded white, evoking a sense of purity and cleanliness, the low hum of commotion reveals the movements of the nursing staff. Nurses buzz in and out of rooms, the physician appears every once in a while adorning their esteemed long white coats. Trailing behind the head physician is an assortment of medical students, interns, and residents, all aspiring to become that physician. The corridor of the maternity ward as plain as it looks, and as clean as it

smells, represents joy, bliss, and life for some. This is probably the happiest place in the hospital, save for the food court; this ward of less than 50 beds, birth bouncing bubbly babies. For others, this hall, this ward, signifies death, theft, and the legacies of slavery. In this hall birth means an illness, a medical procedure. The cost of birthing a healthy baby starts in the thousands of dollars –for a premature or sick baby, the price starts at tens of thousands of dollars. The medical system of the United States –a beacon of medical discoveries and a stalwart of medical research- harbors open secrets revealing dire inequalities, racist, sexist, classist, and ableist histories, and an almost purposeful failure to do no harm to certain populations, especially Black women.

Positioning myself as a future medical professional I believe in the medical system. I believe in hospitals, physicians, nurses, and other practitioners that work tirelessly throughout the week to save lives. I write this not to discredit medicine or instill fear, disdain, or contempt for physicians. Rather, I write this for…

Shalon Irving. Kira Johnson. YoLanda Mention. Alyne da Silva Pimentel. Rafaela Cristina Souza dos Santos. Derline Derilus. Traci Burnley Chocol. Nivia Lashaundra McIntosh. Tanisha Malloy

And the countless of other Black women resting in power.

Elise Salazar. ZaKyia Bell-Rogers. Donielle Bell. Simone Landrum. Keisha Phillips-Mitchell. Erica McAfee. Aprill Coleman Joneigh Khaldun. Serena Williams.

And the countless of other Black women fighting for their voice to be heard.

These women, past, present, and future, give me the strength to explore the pain in their stories, to empathize with the continuous struggle for equity, and most importantly, to celebrate their voices, power, and creativity.

This thesis is an exploration of Black women's choice, power, and radical existence in a historically oppressive system. The modern U.S. medical system traditionally places power in the hands of wealthy white men who have economically and politically benefitted and promoted the ideas of white supremacy in science and medicine. As a result, the medical system present in the United States is rife with systemic racism that continues to have fatal and unethical consequences. These consequences are most seen in the specialty of gynecology and obstetrics, where historically, white, male obstetricians and gynecologists have systematically stripped and reduced the power, autonomy, and instinct from Black women's reproductive and birthing choices. Reclaiming that power, autonomy, consent[1] and instinct are vital in not only Black women's survival and livelihood, but also in rejecting white supremacy. In this sense, we see black women reclaim their power, consent, and autonomy during childbirth outside the sphere of the medical system through their use of midwives and doulas.

[1] I will define these concepts later on in the introduction

Definitions

Throughout this thesis, I mention words such as power, informed consent, and autonomy, all of which require basic definitions for understanding the context in which I claim Black women reestablish their control of such concepts outside of the institution of medicine. In the context of the medical system, informed consent and autonomy are critical to understanding the history of medicine, the role of ethics in medicine, and the disparity in health outcomes that we see today.

The 1979 Belmont Report, made in response to several unethical biomedical research studies like the infamous Tuskegee syphilis study, established precedent for recognizing biomedical ethics, and addressing the power dynamics between patients, physicians, and researchers in medical research. The report identifies three core principles that are relevant to biomedical research, but are nonetheless critical to medical practice – justice, beneficence, and the respect for persons (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978).

Respect for persons, the most applicable principle to this thesis, signifies the incorporation of "two ethical convictions" with the first being that individuals should be recognized and treated as "autonomous agents" and the second that individuals with diminished autonomy are entitled to protection (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978). In this sense, the respect for persons demands an acknowledgment of individual choice, freedom, and autonomy. Beauchamp and Childress (2009), two

leading philosophers in the field of bioethics, define autonomy an individual's ability to act freely "in accordance with a self-chosen plan" (2009). Autonomy requires the individual's intention, understanding, and decision made without coercion. Without each of these aspects in conjunction, there is a violation of autonomy.

Beauchamp and Childress (2009) ultimately state that in order for patients to truly have autonomy, they must have informed consent. An updated understanding of consent has shifted from the physician's obligation to disclose information to patient understanding (2009). Informed consent goes beyond the traditional role of consent, in which a patient, person, or subject, agrees to a procedure or signs a waiver. Rather, informed consent relies upon a competent patient fully understanding not only the benefits of a procedure, but also the consequences; and while understanding the risks and benefits, the patient must agree without intimidation, coercion, or undue influence. Without informed consent, patients and medical subjects do not have enough knowledge and information about procedures to make a truly autonomous decision that is required for the core principle of respect of persons.

Power, unlike informed consent and autonomy, is not a traditional principle of bioethics and for my purpose, the most important of the three. I examine the concept of power through a Black feminist perspective, utilizing Patricia Hill Collins' (2002) definition. Power can be something that groups possess, and ebbs and flows with transitions of social movements, revolutions, or political changes. In that sense, power is often a dynamic that is often looked at through a dialectical relationship

linking oppression and activism. In the case of this thesis, the power dynamic exists as the dialectical relationship between physician and patient, and the current birth justice movement. Another way we can look at power is as "an intangible entity that circulates within a particular matrix of domination and to which individuals stand in varying relationships" (Collins 2000). This approach to understanding power highlights the individual experience within a system of domination, and acknowledges that an individual's power is in flux depending on the situation. Both approaches to understanding power are necessary to comprehend the ways in which Black women reclaim control of their power, individually and collectively, outside of the medical system, and to recognize how the institution of medicine is inherently linked to white supremacy and other forms of domination and oppression.

Methodology + Context

This thesis is a combination of a historical analysis of Black women birthing in the United States and an ethnography of midwifery and doula practice in the United States. Part One concerns the medicalization of birthing, starting in the late 19th century up until the demise of the midwife in the middle 20th century, and how that history has led to the current maternal mortality crisis experienced by Black women in the United States. The first chapter of Part One serves to explain and explore how the U.S. medical system has intrinsic ties with the institution of slavery and white supremacy, and how it is predicated upon exploitation and

experimentation on Black people. The second chapter investigates the decline in midwifery services within the United States. The third chapter reveals how the history of the medical system, specifically gynecology, and the decline of midwifery, has led to current racial disparities in maternal health outcomes. Part Two of this thesis looks at how birth work activism works to oppose the racism, classism, and sexism ingrained in the medical system. The fourth chapter explores the fields of midwifery and birth companionship through ethnography. I examine what makes activist birth work different from the medicalized birthing system, and how Black women use midwives and doulas to reclaim their power, consent, and autonomy.

I analyze the medicalization of birthing in the United States through a Black feminist perspective. I acknowledge how intersecting oppressions combine to form a new experience of suffering for pregnant Black women. Institutions, like the hospitals, insurance companies, and the medical colleges that make up the medical system, especially in the United States, are inherently based upon a white supremacist and neoliberal history that still operates on exploitation, experimentation, and commodification of Black people. Although this thesis focuses primarily on the United States, the topic at hand is not singular to this country, but rather a transnational issue rooted in the legacies of slavery and colonialism –the racism, classism, and sexism, that affect Black, Indigenous, and poor women around the globe.

We see the transnationality of this issue when in November 2002 Alyne da Silva Pimentel Teixeira, a twenty-eight year old Afro-Brazilian woman walked into

the local health center, six months pregnant and complaining of severe nausea and abdominal pain. The obstetrician present prescribed anti-nausea medication, vitamin B12, and a medication for vaginal infection, which Alyne started to take immediately. However, over the course of two days, her condition only worsened. She returned to the health center for her scheduled blood and urine tests at 8:25AM on November 13, 2002, only to be told three hours later that her baby had died in utero. Two hours later, Alyne was induced, and by 7:55PM she finally delivered her stillborn baby, but was left disoriented and weak afterwards. Fourteen hours after her delivery, hours of severe hemorrhaging, vomiting blood, low blood pressure, disorientation, and general weakness, Alyne underwent surgery to remove parts of the placenta and afterbirth; however, Alyne's condition continued to worsen. The doctors ordered Alyne to be transferred to a private, more equipped facility, but the hospital refused to transport her, leaving Alyne to wait and deteriorate over the next eight hours –eventually leading to Alyne going into a coma for the last two hours. Alyne's story tragically ended on November 16, 2002, when she died at 7PM as a result of "digestive hemorrhage" caused by the delivery of her dead fetus (Committee on the Elimination of Discrimination Against Women 2008).

The tragic narrative of Alyne da Silva Pimentel Teixeira mirrors experiences Black women have across the world while pregnant or giving birth within medical institutions. Her story is not exceptional, but nonetheless appalling and preventable. The delay in treatment, the refusal of services, and the overall lack of consideration for Alyne and her family speak to why this thesis is important and relevant. Black

women have been consistently not listened to, and the consequences are apparent in the disparities within the maternal and infant health outcomes transnationally. So in the following chapters, I will attempt to prove why there must be a redistribution of power, consent, and autonomy, from the physician and nurses back into the hands of patients whose lives and health depend upon having control over their health choices**.**

Part One:

Evolution of Birthing While Black in America

" I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art.... Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free."

-Hippocrates of Kos (Murphy 2003)

Two hundred thirty fresh white coats standing on the shoulders of the first year medical students gleam under the fluorescent lights of the auditorium. The loud hum of "I swear to fulfill, to the best of my ability and judgment, this covenant…" fills the room, signaling the symbolic moral standard to do no harm, to respect patients, and to treat when possible. Every year across the country, thousands of medical students stand before their friends, family, and professors, and swear by the Hippocratic Oath. This ancient oath signifies the birth of modern Western medicine, and has transcended all eras of societal transformation. Essentially stagnant and unyielding, the Hippocratic Oath should reflect our Western ideals and moral principles that we have learnt since the Ten Commandments. From the doctors at slave auctions to the attending physicians at teaching hospitals, this Oath binds them to a certain moral standard; however, biases, racism, and socio-political climates have

shaped the way these physicians past and present treat their patients. In the first half of this thesis, I will analyze how the legacies of slavery, racism, and the birth of modern gynecology manifested into the current poor maternal health outcomes for Black women.

Chapter 1:

Enslaved Birthing

To see what no man had seen before is to explore an unknown frontier, to lead the way as Magellan, Lewis and Clark, Aldrin and Armstrong have done in navigating the world, the Western coast of America, and the Moon. When we think of the pioneers –navigators of unchartered territory, so to speak- of medicine, we think of names like Jonas Salk, Charles Drew, and Michael DeBakey. Each of these figures *seems* from our medical history books to have relatively unproblematic histories. Less mainstream yet medically important figures like Albert Kligman, Chester Milton Southam, and J. Marion Sims, represent the more dubious aspect of medical history, research, and discovery. These figures, shrouded in clouds of ethics violations, ultimately shaped the way we understand and practice dermatology, oncology, and gynecology. Kligman, the co-inventor of acne medication Retin-A, performed systematic skin fungi related experiments on Philadelphia prisoners –famously stating when he first went to Holmesburg Prison, "All I saw before me were acres of skin. It was like a farmer seeing a fertile field for the first time" (Meyer 1999). Chester Milton Southam injected live cancer cells into prisoners and disabled patients without their informed consent to see if the cancer cells would grow or die (Mulford 1967). J. Marion Sims, as I will later delve into, birthed modern gynecology through experimentation on slave who had no power to consent to his experiments (OWENS 2017). Each of these figures and their inglorious breakthroughs reflect the results of a

white supremacist, capitalist institution born out of slavery that has historically relied upon an abuse of power and a rejection of humanity and respect for patients. This chapter explores Western medicine's proximity to slavery, modern gynecology's dependence on slavery to provide bodies for experimentation, and medicine's role in state surveillance of Black women's reproductive health.

The way slavery in the Southern United States operated, required access to various facets of society. It was an institution that relied upon laws to legally validate the ownership of persons, capitalism to maintain a profit and a system of labor exploitation, and racism to socially and morally condone the dehumanization of Africans and enslaved African-Americans. The ingrained nature of slavery in Southern society permeated into the larger context of American medicine. Physicians appeared at slave auction to assess the health of captives, experimented and perfected surgical procedures on slaves, worked in hospitals located on plantations, wrote in national academic and medical journals espousing their beliefs on the inferiority and justification of slaves, vaccinated, treated, and insured slaves as a means to protect their assets (Fett 2002).

Dr. A. P. Merrill, a prominent antebellum physician specializing in "negro medicine" described plantation medicine as, "the preservation of the health of slaves is so plain a dictate of both interest and mercy that no planter is to be found in our country who does not aim to practice it as an object of importance" (Kenny 2010). This sentiment, reflected by many antebellum physicians, highlights the economic and self-interest aspect of providing slaves healthcare. Plantation hospitals and

infirmaries came to represent a crucial part of the plantation economy and Southern society. These hospitals were not the only example of medicine's exploitation of Black people in the antebellum South; southern medical colleges used the enslaved as objects of dissection, experimentation, and learning. Negro infirmaries in large urban areas existed to treat the "peculiar" biology of the enslaved and free blacks who lived in cities, or who worked on plantations that did not have hospitals. Every aspect of medicine in the slave South, from medical school to hospitals, seized the opportunity to further exploit Black individuals as a means to further medical research, innovation, and discourse.

The physicians of the South, often upper class white men, were large stakeholders in maintaining slavery and promoting racist ideologies in medical practice. Besides, Dr. A.P. Merrill's insistences of the peculiar nature and disease of Black people, there was Dr. Samuel Cartwright who coined diseases like *drapetomania* and *dysaethesia aethiopica* (Fenner 1851). Both diseases sought to explain enslaved resistance like running away or slowing down work, while also justified the treatment of slaves through violent punishments and paternalistic condescension. François-Marie Prevost, a French physician who relocated to Louisiana from Haiti after the Haitian revolution, pioneered the Cesarean-section after experimenting solely on enslaved women (OWENS 2017). The "father" of the ovariotomy or the surgical removal of the ovaries, and alleged grave robber Ephraim McDowell successfully removed a twenty-pound ovarian tumor from a white woman, but spent his later years experimenting on four Black women

suffering from ovarian tumors in Danville, Kentucky (2017). These prominent physicians based their medical practice and research on the lack of consent and powerlessness of slaves. They embody the intertwined history of American medicine, specifically obstetrics and gynecology, and slavery. Without the enslaved to experiment on, the economic interest of slave owners, and the disregard of consent and Black life, these physicians and many others like them, would not have had the freedom to make the medical advancement that they did.

The role of physicians and their proximity to the slave-owning class created a dynamic that distorted the traditional patient-physician relationship when treating enslaved persons. The consent required from free white patients, ceased to exist for enslaved Black patients. According to the American Medical Association's 1847 Code of Medical Ethics, there should be reciprocity between the patient and physician. Patients have a duty to "attentively and respectfully listen" to their physicians, while doctors have a duty to "exercise the greatest kindness…avoid expensive complications and tedious testimonials… investigate into both the physical and moral state of the patient" (1847). With their white, free patients, physicians obtained consent, maintained privacy, and to an extent displayed some respect of autonomy for these patients. In other words, the patient-physician relationship did not display an extreme discrepancy in power, although there was still a power differential. However, physicians treating enslaved Black patients, sought consent from their owners, shared patient information with owners, and disregarded patient's capability of choice. Enslaved patients were powerless in the antebellum

South, their power, consent, autonomy, and perceived humanity lied in the hands of the slave owners. In Sharla Fett's *Working Cures*, she describes one particularly graphic incident of a physician removing a Black woman's breast despite her apparent and obvious objections.

> "More appalling still was the 1845 account of an operation on a New Orleans 'negro woman' for a hardened mass in her breast and lymph nodes. According to the author's dispassionate description, 'She was frightened nearly to death, and could not be prevailed on to submit with any composure. While she was writing and screaming with all her power, Dr. S., with characteristic firmness, proceeded with his incisions, and removed the entire mamma [breast], as also an indurated axillary gland.'… Surgery proceeded in the face of her unquestionable objection and terror"
>
> (Fett 2002, 147)

The continuation of the procedure by the physician is an example of how physicians disregarded Black women's consent and autonomy, through an abuse of authority and power.

The screams of Dr. S' patient in 1845 New Orleans echoed the screams of Anarcha, Betsy, and Lucy in Montgomery, Alabama during that same year. These three enslaved women, bounded by slavery's dependence on breeding, led to discoveries that revolutionized the field of women's medicine and gynecology. These women were the mothers of modern gynecology, the patients, and the experiments, of J. Marion Sims. In Sims' autobiography, he exclaims that he "saw everything as no man had seen before." This pioneer directly benefited from a system that did not grant slaves autonomy or consent, and viewed Black women as a means of reproducing the next yield of slaves. The closing of the Transatlantic Slave Trade to the United States in 1808, brought along the need to maintain a slave

population through forced reproduction and breeding. As forced breeding allowed the perpetuation of slavery, slave owners held an economic interest in Black women's reproductive health, and thus governed Black women in ways that they did not White women (Roberts 1997). Some slave owners would manufacture relationships between slaves, while other slave owners would rape their female slaves. Either way, this dominion over Black women's reproduction set the foundation for state interest in Black women's reproductive health.

As necessary as Black reproduction was to maintain the slave system, pregnant Black women were laborers before they were mothers. These women were sites of reproduction and production of the slave labor force and capitalism. The duality of the role of Black women in slave society often meant that their status as a field worker conflicted with the requirements of birthing and childcare. As Dorothy Roberts puts it in *Killing the Black Body*, "the relationship between Black women and their unborn children created by slavery is the first example of maternal-fetal conflict in American history" (1997). Roberts defines maternal-fetal conflict as a term "to describe the way in which law, social policies, and medical practice sometimes treat a pregnant woman's interest in opposition to those of the fetus she is carrying" (Roberts 1997). Black women were valued as laborers and reproducers, but often times these labels were applied to Black women separately despite sometimes existing as both simultaneously. We see this with enslaved women "employed in plantation labor until within a few hours of their delivery," and in some instances where children were born in the fields (Johnson 1981). One

account from former slave, James Lucas, reveals that after he was born in the cotton field, "de wimmin fixed my mammy up so she didn' hardly lose no time atall" (Federal Writers' Project: Slave Narrative Project, Vol. 9, Mississippi, Allen-Young n.d.). Another former Mississippian slave, Jennie Webb, recounts "My ma wuked in de fiel's up to de day I was born. I wuz born 'twix de fiel's an' de cabins" (Johnson 1981). Lizzie Williams' memory of a "nigger woman dat was fixin to be confined do somethin' de white folks didn't like. Dey [the white folks] would dig a hole in de ground just big 'nuff fo' her stomach, make her lie face down an whip her on de back to keep from hurtin' de child," speaks to the separation of Black women as laborers and Black women as reproducers (Johnson 1981). The roles of enslaved women as producers and reproducers necessitated a separation of mother and unborn child. The separation meant the rejection of Black motherhood, as Black women's only function in slave society was to produce capital and reproduce the labor force. Not only did slave owners see Black women as their property, but deemed it necessary to have control of their reproductive health, their sexuality, and the discourses on their sexuality and reproduction.

The control of Black women's reproductive health led Anarcha, Betsy, and Lucy to J. Marion Sims, but also established controlling images and stereotypes of Black women that justified the continual state control and interest in Black reproduction during slavery. As Cheryl Gilkes states, "Black women emerged from slavery firmly enshrined in the consciousness of white America as 'Mammy' and the 'bad black woman'" (Gilkes 1983). The images of Black women as the Mammy, the

bad mother, or the seductress, originated from the Western ideal of femininity applied to White women. True womanhood required piety, purity, submissiveness, and domesticity (Collins 2000). Middle class and slave-owning White women embodied these virtues through their domestic activities, loyalty to their husbands and fathers, and commitment to a guise of innocence and religiosity. Black women, bounded by slavery, were not only denied femininity, which positioned them as the Other, but were also relegated to certain stereotypes that justified their enslavement, control, and sexual exploitation.

Patricia Hill Collins' *Black Feminist Thought* expands upon the history, meaning, and impact of controlling images like the Mammy, the Matriarch, the Breeder woman and its contemporary Welfare mother, and the Jezebel (Collins 2000, 80-93). Both the Matriarch and the Mammy focus on Black mothering. While the Mammy is overly caring to her master's children and seemingly apathetic towards caring for her own children, the Matriarch is the bad mother, too dominant and independent, always working, and emasculating the man. The Mammy and the Matriarch deem Black women as unfeminine, as they lack the womanly instinct to care for her children and be submissive to her husband. They depend upon heteronormative ideals and work to perpetuate the patriarchal notion that a woman should be dependent on a man. The Mammy in particular, emphasizes Black women's subordination to Whites, as she is the always tending to the needs of White children and families. The subordination of Black women was an important factor in

physician abuse of power and contempt for Black women's autonomy and consent in medical procedures.

The breeder woman portrayed Black women as vehicles of reproduction. Coming directly out of slavery and Southern slave owners' need to create a self-sustaining slave population after the 1808 ban on the importation of slaves, this stereotype likened Black women's ability to reproduce to breeding animals. Its contemporary, the welfare mother, is a working-class single woman with many children dependent on the state for assistance. The welfare mother and breeder woman, have served as justification to the State interest and intervention in Black women's fertility and sexual health. In a similar fashion, the Jezebel, or the sexually promiscuous Black women, has also been used as pretext for state and white, male interest in controlling Black women's reproduction. In particular, the jezebel image justified the sexual exploitation and assault of Black women –coinciding with the prevailing thought during the antebellum era that 'Black women could not be raped.'

These stereotypes and images of Black women informed and still inform physicians' treatment of black patients. Physicians like Sims prescribed little to no pain medication because 'Black people have thicker skin, and therefore do not feel as much pain'. The stereotypes gave reason to the lack of care physicians prescribed Black patients. White men –slave owners, lawmakers, physicians, and business owners- held control and interest in Black women's reproduction. They utilized this control as a means of terror over Black women, and as a means of gaining capital. Sims, just one example of a physician ingrained in Southern society and its beliefs of

Black women's degeneracy and inferiority, performed thirty procedures without anesthesia on Anarcha over the course of five years, yet he utilized anesthesia when he repaired vesicovaginal fistulas of white women.

Physicians at the time utilized the stereotypes of Black women's sexuality, and conceptions of Black people's biology and susceptibility to diseases, to create a system of medical practice that required experimentation on Black bodies to perfect procedures for White patients. This standard in medical practice created a medical gaze upon which Black people are viewed by White physicians as objects of opportunity for medical research.

Chapter 2:

From Black Midwives to White Physicians

Western medicine is and has been a field based upon social norms and pressures; it is dynamic in the sense that our perceptions of identities ebb and flow with shifts of power and knowledge. Hegemonic notions of race, gender, and sexuality guide the thoughts of the physicians, nurses, scientists, and pharmacists who converge to create the modern American medical system. That being said, the medicalization of birth during the late 19th century and early 20th century in the United States is rooted in sexist, racist, and classist perversions of the supposed objective science of medicine. Prior to the hospital beds with stirrups, the lithotomy position, the advice of men who have neither given birth nor believed in the strength of women, and the prodding and grasping of metal forceps, there were midwives. These midwives based their practice on tradition, the spiritual, healing, and most importantly the woman. The midwife played a pivotal role in Southern society; not only did she catch the babies of slaves, but also the infants of the White mistresses who benefitted from the peculiar institution. Her art transcended racial lines, and therefore permitted her to enter spaces no man or other Black woman could occupy.

> "The midwife delivered babies for African American and white women. She was expected to have some knowledge of the techniques of biomedicine and also to be able to call on God and use the herbal remedies and patent medicines at her disposal. She was a woman, often a mother and wife, but because of her special calling, she transgressed many of the rules and expectations of what a woman should be and do. Few women could leave husband and children at night, or for days on end, un-chaperoned and

> without having to ask permission. She crossed other boundaries –racial, professional, and class-based ones –those that divided life and death, and those that supposedly marked the divide between tradition and modernity in the South."
>
> (Fraser 1998, 43)

Despite the midwife's importance, systematic movements to decrease and limit her practice started in the late 19th century, as there were efforts to bring more births into hospitals and the into hands of white, male physicians. This chapter investigates the systematic invalidation of granny midwifery in the South and the subsequent normalization of hospital births for women of all classes and races in the United States.

The field of midwifery has existed for as long as women have given birth. We see examples of midwifery in the Bible, ancient texts, and classical figures like Socrates' mother, slave narratives, and even early medical journals. The role of the midwife in the United States has traditionally been one of a community leader. Midwives on plantations "represented the high point of authority and control…they bestowed healing among women" (Davis and Ingram 1993). Midwives bore the next generation of a community, and because of this, midwifery was a field that allowed women greater autonomy and control over their actions, education, and capital. They not only provided care and assistance to royalty and nobility, but they also served as access points for perinatal care for poor women who could not utilize the posh services of physicians in the modern centuries (Susie 1988).

The beginning of the midwives' demise played out in different ways in the Northern and Southern United States during the late 19th century into the early 20th century; however, the result was the same –the marginalization of midwifery services. As Debra Anne Susie describes in *In the Way of Our Grandmothers*, the dissolution of midwifery in the Northern United States came as a result of bureaucratic measures to limit immigrant populations and influences (Susie 1988). The downfall of the Northern midwife came at a time of increasingly popular xenophobic attitudes. Academics and politicians frolicked in the fields of Social Darwinism, Eugenics, and nativism, all of which espoused the application of classist, white supremacists suppositions to the social, political, and economic aspects of United States society. These movements sought to limit the immigration and reproduction of certain populations that were considered not white, while also blaming poor health and living conditions on those populations –citing their race, ethnicity, and DNA as the cause for their destitution (Sumner 1883). Nativist sentiments about the lower class immigrant population in northern cities prompted xenophobic legislation such as the Johnson-Reed Act, inspired Margaret Sanger to advocate for birth control and establish Planned Parenthood, and further encouraged the work of eugenicists like Charles Davenport. The goal of these bureaucratic efforts, led by social conceptions of culture, race, and class, was to create a paradigm shift from the "foreign, dirty, poor, ignorant" midwifery practices to the "American, clean, scientific, modern" obstetricians in hospitals.

The rhetoric used to describe immigrant populations in the North paralleled the rhetoric used to describe and address Black Americans in the South. The discreditation of midwives in the South came as a result of systematic bureaucratic measures meant to specifically target Black granny midwives. This process, unlike the relatively abrupt decrease in immigrant populations as a result of federal immigration laws, was a prolonged, well planned, and permanent attack against the Black midwife. The development of the birth certificate, midwifery licensure and registration programs, as well as midwifery education services and programs served as instruments in the invalidation of the African-American midwife in the South (Fraser 1998, 33-39).

The 1902 Act of Congress not only cemented the Bureau of Census as a permanent federal agency, but also permitted the agency to develop, standardize, and collect birth registration for the entire country(Brumberg, Dozor, and Golombek 2012, 408). This was the beginning of federal, standardized vital statistics through birth, death, and marriage statistics. Over the next thirty years, the national birth registration areas in the United States expanded to include the entire contiguous United States. Eventually, the birth certificate came to signify proof of citizenship during World War II (Brumberg, Dozor, and Golombek 2012, 408).

The birth certificate became a legal document and institutional instrument for dismantling Southern midwifery practices due to the fact that it not only required illiterate, rural midwives to fill out the form, but also essentially held U.S. citizenship hostage to those who used the Southern Black midwifery services.

Because Black midwives practiced midwifery through apprenticeship, and not through formal educational programs, there was no emphasis on becoming literate. The books white physicians read to understand obstetrics and gynecology, were not only unobtainable to Black midwives through structural barriers, like legalized school segregation, threats of violence, and lack of funding, but also not needed as midwifery for many Black midwives came as a natural vocation or calling from God.

In a 1948 book entitled, *A Birth Registration Handbook for Colored Midwives*, we see how nurses, physicians, and the state weaponized the notion of citizenship and its connection to the birth certificate. Specifically, Clayton reminds midwives the benefits associated with a birth certificate, ergo citizenship:

> "When you are too old to work you may need an old-age pension to help you out. To get this pension you will have to prove that you are 65 years old. Sometimes this is very hard to do. If your birth certificate is on file in the state health department, it will be easy to do."
>
> (Clayton 1948)

> "It is your duty to register the births of all babies delivered by you. It is not only your duty; there is a law which requires it. A birth certificate can be used to prove a person's right to: Enter School. Collect insurance. Inherit property. Marry. Get social security benefits for blind and dependent children."
>
> (Clayton 1948)

> "Many places of work require a person to show a person a certified copy of this birth certificate before they will give him a job. During the 1st war [sic], defense plants could not hire a person until he had proved he was an American citizen. This was done to protect the security of our country."
>
> (Clayton 1948)

Elizabeth Clayton's words of advice to Black midwives assumes the birth certificate and citizenship of Black Americans equates to the right to work, learn, earn wealth, and marry. This assumption fails to recognize the structural and institutional barriers Black Americans face in access to well-paying jobs, adequate education, and owning a home. Clayton's assumes that Black people during this time had accessibility to acquiring loans, when many banks across the nation refused to lend money under the Federal Housing Authority to hopeful Black homeowners –what we now refer to and understand as redlining. Similarly other benefits of the New Deal that helped white families gain lasting wealth, like the Social Security Act failed to apply to jobs that Black people traditionally filled such as domestic and agricultural work (The Decision to Exclude Agricultural and Domestic Workers from the 1935 Social Security Act n.d.).

Furthermore, this association of the birth certificate and the rights that comes with citizenship reveal the state's intention of control over the lives of Black midwives' autonomy and authority, and the Black community as a whole. As Fraser puts it, the birth certificate "fitted the newborn child to enter properly into American society, its completion superseded other concerns [the family] may have had regarding the ritual entry of child into personhood" (Fraser 1998, 47). This entry into American society mandates an immersion into a white supremacist, capitalist system in which Black people are economically, politically, and socially controlled and limited by the state, and exploited by capitalist entities.

Other means of bureaucratic control over midwifery practice included forced retirement for older midwives, public campaigns declaring midwives as dirty, unclean, and dangerous, and midwifery education and licensure programs (Lee 1996, 7). The emphasis on the cleanliness of midwives and formal training through licensure and education stemmed from the racist notions that Black people are dirty, ignorant, and unskilled –with a particular emphasis on the perceived ineptitude of midwives. These stereotypes of Black midwives, and Black women, stemmed from the controlling images created during slavery, yet contradicted the reality of Black midwifery practice and outcomes. A 1923 report based upon data from Richmond, Virginia stated that the maternal mortality rate for midwife-attended births was 67 per 1,000 while the maternal mortality rate for physician-attended births was 78 per 1,000 (Hudson and Rucker 1923, 300-304). A similar article revealed that from a sample of 767 maternal deaths in the final trimester, with 276 being from urban areas and 491 from rural environments, "puerperal septicemia caused 50 percent of the urban white deaths, 48 percent of the urban colored deaths, 35 percent of the rural white deaths, and 33 percent of the rural colored deaths" (Rothert 1933, 238). Urban white women had greatest access and utilized physician care the most, and had the highest percentage of death caused by puerperal septicemia, which is essentially a infection of the reproductive tract that can be caused by bacteria due to improper hand washing or unclean tools. This fact not only speaks to the baseless, racist argument of incompetency and uncleanliness directed towards

midwives, but also reveals the transition from midwife-attended births to physician-attended births occurred from rich, urban white women to poor, rural Black women. In other words, utilizing an obstetrician was a symbol of power and class that aligned with modernization and the industrialization happening in the late 19th century and early 20th century.

The "Othering" of poor immigrants in the North and Black Americans, especially Black women, reflects society's rejection of anything stemming from non-Anglo roots or classical literature. The notion of modernity in medicine, via the medicalization of birth, obscures the racist roots of what the American medical system and society consider modern. Often times, scientific, technological, and medical modernization means a certain rejection of non-Western concepts of science, technology, and medicine. We see this in the way Western science trivializes and exoticizes traditional Chinese medicine, indigenous medicinal rituals, and herbalism despite their centuries of practice and study. The transition from midwifery to clinical obstetrics reveals the values and beliefs of the dominant American culture. Specifically, we see how the racist sentiments of the post-Reconstruction and Jim Crow eras pervaded into birthing.

Ultimately, physician monitored births in lieu of midwife assisted births in the South exposed a shift of power and control from within the community to further state surveillance and control over poor and Black women's bodies. The transition reinforces the racist, sexist, and classist origins of American gynecology

that relies upon disparate power dynamics, and the rejection of Black women's consent and autonomy.

Chapter 3:

21st Century Black Death

The symptoms of hypertension, pre-eclampsia, eclampsia, pulmonary embolisms, blood clots, hemorrhaging, bacterial infection, septicemia, and complications from a Cesarean section: a headache so painful that your head literally pulsates and you can't open your eyes, blurry vision, maybe even transient blindness, seizures and swelling, shallow and chaotic breaths, hospital pad after hospital pad drenched in blood, a fever causing you to sweat in a 68˚F room, chills and shivers in a 75˚F room, racing heart rate, thready pulse, extreme fatigue, vomiting, diarrhea, severe abdominal pain, and the list goes on.

Every year in the United States, about 700 to 900 women die from complications from childbirth, and nearly another 50,000 women are left severely maimed after nearly dying from said complications (Young 2018). The rate at which women in the United States have died from childbirth has nearly doubled since the 1990s, making the United States the only developed nation with an increasing maternal mortality rate(Kassebaum et al. 2016). Standing at a national average of 26.4 deaths per 100,000 live births in 2015, the United States maternal mortality rate is triple that of Canada's, four times the rate of Japan's, and six times the rate of Finland's maternal mortality rate (Kassebaum et al. 2016). As daunting as the increasing national maternal mortality rate is, the nation's average does not reflect the disparate mortality rate for Black mothers and white mothers. If we take into account race, 43.5 per 100,000 Black births result in maternal fatality, whereas 12.7

per 100,000 white births result in maternal mortality (Martin et al. 2017). The situation only gets worse if we look specifically at Texas, where the maternal mortality rate in 2018 was 34.2 deaths per 100,000 births. Black mothers in Texas have a maternal mortality rate of 85.6 deaths per 100,000, while white mothers have a rate of 38 deaths per 100,000 (Explore Maternal Mortality in Texas | 2018 Health of Women and Children Report n.d.). In this chapter, I will analyze how the current medical system, influenced by the historical institutional racism discussed in previous chapters, has created poor health outcomes for Black women across all classes, and still perpetuates state control and surveillance of Black women's bodies as a means to limit Black women's power, autonomy, and consent.

> "The next day, while recovering in the hospital, Serena suddenly felt short of breath. Because of her history of blood clots, and because she was off her daily anticoagulant regimen due to the recent surgery, she immediately assumed she was having another pulmonary embolism. (Serena lives in fear of blood clots.) She walked out of the hospital room so her mother wouldn't worry and told the nearest nurse, between gasps, that she needed a CT scan with contrast and IV heparin (a blood thinner) right away. The nurse thought her pain medicine might be making her confused. But Serena insisted, and soon enough a doctor was performing an ultrasound of her legs. 'I was like, a Doppler? I told you, I need a CT scan and a heparin drip,' she remembers telling the team. The ultrasound revealed nothing, so they sent her for the CT, and sure enough, several small blood clots had settled in her lungs. Minutes later she was on the drip. 'I was like, listen to Dr. Williams!'"
>
> "Serena Williams on Motherhood, Marriage, and Making her Comeback", *Vogue* (Haskell 2018)

> "Over the next two weeks, Shalon's records show three more visits to Emory and two nursing visits at home. She feared that the incision wasn't healing fast enough, perhaps because the blood thinners she was taking to prevent an embolism —another C-section risk — were hampering coagulation... Shalon saw a nurse practitioner. 'We said, 'Look, there's something wrong here, she's not feeling well,'' Wanda recalled. ''One leg is larger than the other, she's still gaining weight'— nine pounds in 10 days — 'the blood pressure is still up, there's gotta be something wrong.' The nurse's records

> confirmed Shalon had swelling in both legs, with more swelling in the right one. She noted that Shalon had complained of 'some mild headaches' and her blood pressure was back up to 163/99, but she didn't have other preeclampsia signs, like blurred vision. She checked the incision — 'warm dry no [sign/symptom] of infection' — and noted Shalon's mental state ('cooperative, appropriate mood & affect, normal judgment'). She ordered an ultrasound to check the legs for blood clots, as well as preeclampsia screening. Both tests came back negative. As Wanda remembers it, Shalon was insistent: 'There is something wrong, I know my body. I don't feel well, my legs are swollen, I'm gaining weight. I'm not voiding. I'm drinking a lot of water, but I'm retaining the water.'
>
> "Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why", *NPR ProPublica* (Martin et al. 2017)

The birthing stories of Serena Williams and Shalon Irving reveal why Black women have a maternal mortality rate nearly four times that of white women, and suffer from life-threatening complications at higher rates than white women (Chakraborty 2017). Many of these deaths and complications are preventable with supervision based upon listening to patients, believing patients, and respecting the patients' knowledge of their own bodies and health. Yet, health practitioners hold implicit biases that affect the care they provided. Such biases include notions of a biological difference between Black and white people, a difference in pain tolerance in Black and white patients, greater fertility in Black people than in white people, and other health related falsehoods. A 2016 study exposed these racial biases within medical students and residents in Virginia. 58% of 222 white medical students and residents from the University of Virginia Medical School, a top ranked program, believed that Black people had thicker skin than white people. 24% of the 222 medical students and residents believed that Black people's blood coagulates more quickly than white people's blood (Hoffman et al. 2016). These beliefs are

based in racist rhetoric used to justify enslavement of Black people, experimentation on Black people, and the development of the medical field of "Negro medicine." Although many of these future and current physicians may not be outright racists, their biases on the biology of Black people has fatal consequences and outcomes that reflect in the present disparities.

The implicit racial biases of physicians, nurses, and other health care professionals manifest into real life health crises for Black patients, especially Black women. Currently in the United States, approximately 98% of all births occur in hospitals(MacDorman, Mathews, and Declercq 2014). This fact compounded by the fact that hospitals with a predominantly Black patient population typically have more severe maternal morbidity and health outcomes compared to predominantly white hospitals, only emphasizes the role of biases in delivery of care. Hospitals have different outcomes depending on a variety of factors that include if it is a public or private entity, non-profit or for-profit, and what kind of population they serve. One study analyzing hospital patient population and maternal morbidity and complications revealed that 100% of the Black serving hospitals in Arizona, California, Florida, Michigan, New Jersey, New York, and North Carolina, are in an urban setting. 53% of the patients in Black serving hospitals in these states were among the poorest in the state, 64.06% of the deliveries in these hospitals were funded by Medicaid, 78.80% of the deliveries occurred in teaching hospitals, and 44.3% deliveries happened in public hospitals. Whereas hospitals with predominantly white patient populations had 96.63% of deliveries in an urban

environment, 21.87% of the patients were among the poorest in the states, Medicaid funded 35.05% of the deliveries, 48.52 deliveries occurred in teaching hospitals, and 8.2% of these deliveries occurred in public hospitals (Creanga et al. 2014).

The characteristics of the hospitals where Black women give birth, many of them public, teaching hospitals, reify the notion that health care education relies upon experimentation and exploitation of Black health and trauma. This medical tradition dates back to the plantation hospitals, Dr. Sims' and others experimentation cabins, and the uncanny fascination with the Black body. These hospital and their medical staff have higher rates of maternal morbidity and complications from childbirth due to not only having a higher risk patient population due to patients' lack of adequate and consistent preventative healthcare and the dearth of wealth, resources, and opportunities for healthy living, but also because of health care provider implicit bias that has impeded equal and equitable healthcare. Implicit biases work to undermine patient power, autonomy, and consent, by invalidating patient experience, knowledge, and concern. We see this in the way the nurses dismissed Serena William's correct self-diagnosis, the way Shalon Irving repeatedly went to the hospital because she felt something was wrong and still ended up dying due to hypertension.

The Black serving hospitals in Arizona, California, Florida, Michigan, New York, New Jersey, and North Carolina depend on Medicaid for funding a majority of the births and serve predominately working class and poor patients. Not only is giving birth in a hospital an expensive endeavor, but for those who require Medicaid

services, it brings about a system of surveillance that patients with private insurance do not undergo. Medicaid recipients in New York, for example, undergo glucose challenge tests twice, multiple drugs tests, are tested for sexually transmitted diseases three times, during their prenatal visit, third trimester, and postpartum visits, and are constantly bombarded with contraceptive suggestions despite might not wanting to be on birth control. Whereas their privately insured counterparts only receive the glucose challenge test once at twenty-eight weeks, are tested once for sexually transmitted diseases during their prenatal visit, and receive information about contraception at their request (Bridges 2011). The deluge of diagnostic tests demanded by the government for poor and uninsured women speaks to the paternalistic nature of state control and their view of these women. The Medicaid laws put in place concerning screenings for STDs and STIs during the third trimester, and postpartum visits go beyond the American College of Obstetricians and Gynecologists, the leading non-profit organization consisting of obstetricians and gynecologists.

The insistence of contraception to working class, young, Black women after giving birth, such as the intrauterine device or IUD, reflects the notions arising from the eugenic movement that strove to limit reproduction of the working class and minorities. The Negro Project in 1939, supported by Margaret Sanger's Birth Control Federation of America and W.E.B. DuBois, strategically pushed birth control and contraception to poor Black women in the South without genuinely listening and taking into account the needs of these women (Margaret Sanger Papers Project

2001). Despite the intentions, the Negro Project served to reproduce the eugenic agendas rampant at the time.

More extreme measures of contraception took place as many physicians across the country in the early 20th century resorted to permanently sterilizing Black women without their consent. The 'Mississippi Appendectomy', coined by Fannie Lou Hammer, was a popular procedure in which black women had their uteruses surgically removed. Hammer, who went to the hospital to have a tumor removed in 1961, left the hospital without a uterus or the ability to have children. Mary Alice and Minnie Relf, aged 14 and 12, were sterilized after their mother, who was illiterate and believed her daughters would solely receive a non-permanent form of birth control, signed a consent form. The Southern Poverty Law Center uncovered around 100,000 to 150,000 experiences like that of Fannie Lou Hammer and the Relf sisters in Alabama, utilizing federal funds.

Contemporary forms of long term and permanent birth control, such as Norplant and Essure, still present cases of the rejection of autonomy and consent for Black women's reproduction. In the 1990s, Norplant was not only marketed to young Black girls in middle and high school, but also utilized as a political and punitive tool. David Duke, a former Louisiana State Representative and Grand Wizard of the Ku Klux Klan, proposed a bill that would incentivize young, poor, and ultimately Black women to be implanted with Norplant for $100 (Chakraborty 2017). Judge Howard Broadman gave defendant, Darlene Johnson, the option between a "seven year prison sentence or only on year in prison and three years on

probation, with the condition that she be implanted with Norplant" (Roberts 1997, 151).

Surveillance of Black women's reproduction, especially poor Black women, has roots in the stereotypes and controlling images of Black mothers. The welfare queen and the Jezebel in particular, led many politicians to hold a contemporary stake in Black women's reproduction similar to that of slave owners during the antebellum period. The notion of the promiscuous, poor Black woman with too many children mooching off the government became a rallying crying for welfare reform. City officials advocated for birth control for Black teens and middle school children. Physicians performed hysterectomies or other forms of permanent sterilization on Black women who had just given birth, or came in for a different operation. These stereotypes of Black women have manifested in different aspects of society, ranging from the political, social, economic, and even medical, in ways that have negatively impacted Black women's lives. In essence, the welfare mother, the Jezebel, the Sapphire, have created justification for the modern state control and interest in black women's reproduction by depicting Black women as reckless, incapable of informed choice, and bad mothering. We see physicians and other health professionals, unconscious or consciously, lower their standards of treatment for Black women because of biases based on these controlling images that essentially negate the agency, respect and knowledge that Black women have to make decisions for themselves. As a result of this bias, the American medical system's historical dependence upon Black bodies, and the general power

discrepancy between a physician and a patient, it is no wonder that the lack of power, autonomy, and consent, has created and exacerbated the current maternal morbidity crisis in the United States.

Power, autonomy, and consent have been stripped away from Black women by the medical system with the help of state surveillance as a means to create the field of modern gynecology, and to advance research on birth control. We have seen this with patients of Dr. Sims, Dr. McDowell, and Dr. Provost, the proponents and recipients of Norplant and Essure, the surveillance of Medicaid patients, and the medicalization of birth and the invalidation of Black midwifery. These processes have led our medical system to discredit Black women no matter educational attainment, socio-economic status, or cultural impact, and to consciously or unconsciously deny Black women equal and equitable treatment. The medicalization of birth started less than 200 years ago and became the norm less than 100 years ago. We have pathologized birth, especially Black birth, in the hopes of bringing modernity, science, and civilization. Yet, our medicine impoverishes, controls, surveils, and trivializes patient choice, as a means to reify the power disparity between physician and patient, perpetuate the capitalist foundation of Western medicine, and intrude upon a women's right to her body.

Part Two

A Reclamation of Power, A Celebration of Choice

"Josie told me that Michelle was probably about 8 centimeters dilated when she arrived at the hospital. But upon admission, Michelle was told she was less, which justified administering Pitocin, the synthetic version of Oxytocin, a hormone that is naturally produced by the body, that induces contractions. Because she was on Medicaid, Josie believes the labor and delivery staff told Michelle she was only allowed to have one person in the room with her; they made her choose between her mother and her doula. "She chose me," Josie said. Josie was baffled because she had been at the same hospital a week earlier with a white private pay client who had "had six people in her room." Josie continued by saying that in the labor and delivery room, the doctor put Michelle's legs up in the stirrups, and scolded Michelle saying, "I did not know you were having a doula. Why didn't you tell me?" When Michelle pushed, the doctor, who was Black and the nurses instructed her to stop. They told her there was a cord prolapse, which is when the head is really high and the umbilical cord comes down. But according to Josie, Michelle's water had not broken yet, so there could not have been a cord prolapse. Eventually, Michelle gave birth. And, although she did not have a lot of bleeding, the doctor said, she had clots and aggressively went in to remove the clots. Aggressive entry after a birth can cause infection."

(Davis 2018)

I first heard Paula Rojas speak at a Dell Medical School event for students interested in the current maternal mortality crisis, especially within the Austin community. She spoke with passion, vigor, and a necessary anger for the situation at hand. She explained the importance of midwives and doulas or birthing companions for Black and Latinx mothers to a room full of future medical students, including myself, who had been socialized to discredit and delegitimize midwifery. Nodding heads and furrowed eyebrows colored the faces of the audience, some skeptical of her words, others enlightened and impassioned by the thought of a radical return to our roots for improvements. Her words reverberated and ricocheted off the walls and into our ears. She walked into the lion's den and told the lion it was her space

now. It was her space and it was open to all the Black and Brown women who looked like her. If Dell Medical School were to be the different from the traditional medical schools, it would have to be held accountable; it would have to be for the community, it would have to disassociate its foundation in medicine from the influence and guidance of capitalism and white supremacy. Paula stood at the front of the auditorium of a medical school, and humbled the current and future physicians who valued science over the experiences of the people they treat.

In this half of my thesis, I aim to examine how Black women reclaim the power, autonomy, and consent with midwives and doulas through an analysis of contemporary midwifery, reproductive justice, and birth work movements.

Chapter 4:

Midwifery Care Model, An Ethnography

I drive down the winding road of Camino La Costa that leads me to the new People's Community Clinic. The clinic, born in 1970 out of the hippie movement by volunteer nurses and doctors wanting to help treat college students and workers, now serves as nearly 17,000 underinsured and uninsured patients across Travis County. People's Community Clinic, as such, is one of the settings of activist birth work taking place in Austin, Texas. Every other Thursday, I met with members and participants of Mama Sana Vibrant Woman, a local organization founded in 2012 that strives to improve the pregnancy and birth outcomes for Black and Latinx women in the Austin area through individual and collective self-determination. Their radical practice of offering doula services, yoga, acupuncture, group therapy, and even midwifery services for free, in a city where doula services average $1,000 and birthing centers with midwives can be $6,000 with insurance, serves to not only give Black and Latinx women the option of choice and support, but also empowers them to have a say in the pregnancy and birth they want to have despite any socioeconomic barriers. In this chapter, I explore how the midwifery model of care and birth work help Black women regain a sense of power and autonomy in their own health care and pregnancy.

The midwifery model of care takes a more holistic approach to pregnancy and giving birth. It rejects the notion of the maternal-fetal conflict, and addresses both child and mother as one, in conjunction with each other, and not in conflict

with one another. Midwives incorporate the pregnant person's mental, emotion, and social wellbeing, and how those aspects of their life are influenced by and impact their pregnancy. With a midwife, the woman takes an active role in her own pregnancy and birth. She births the baby, and the midwife catches the child. With a physician, the woman is a passive participant being treated; a physician delivers her baby while she lets birth happen to her. In the Black Women Birth Justice report, participants felt that "ob-gyns used fear to ensure compliance with medical advice. In contrast, midwives were more open to exploring alternative approaches to ensure that the pregnant person achieved and maintained optimal health" (Oparah et al. 2018, 47). In other words, midwives allowed for pregnant women to explore and practice their autonomy and choice in determining their health care, whereas physicians relied upon fear and the power discrepancy to essentially coerce pregnant women into doing what the physician thought best.

> "[M]y appointments were always so different, I would go to the hospital and it was very rigid, and you know, charting and preparing me for a C-section, you know it was always like WAH! Run out as fast as I could. And my midwife's appointments were like on the couch and comfortable and you know, like talking about my day, always so different."
>
> Samirah, 38, home birth, vaginal birth (Oparah et al. 2018)

> When Landrum complained about how she was feeling more forcefully at the appointment, she recalls, her doctor told her to lie down — and calm down. She says that he also warned her that he was planning to go out of town and told her that he could deliver the baby by C-section that day if she wished, six weeks before her early-January due date. Landrum says it seemed like an ultimatum, centered on his schedule and convenience. So she took a deep breath and lay on her back for 40 minutes until her blood

> pressure dropped within normal range. Aside from the handwritten note, Landrum's medical records don't mention the hypertensive episode, the headaches or the swelling, and she says that was the last time the doctor or anyone from his office spoke to her. "It was like he threw me away," Landrum says angrily.
>
> (Villarosa 2018)

Contemporary midwifery means a return to the instinctive process of birthing. It emphasizes the role of the woman giving birth and as a result empowers her. Complementing the empowering effect of midwifery, are the support doulas or birthing companions lend to pregnant women and their families. Doulas are "trained professionals who provide continuous physical, emotional, and informational support to a mother before, during, and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible" (What Is a Doula n.d.). What may seem like a minor role in the birthing process, doulas substantially influence the way women experience their pregnancy and birth. According to one study analyzing the role of continuous support, in twenty-two trials involving 15,288 women, women with continuous support or a doula, were more likely to have a spontaneous vaginal birth, less likely to have intrapartum analgesia, or pain relief during labor, a C-section, regional analgesia, or pain relief in a localized area such as the spine, instrumental vaginal birth, or a baby with a low five-minute Apgar score; in addition, the amount of time spent in labor was typically shorter if the woman had a doula (Hodnett et al. 2012). We see the effects of having a doula with Simone

Landrum's story in the New York Times article "Why America's Black Mothers and Babies Are in a Life-or-Death Crisis."

> ""May I speak to you outside," Giwa [Landrum's doula] said to the nurse caring for Landrum. In the hall, she asked her to please make a note in Landrum's chart about the stillbirth. "Each time she has to go over what happened, it brings her mind back to a place of fear and anxiety and loss," Giwa said later. "This is really serious. She's having a high-risk delivery, and I would hope that her care team would thoroughly review her chart before walking into her room."
> One of the most important roles that doulas play is as an advocate in the medical system for their clients. "At the point a woman is most vulnerable, she has another set of ears and another voice to help get through some of the potentially traumatic decisions that have to be made," says Dána-Ain Davis, the director of the Center for the Study of Women and Society at the City University of New York, the author of a forthcoming book on pregnancy, race and premature birth and a black woman who is a doula herself. Doulas, she adds, " are a critical piece of the puzzle in the crisis of premature birth, infant and maternal mortality in black women."
> As Landrum loudly complained about what occurred, her blood pressure shot up, while the baby's heart rate dropped. Giwa glanced nervously at the monitor, the blinking lights reflecting off her face. "What happened was wrong," she said to Landrum, lowering her voice to a whisper. "But for the sake of the baby, it's time to let it go."
> She asked Landrum to close her eyes and imagine the color of her stress.
> "Red," Landrum snapped, before finally laying her head onto the pillow.
> "What color is really soothing and relaxing?" Giwa asked, massaging her hand with lotion.
> "Lavender," Landrum replied, taking a deep breath. Over the next 10 minutes, Landrum's blood pressure dropped within normal range as the baby's heart rate stabilized."
>
> (Villarosa 2018)

Giwa, Simone Landrum's doula, was not only an emotional support for Simone during an aggravating encounter, but also served as her advocate –making sure that hospital staff listens to and respects Simone's decisions, autonomy, and agency as a the person giving birth. Birth work, especially the work done by and for Black women, highlights the fight for autonomy, self-determination, and justice with

an intersectional lens. As Alana Apfel says, birth work "draw[s] attention to the politicized nature of caregiving under capitalism…[they] help destabilize the fear-based foundations upon which the modern labor and delivery Is based" (Apfel 2016, 4-8). In the most basic sense, doula work and midwifery represent radical alternatives to hospital and physician led births because they re-center and focus birth from the physician to the woman. Birth work is a matter of advocacy and empowerment for women, especially Black women.

Listening to the stories of local Austin midwives and doulas only reinforced this notion that birth work is a matter of advocacy. Many of the Black birth workers I met experienced some sort of traumatic birth story that brought them into the world of birth work. They cite the feeling of not wanting what happened to them to happen to someone else, and allowing women to have the birth that they choose without coercion from physicians or inaccessibility due to finances. Many of their stories involve physician intimidation into doing invasive procedures, inducing labor early, and C-sections –all of which produced tremendous guilt, fear, and doubt within these women and their abilities to give birth. Paloma, who is a midwife of four years but has been in birth work for the past 15 years, explained how when she was 41 weeks pregnant, her obstetrician pushed for her to have an induction. However, she did not want to be induced, and the doctor made her sign a waiver that essentially let Paloma know that if her baby died, it was her fault. This fear tactic of making women sign waivers assuming responsibility for the possible death of the unborn baby mainly speaks to how hospitals either pressure women into

abiding by the physicians requests, or if the patient doesn't abide, protects itself from litigation by forcing patients to assume complete responsibility for the worst case scenario. Rather than listening to the patient, or even meeting the patient halfway, physicians, largely bounded by hospital policy, pressure women into doing unnecessary procedures by instilling this false sense of urgency and fear.

When assisting a woman giving birth in a hospital, one doula named Elaine, recalled repeatedly asking the nursing staff for a birthing bar, which is an attachment that can be added to hospital beds to help facilitate a squatting position. The staff claimed to have only one bar per floor, and when Elaine requested the bar again, the nurse said, "Oh, you were serious about that." Another Austin doula, Eleanor, told me how she has had many clients who wanted to walk around, not be connected to so many machines and monitors, or utilize water therapy, and had their requests initially denied. However, through persistence and essentially nagging of the hospital staff, Eleanor helped her clients get rooms that are big enough to walk around, portable or Bluetooth connected fetal heart monitors, and rooms with bathrooms that are large and have hot water. The dismissiveness of the hospital staff, whatever the reason, only reinforces the stark differences between the medical model of birth and the midwifery model of birth. Birthing within a hospital with an obstetrician, for the most part, is quick, brief, depersonalized care that is bureaucratic, hierarchical, and treats pregnancy as a disease or ailment. Whereas birthing with a midwife, for the most part, is intimate, more egalitarian, and emphasizes the role, emotional and physical health of the woman. In other

words, midwives, doulas, and others involved in the birth work movement view pregnancy and birth as an empowered event within a woman's life; and therefore, must require the woman's consent to be assisted, autonomy to choose how and where she wants to give birth, and power to assert her role as the primary player in a birthing event.

Much of the contemporary birth work movement revolves around a reproductive justice and birth justice framework. The Reproductive Justice framework, formally established in 1994, adheres to a core concept of Black feminist thought –choice. Specifically, this framework guides activism in the hopes of addressing the aspects of reproductive rights that the abortion rights movement failed to incorporate. As one of the founders of the Reproductive Justice framework, Loretta J. Ross, states reproductive justice as "the human right to have the children we wanted, under the conditions we choose…the right to parent our children in safe and healthy environments" (Apfel 2016). Reproductive Justice birthed the birth justice movement that emphasizes choice and access to safe, desired births.

The automatic doors slid open as I approached the entrance to People's, exposing the polished concrete floor, a winding staircase, and a hall that leads to somewhere. I quickly find Jeanette, one of the founders of Mama Sana, who then guides me to the kitchen where they set up for dinner. One of the main components of Mama Sana's praxis is to provide free, healthy, and well-balanced meals to the women and their children who attend the prenatal groups. I immediately start plating rice, chicken, and an assortment of fresh vegetables and fruits. The

incorporation of food security and food justice into Mama Sana's work highlights the holistic nature of reproductive justice work. It is not only a matter of pregnancy, giving birth, or having an abortion, but also the call for healthy food options, clean air, and a safe environment for children and families.

Ultimately, Mama Sana Vibrant Woman and other organizations and individuals involved in reproductive justice and birthing justice emphasize the importance of autonomy, consent, and power. They do not try to dissuade women giving birth in a hospital, having an ob-gyn, or believing in the medical system. Rather, birth workers critique the medical system for historically and continuously stripping away the power, autonomy, and consent of Black women at disproportionate and fatal rates. Birth work relies upon an ideology that gives women back the power to choose their experience, and as a result of this reclamation of power, consent, and autonomy, many Black women have had more positive experiences while birthing.

Part Three

Concluding Thoughts

We realize that the liberation of all oppressed peoples necessitates the destruction of the political-economic systems of capitalism and imperialism as well as patriarchy. We are socialists because we believe that work must be organized for the collective benefit of those who do the work and create the products, and not for the profit of the bosses. Material resources must be equally distributed among those who create these resources. We are not convinced, however, that a socialist revolution that is not also a feminist and anti-racist revolution will guarantee our liberation… A political contribution which we feel we have already made is the expansion of the feminist principle that the personal is political.

-Combahee River Collective Statement(Collective 1986)

This final part is a reflection on what health and healthcare is within the greater context of the United States and around the globe. Our notions of health, science, and healthcare center on this rhetoric of these issues being objective, based upon logic, and truth; however, we see that isn't the case, nor has it ever been. Healthcare is just like any other institution; it is built upon our passed ideologies as a country, molded by our current cultural values, and guided by our intentions for the future. And so as we look towards the future, we must guide our healthcare into a place where it can be objective, where your health outcomes don't depend upon your race, class, sexuality, or gender. I included this quote from the Combahee River Collect, a Black feminist lesbian organization based in Boston, because it describes the necessary liberation from the systems that corrupt the basic fundamentals of health and healthcare. Only through a dismantling of capitalism, white supremacy, and patriarchy can we, as a society, reclaim our health and liberation.

Chapter 5:

Rethinking Health and Power

For the past eight years or so, I have occupied different roles in the hospital. In high school, I volunteered at one of the best children's hospitals in the nation. I shadowed physicians in the world's largest medical center. I walked through the various hospital hallways during medical school tours, envisioning myself as a future attending physician treating patients. With each role, I reflect on my experience and my thoughts on our health care system, with emotions ranging from awe at the life-saving procedures to disappointment at the inequity and lack of access to equal outcomes and affordable care. To engage outside of the medical system when I have been ingrained and socialized to think of it as natural, is to decolonize my understanding of healthcare and reconstruct how I view health.

What does it mean to decolonize healthcare, and reconstruct health? For the Black women, who are not believed, heard, or respected, decolonizing and restructuring our understanding of health is a life-or-death issue. Decolonization strives to dismantle the white supremacist, patriarchal, and capitalist systems that form the basis of institutions like medicine, education, and government. Decolonization does not mean an abandonment of medical technologies, progress, or research, and a return to ancient traditions, blood letting, and other superstitions. To say that is reductionist. But a true decolonization would mean an end to the exploitive and capitalist nature of hospitals, the predatory practices of the pharmaceutical and medical device industries, and the anti-blackness ingrained

within medical research. It would mean a more equal dynamic between patient and physician, an emphasis on informed choice, accessibility and eradication of structural barriers like transportation and cost, and solutions to the environmental pollution within Black and poor communities.

Health is power. Not only is it dependent upon a person's non-coerced autonomy, informed consent, and respected individual power, but also is dependent upon a person's cultural background, values, and customs. Health depends on power. Our current health system relies upon power differentials that for one minimize the voice of the patient, and secondly differs for each patient based on external identities like race, gender, class, and sexuality. We saw how health professionals' racial biases discredited Black women's concerns and reports of pain, whereas clinicians overprescribed opioids to white patients, which has led to the current opioid crisis. At the end of the day, both extremes disadvantage all patients and reify a healthcare system that is reactionary rather than preventative.

Power exists in every aspect of every society. We are reminded of this fact with the story of Alyne in Brazil, and so many others who share her experience around the world. And although my thesis focuses solely on the United States, we cannot forget that the power differentials that are rooted within the international system of medicine are transnational and affect marginalized women and birthing people all over the world. Decolonizing medicine would mean to address the power dynamic that allows physicians and health care professionals around the world to minimalize, trivialize, or dismiss patient concerns, desires, and lives.

I recently went to a talk given by Paul Farmer, one of the most renowned medical anthropologists and physicians leading the fight against global health inequity. He spoke about the concept of global health equity, and its importance in ensuring a safe, healthy world in which access to clean water; hospitals and medicines are basic human rights for everyone around the world. At one instance, he said, “Planning a policy response around them [health disparities] is not a good strategy without the notion of equity.” Despite talking in the context of global health, I could not help but to think of global health equity within the context of our own nation, where health outcomes of certain populations differ like those of first world and third world countries. His words reminded me of how we, as health professionals, policy makers, politicians, and educators, must incorporate notions of equity into our practices. Without it, we are stuck in a cycle created by the brutal legacies of the institution of slavery.

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