

Life and Death: Examining the Power Dynamic Between Black Women, Physicians, and Society Through Narratives

By

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Abstract

The current research examines the maternal narratives of four Black women who struggled during childbirth due to negligence by medical staff. Historically, Black women have struggled to receive equitable care for reasons such as lack of consent, insurance and forced sterilizations. To analyze the narratives of the four Black women, I used a thematic analysis to determine several themes and displays of power relations between medical personnel and Black women. The guiding theories for this research include muted group theory, Black feminist theory, standpoint theory, and narrative theory. In assessing these narratives, three themes were found, self-help narratives, where Black women's self-advocacy was essential to the care they received, wronged narratives where Black women felt doctors had not treated them properly or considerately and ignored narratives where women demonstrated that doctors ignored their reports of pain and distress. The current research informs the theories applied by suggesting the importance of listening to the Black female voice and recognizing that it does not mirror the same experience of other gendered and racial groups.

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Chapter 1: Introduction

Since the start of slavery in America, African and Black Americans have been subjected to harsh treatment by their White counterparts. Even after the abolishment of slavery, Blacks continued to experience inequalities through segregation. African Americans faced hardship when integrating into society because of laws such as Jim Crow that enforced segregation. Black people struggled with gaining access to housing, transportation and health care (Bailey et al., 2017). Even after America was rid of legalized segregation, Black people continued to struggle. While the circumstances have changed over the centuries, the treatment of Black people has not altered substantively.

One specific area where people of color continue to struggle is with access to adequate healthcare. African and Black Americans often face inequities in health care whether it is through means of insurance or the type of treatment they receive from medical personnel (Sohn, 2016; Noonan, Velasco-Mondragon & Wagner, 2016; Hall et al., 2015). From the early 1900s, scholars like W.E.B. DuBois noted how the American healthcare system did not ensure quality care for Black Americans. W.E.B. DuBois (1906) wrote, “The Health and Physique of the Negro American” noting that the health care system produces negative outcomes for Black people due to their racial and ethnic background; because Black Americans are Black, their health care trails that of a White American. DuBois writes: “the matter of sickness is an indication of social and economic position [but] the Negro death rate and sickness are largely matters of condition and not due to racial traits and tendencies” (DuBois, 1906, p. 276). This quote becomes exceedingly important because similar claims have been made about Black health in today’s society.

While today’s discrepancies in healthcare are thought to be due to social status, economic power, or individual behaviors, these explanations are not always the case for Black people

(Hayward et al., 2000; Adler et al., 1994). Following DuBois's argument that the unequal care that African-Americans receive is not due to any particular racial traits or behaviors they engage in, contemporary scholars acknowledge that racism is a factor in racial and ethnic disparities in health outcomes (Butler et al., 2018).

In 2015, the Center for Disease and Control (CDC) released a report that detailed health disparities between racial groups. The report revealed that Black people have lower life expectancy, higher infant mortality, higher rates of pre-term births, are more likely to deliver their babies via cesarean section even if they are classified as low-risk, and have high rates of obesity and hypertension. From the CDC report, it is evident that many disparities involve Black mothers and their babies. Particularly for maternal care, the racist and sexist climate against Black women in the United States widens the mortality gap between Black women and women of other races (Chalhoub & Rimar, 2018). The American healthcare system is a point of focus here because the differences in birth outcomes are specific to Black American women and not just to Black women, as Black immigrants do not have the same birth outcomes as Black Americans (Rosenthal & Lobel, 2011).

Although public health discourse has extensively considered why maternal disparities exist, there are still many unknowns. According to Chalhoub & Rimar (2018), when controlling for factors like socioeconomic status and education, African American women are still three to four times more likely to die from childbirth than non-Hispanic White women. Other scholars have looked at geographic maldistribution of medical resources, racial differences in patient preferences, pathophysiology, insurance coverage, as well as in trust, knowledge and familiarity with medical procedures as reasons for maternal disparities (Williams & Rucker, 2000). However, even when accounting for all those factors, maternal disparities still exist.

Although scholars have recognized that racism is a driving force behind maternal health disparities (Williams & Rucker, 2000; Griffith et al., 2007), there have not been effective improvements to these problems. The current research specifically looks at maternal health disparities that Black women face by examining their post-partum maternal narratives in popular media. The effective use of narratives from Black women about their experiences in healthcare is one addition to the discourse that could raise awareness and motivate change.

The humanization created through storytelling will make maternal statistics more real and give voice to Black women. Researchers have examined the impact of statistical and narrative evidence on the beliefs, attitudes and intentions on persuading people and found that narratives are more like to encourage intention than statistical evidence (Zebregs et al., 2014). The personification of characters in a story allows for audiences to better connect to the information being shared and encourages change. Understanding this phenomenon helps demonstrate why storytelling and the sharing of experiences is powerful and relevant to the present study.

In order to better understand the racial implications of creating equitable care, chapter two analyzes the history in which Black women have been abused, coerced and neglected in medicine to understand the genealogy of treatment they have endured as well as provide some information on the common complications women face postpartum. Doing so will first provide some insight on where health disparities for Black women have stemmed from and also provide some linguistic background for experiences they have postpartum. In chapter three I review theoretical literature to help understand the importance of Black female voice and the need for their narrative. The theories used in the present study include narrative theory, muted group theory, standpoint theory, and Black feminist theory. Chapter four outlines a qualitative thematic analysis as the analytical tool used to dissect the maternal narratives. Chapter five identifies

several narrative themes that have been found. Chapter six outlines theoretical and practical implications of the current research as well as suggest future directions.

Before continuing, a note on terminology is necessary. In this paper, I will use African-American and Black interchangeably. African-American refers to those of African descent who either migrated or were forcibly brought to the United States. To be Black means that you could be African-American but could be a descendant from other areas of the world such as the Caribbean or Latin America. Most of the research that has been conducted does not make the distinction between African-American and Black, grouping together these minorities. In this thesis, the stories of both African-Americans and other Black Americans will be told.

Additionally, this paper compares Black and White healthcare outcomes exclusively. This focus was chosen because most of the existing literature on maternal disparities compares Black women and White women and do not include women of other races. In addition, history has shown that White people have always received superior care in comparison to other minority groups (Geiger, 2003).

Doing this analysis informs current discussions on maternal disparities by demonstrating how narratives have become a part of maternal discourse. Seeing how Black women have described their treatment allows for audiences to gain better insight to the type of treatment Black women experience in medical centers. This discussion allows for different way of understanding maternal disparities because it provides a reason for listening to maternal narratives in order to make positive changes in maternal care and decrease maternal disparities. In addition, the present study finds new ways to use Black feminist theory, narrative theory, standpoint theory and muted group theory in health communication.

Chapter 2: Historical Treatment of the Female Black Body

The mistreatment of Black women and their reproductive organs face is not a new phenomenon. The following section traces Black women's lack of agency and voice in medical procedures from the Antebellum period to present day.

Antebellum period

During the Antebellum period (1800s), slaves were subjected to medical experimentation in order to learn about the anatomy of the human body and to further arguments about whether there were biological differences between Blacks and Whites (Savitt, 1982). Although little is known specifically about how Black women's bodies were treated, it is known that they were subjected to medical experimentation to learn more about the female reproductive system. One example of the mistreatment of the female Black body during this period is that of Anarcha, a slave woman who underwent 30 vaginal surgeries under the care of Dr. James Marion Sims in Montgomery, Alabama.

Dr. Marion Sims is known for conducting the first successful vesicovaginal fistula repair. This procedure is performed on women who have an abnormal opening between their vagina and their bladder making urination difficult to control (Stamatakos, Sarged, Stasinou, & Kontzoglou, 2014). This procedure is often necessary after a woman has given birth in order to repair tears from childbirth. Dr. Sims experimentally performed his method on several slave women that were gifted to him by other slave owners in Alabama (Wall, 2006). Noting that he perfected the vesicovaginal fistula repair on slave women is important because it highlights one of the first times in recorded American history where Black women were experimented on without their consent. This example serves as the origin of lack of voice that Black Americans have in their medical treatment. Here, consent was given by slave owners, not the slaves themselves. During

the Antebellum period, slaves did not have a true voice. They were property and therefore would have to abide by any request of their owners.

While it is apparent that the Black women Sims performed on were non-consenting individuals and therefore Sims' decision to perform on them was unethical (Ojanuga, 1993), not all see him as an unethical practitioner (Wall, 2006). Wall (2006) argues that Sims' behavior was in fact ethical because his experimentation saved the lives of the slave women. Wall argues that slave women could be consenting individuals because they were in distress and that Sims' methods should not have been withheld from slave women. Wall continues his argument in support for Sims' by adding that without his experimentation, these women would have gone untreated and would have continued to suffer.

It is important to note that there were individuals who did not see Sim's procedures as exploitive because the Black body was viewed as inhuman (Powell, 1979) and a tool that could be beneficial to science through experimentation. Wall argued that Sims was doing a service to save the lives of these women and that his procedure should not be viewed as racist. Wall's rationalizations help to hide unjust treatment of Black people. Rationalizing Sims' behavior allows for a system of injustice to continue.

Experimentation of the Black body was a common occurrence during slavery (Fisher, 1968). Physicians hoped to learn about the anatomy of the body through procedures on slaves. As stated, exploitation stemmed from the views of the time that slaves were less than human and because of that, no consent was needed. In the following section, I demonstrate how Black women's bodies were treated in the 20th century, even as views about Black Americans had ostensibly changed.

20th Century

Government involvement in Black women's reproductive care.

In addition to Black bodies being instruments for learning about human anatomy, they were also seen as things needing to be controlled. So far, I have illustrated how Black bodies, specifically Black women, were controlled during slavery as their reproductive organs were educational tools for southern doctors. Now, I consider the history and origins of contemporary health disparities to demonstrate how malpractice have persisted beyond the bounds of slavery. In particular, I focus on the role of government regulations and policies in creating and perpetuating these disparities.

Welfare. During the 1930s through the 1970s, Black women were victims of involuntary sterilization (Lee, 2000). Fannie Lou Hamer is a well-known example of this practice. In 1962, Hamer undergone a complete hysterectomy when she believed that doctors were only removing a tumor from her uterus (Weatherford, 2015). Hamer was not the only woman to be sterilized during this time. Women feared that if they did not undergo irreversible sterilizations, their welfare benefits would be revoked (Bocquillon, 2018). Alice, age 14 and Minnie, age 12, were sterilized because their illiterate mother believed she was consenting to birth control (Davis, 2003). Their mother thought she was signing a form allowing her daughters to test an experimental, long-term birth control drug (Dorr, 2011).

The treatment that these young girls and woman endured is reflective of the racism embedded in the healthcare system. Rodriguez-Trias (1976) notes that in 1970, 43% of the women sterilized in federally-financed family planning programs were Black, although they only represented one-third of the patient population. During this time period, people argued that sterilization was a way to control Black woman's reproduction and the Black population

(Weisbord, 1973; McFalls & Masnick, 1981) and revealed the power that physicians had over reproductive rights (Bocquillon, 2018).

While tragic events persisted from the 1800s into the 1900s, it is important to note the shift in how female Black patients were treated in medicine. As stated, during the 1800s, Black women were not granted consent. However, after the end of slavery and events like the Syphilis¹ experiment in Tuskegee, Alabama, consent was required for procedures performed on patients. However, practitioners did not abide by the rules of consent. While the preliminary act of asking for consent to test and perform surgeries was in effect, doctors performed test beyond the bounds of what patients consented to. Abuse and control over the Black body took new form as Black patients were unaware of what procedures they were really signing up for.

Insurance. Davis (1984) states that Black women have been denied treatment during pregnancy for lack of insurance or because the hospital believed the women were lying when claiming they did have insurance. Davis exemplifies this statement by sharing the story of Sharon Ford, a pregnant Black woman, who gave birth to two stillborn children because hospitals refused to treat her. Medical personnel believed that she was lying about her insurance even though she did have a health plan. This exemplifies how Black women have been negatively stigmatized as they have been viewed as liars. The negative stigmas associated with Black women are detrimental to the care they receive because they either receive no treatment or delayed treatment which can lead to increased risks of complication or mortality.

Insurance is a significant factor in the morbidity and mortality of an infant and mother (Braveman et. al., 1988). Braveman et al. (1988) note that the maternal care a mother receives

¹ In 1932, the U.S. Public Health Service funded the syphilis experiment that sought to determine the natural course of the syphilis disease. The experiment raised ethical issues because 400 men were led to believe that they were being treated when they weren't even after a cure (penicillin) was discovered (Brandt, 1978).

during her pregnancy is important to the health outcomes of the baby and mother. They also note an increase in mortality rates of Black women which they suggest could be in part due to inadequate healthcare. Many Black women who are low-income and insured through Medicaid have high morbidity and mortality rates because many ob-gyns will not treat a patient insured through Medicaid (Braveman et al., 1988). According to Braveman et al. (1988) the reimbursement from Medicaid is often slow which is why obstetricians will refuse to treat women insured through them. Policy holders are not involved in the reimbursement but are negatively affected by delayed payments.

Today, issues with insurance continue to be problematic for new mothers. Low-income women that are insured through Medicaid face a lot of uncertainty when seeking prenatal, intrapartum, and post-partum care. For example, Masho et al. (2018) notes that after 60 days of delivery, recipients of Medicaid have limited insurance coverage. Although the postpartum period is marked as six to eight weeks after delivery, full organ function does not occur during this small-time frame leading some to believe that the postpartum period should extend to 12 months after delivery (Berens, 2018). Adding to this, Murray Horwitz, Molina & Snowden (2018) notes that more than half of pregnancy-related deaths occur during the year after delivery. With insurance ending or being limited after the six to eight-week span, many women are at risk to running into a complication and not having the means to pay for treatment.

In addition, new health policies like short-term, limited duration (STLD) health insurance which provides insurance for people who experience a temporary gap in health coverage, does not have to cover essential health benefits like maternal care (Pollitz, 2018). Mothers who have recently experienced being laid off or are transitioning into a new job or career may use a STLD policy and because these policies can refuse to cover maternal care, these mothers suffer.

Consent. Building off the issues of sterilization during the 20th century and involuntary procedures, I consider another well-known incident in which a Black women's body was used for medical advancement; the story of Henrietta Lacks. Lacks' story contributes to the overall conversation about health disparities because it provides another example of how Black women have been used for to gain knowledge within the field of medicine. It also suggests why some Black people may be wary of the medical establishment. While the focus of this paper is not to understand why Black women are reluctant to visit hospitals or other medical sites, understanding the treatment they endured in such environments provides a deeper understanding of disparities.

In 1951, Henrietta Lacks went to John Hopkins Hospital with complaint of vaginal bleeding. Her symptoms led to the diagnosis of cervical cancer. Dr. Lawrence Wharton took samples of Henrietta's diseased and healthy cells without her consent or knowledge (Skloot, 2010). Since then, Lacks' cells, now known within the medical world as HeLa cells, have been sold and used in medical research all over the world. HeLa cells led to the development of the polio vaccine and continue to aid in cancer and AIDS research (Chung, 2017). Although the extraction of Lacks' cells did not cause her harm, her consent was not sought and it was only many years later that her family learned of the role that her cells played in medical research (Skloot, 2011).

Although informed consent did not exist in its present form until 1972 (Murray, 1990), the idea of consent goes back further. Justice Benjamin Cardozo said in the 1914, *Scheendorff v. Society of New York Hospital* case that, "every human being of adult years in sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patients' consent commits a battery for which he is liable in damages"

(Murray, 1990, p. 104). Consent as a government requirement was therefore not new and patients should have been made aware of procedures being performed on them.

Victoria Baptiste, a relative of Henrietta Lacks believes that the extraction happened to Lacks' because she was a woman of color (Chung, 2017). She says, "I think a lot of [mistreatment] did come because she was an African-American woman, and at that time there weren't a lot of hospitals that treated people that were of color and were of low socioeconomic means" (Chung, 2017). Geiger (2003) notes that the experiences of minorities within the healthcare system differ considerably from White Americans.

Geiger (2003) provides several reasons for the difference in experience such as issues of lack of access to care even with the addition of Medicaid and Medicare, differences in social, physical and biological environments such as income, education, occupation, housing and nutrition as well as stereotyping and unconscious bias. Stereotyping and unconscious bias informs the rationale in believing that more consideration and consent would have been extracted from a White patient as more respect is given to individuals who are not stereotyped against. Stereotyping and bias can lead to medical personnel to not treat patients equitably.

Hoberman (2012) provides another example in which Black women's reproductive organs were at the disposal of White doctors and used to gain more knowledge on the anatomy of the female body. In 1970 Surgeon General David Satcher wrote in the *Journal of the National Medical Association* that Black patients "are frequently exploited for teaching sessions. One Black woman related to me that she had had nine pelvic examinations by physicians and students and had never been told whether her pelvis was normal or abnormal" (Hoberman, 2012, p. 64).

Research has also found that medical practitioners are aware of how they treat Black patients, but changes have not been implemented. Hoberman (2012) wrote:

American medicine has reacted ambivalently to the hundreds of studies that have documented racial disparities in health care. On one hand, medical journals publish the reports that confirm the disparities, and these reports are sometimes accompanied by editorial commentaries that describe the disparities as intolerable and call for action to reverse them. At the same time, these medical authors have developed a rhetorical strategy that allows them to deplore racial health and treatment disparities without taking responsibility for them. Even the liberal white doctors who actually care about racial injustice in medicine have found ways to formulate their analysis of physician behaviors in such a way as to avoid threatening their own self-images and exposing the profession to critical scrutiny by outsiders (p. 37).

With all of the research demonstrating the inequalities of care based on race, healthcare as a system ignores systemic racism as an issue. Hoberman (2012) provides an example of this erasure of health disparities when discussing how in 2003, the Department of Health and Human Services changed the number of times the word “disparity” appeared in a report from 30 to two, softening the realities of racism present in medicine. Another study conducted by Bailey et al. (2017) notes how terminology becomes significant when learning about the impact of race on health disparities. In their study they write:

In a Web of Science search done on Sept 7, 2016, with the term “race” in conjunction with “health,” “disease,” “medicine,” or “public health,” 47,855 articles were retrieved. However, when “race” was replaced by “racial discrimination,” only 2061 articles were located, and only 1996 articles were found when it was replaced by “racism.” Furthermore, when “race was replaced by “structural or systematic racism,” only 195 articles were identified.

These findings demonstrate that systemic racism in medicine can be molded to hide health disparities, inequalities, and inequities and make such issues difficult to find information about simply based off terminology. I argue that Hoberman (2012) and Bailey et al.'s (2017) arguments show that the existence of health disparities is not a secret, but information is often framed to disguise this reality. It is important to note this here because I argue that Black maternal disparities are often hidden because of how they are discussed in health literature. When conducting the initial search for information on maternal disparities, the search phrases of "inequalities in Black health" and "disparities in Black maternal health" were used. The former yielded less results than the latter. To this, I argue that the term "inequalities" is a harsher descriptor than simply characterizing the issue as a disparity. The word "disparities" generated 16,100 more results than "inequalities." This demonstrates the difficulty in finding information on maternal disparities.

Contributing Factors to Maternal Disparities in the 21st Century

While some of the issues that Black people face are not presented in the same way they have been in the past, e.g., forced or coerced sterilization, Black women continue to struggle to gain equitable healthcare. In the United States, there has been an increase in deaths related to maternity. While studies do not differentiate between the races of women who die in childbirth, Jones (2018) notes that Black women are three times more likely to die during child birth. Carroll (2017) explains that in 2015, 25 out of 100,000 women had died from childbirth. Following this statistic, if the racial composition of these deaths were only included Black and White women, for every six or seven White mothers to die from childbirth, 18 or 19 Black mothers would die. Noting this difference helps reveal the discrimination against Black women

and why it is an issue needing attention. The World Health Organization (2018) argues that one cause for high numbers of maternal deaths is inequalities in access to health care.

Scholars like Rosenthal and Lobel (2011), state that these disparities exist because of gendered racism and the “medical system’s history of [abuse] of Black American women and power dynamics in obstetrics” (p. 977). Krieger et al. (2013) adds that laws and policies also impact mortality rates. They support this notion by demonstrating the impact of Jim Crow. Infant death rates for Black babies between 1970 and 1974 were lower than in 1960 through 1964 when Jim Crow laws were still in effect.

Scholars have also examined factors such as socioeconomic status and education as explanations for why these health disparities exist, however, when controlling for socioeconomic status and prenatal health behaviors, disparities still exist (Alexander et al., 1999). In fact, some researchers have argued that with increased education, racial disparities in health outcomes also increase (Rosenthal & Lobel, 2011). Noting this suggests that health disparities are not the fault of the patients. Regardless of how informed or knowledgeable a patient is, they are still subjected to higher mortality rates simply based off their racial background.

While much research has examined external factors that patients might be able to control (e.g., finances and education) other explanations look at society and the way in which practitioners engage with patients. Some scholars argue that Black people experience worse health outcomes due to “weathering” (Geronimus et al., 2006). Weathering posits that Blacks have worse health outcomes as a consequence of repeated social, political, and economic adversity. Weathering supports the notion that racism negatively affects the health of an individual. It argues that the lifelong stress from a person’s environment can affect their health even if their direct medical practitioner treats them equitably. Understanding the concept of

weathering allows for a deeper understanding for the impact various elements have on the health of Black people. The treatment Black people are subjected to in various settings, including medical practice, can negatively affect their health and contribute to the negative health outcomes they experience.

Racialized tragedies have not only impacted the individuals who have been directly abused in these situations, but their families and the Black community have also come to distrust the medical establishment. The Tuskegee Syphilis experiment played a significant role in this distrust. After the Syphilis experiment, many Black men were reluctant to visit the doctor's office and mistrust for the medical profession among African-Americans is still prevalent today (Lee et al. 2018). Thomas & Quinn (1991) note that the treatment Black men faced during the Tuskegee syphilis experiment created lasting effects on the Black community as Black people have a distrust for public health officials. They quote Smith (1990) in saying that the experiment provided validation for the suspicion that Black people have of medical research and those who try to help. The mistrust that the Black community has for medicine is rooted in the historical abuse that their ancestors have endured (Thomas & Quinn, 1991; Washington, 2006). History has shown that medicine has little consideration for Black people because of issues with consent and forced sterilizations. As a result, African Americans are more likely to receive treatment at teaching hospitals, community-based clinics, and emergency rooms (Smedley, Stith, & Nelson, 2002) and are less likely to have primary care physicians (Jacobs et al., 2006) suggesting that Black people only seek treatment in emergent situations.

Other scholars like Schulz and Mullings (2006) suggested other reasons why Black women have poor health outcomes. They note that minority women are often thought to not have the ability to accurately articulate their symptoms. Therefore, their health is not always taken

seriously. They argue that current health disparities are associated with discriminatory practices within the health care system and suggest that more regulation should be implemented in order to decrease such disparities. In addition, they state that while information about disparities is available, physicians are reluctant to believe that their actions negatively affect minority patients.

One flaw of physicians that has been seen in maternal narratives is that physicians ignore reports of pain from mom during delivery. Reporting pain while seeking treatment is essential in the type of care a patient receives. During childbirth and post-partum, women report pain association with a number of different health conditions. According to March of Dimes (2018), a non-profit organization that seeks to improve the lives of babies and mothers, and World Health Organization (2018), an organization formed by the United Nations that is concerned with international public health, some of the most dangerous postpartum conditions for mothers are postpartum hemorrhaging², uterine atomy³, pre-eclampsia and eclampsia⁴, pulmonary embolisms⁵, infections and excessive bleeding. However, even when a patient is able to effectively report distress, physicians and other medical personnel are sometimes reluctant to listen and attend to them. This theme is prevalent in the narratives presented later in this thesis.

Examining the health narratives of these women will not only allow for the sharing of their stories but can create change in maternal care for Black women. Health narratives have the potential to be more persuasive than statistics alone as they make a situation more real and

² Postpartum hemorrhage (PPH) is an unpredictable birth complication that is characterized by bleeding at/from the placental site due to uterine atony and can lead to the death of a mother after childbirth (Bros, et al., 2011). In order to treat women experiencing hemorrhaging, medical practitioners should immediately take action when the mother or loved reports excessive bleeding or if the practitioner notices excessive bleeding. At that point, doctors should inject oxytocin (Charbit et al., 2007).

³ Uterine atomy is when the mother uterus fails to contract after she delivers the baby (Breathnach & Geary, 2009).

⁴ Preeclampsia and eclampsia are understood as hypertension aggravated by pregnancy and can result in the early separation of the placenta from the uterus (abruptio placentae), complications in the brain or heart, kidney failure or death (Mackay, Berg & Atrash, 2001).

⁵ A pulmonary embolism (PE) is a preventable complication that a woman can face during pregnancy and occurs when a blood clot travels to the lungs (Chan et al, 2002).

increase intentions to change (Greene & Brinn, 2011). When Black women share their stories about childbirth, they can shed light on health disparities in more powerful ways. Sharing stories allows people to connect to the individual, building empathy in the audience, and allows for deeper engagement and connection to the audience. Emphasis on their narratives gives them the platform to articulate the inequalities that they face which can help improve patient-doctor relationships.

The purpose of examining health disparities as it relates to Black women and not women as a whole is because “the experience of Black women in the U.S. is unique due to the convergence of their multiple identities as women and Black throughout their lives” (Rosenthal & Lobel, 2011, p. 978). There is much to learn and gain from analyzing the Black woman’s experience in order to have a better understanding of maternal care and how to provide better care for Black women. Understanding the views of Black women is important because they are absent in medicine. Research has shown that Black people are less likely to visit a doctor’s office (unless it is an emergency) or to partake in experimental research (Bulatao & Anderson, 2004). Aside from the historical context that would explain why Black people abstain from doctors’ offices, knowing how Black patients feel about or perceive their care can help make the experience better for them.

Chapter 3: Literature Review

Narrative Theory

Narratives are an important tool for understanding the way people experience life (Fisher, 1984; Lee et al., 2016). In trying to understand maternal disparities, it is beneficial to understand the perspectives of Black women and how they view their experiences because it can decrease the inequity they face. Narrative communication is suitable for health research because narratives are often used to encourage individuals to participate in healthier behaviors (Hinyard & Kreuter, 2007; McQueen et al., 2011).

McQueen et al. (2011) used narrative communication to encourage African-American women to seek treatment and participate in trials and experimental research for breast cancer by changing the attitudes and beliefs amongst the Black women participating in the study. The results found that through storytelling, more women were encouraged to go through cancer screenings. While sharing stories impacts behavior, everyone's story is not the same and the types of stories shares are not the same.

Robin (2006) notes three types of storytelling: 1) personal narratives stories that are significant to an individual 2) historical documentary stories are about dramatic events to help people understand the past, and 3) stories that are used to inform or impose change in the audience about a concept or behavior. The types of storytelling that Robin (2006) outlines are all narratives that can be used to further the current research. The personal narratives of Black women and historical documentation of the ways in which Black women have been treated in medicine can provide people with a better understanding of health disparities and hopefully change the way Black women are treated during their maternal care.

The impact of narratives and storytelling can be explained by three psychological mechanisms which allows a listener to immerse themselves into the experience of the storyteller: 1) transportation 2) identification and 3) realism (Lee et al, 2016). Transportation allows the listener of the story to experience what is occurring in the story to enhance the influence of the story (Lee et al., 2016). Identification allows the reader or listener to take on the perspective of the speaker (Busselle & Bilandzic, 2009). Realism is whether the story is perceived to be similar to the real world (Murphy et al., 2013). If the storyteller or character's experiences are thought to be real, then the listener can identify, understand, or respect the experience more than and are less like to argue against an issue than if a story is fiction (Lee et al., 2018).

Two other mechanisms highlighted in narrative persuasion are empathy and cognitive response (Oliver et al., 2012). Oliver et al. (2012) sought to examine the impact narrative formatting has on the judgments of stigmatized groups. Specifically, they instructed participants to read and rate one of six different versions of a newspaper story that varied the story format (narrative vs. non-narrative) on a story about the health care of elderly persons, immigrants or prisoners. In the narrative versions, the health care issue included the story of a specific person and his or her experiences to frame the information. The non-narrative versions presented the information as policy quotes from experts. At the end of the study, participants were also told that they could spend a few moments visiting the websites of advocacy organizations for the target group. They found that narratives produce more compassion towards the story-teller or individuals in the story, more favorable attitudes towards the group, more beneficial behavioral intentions, and more information seeking behavior by the listener. In turn, this study revealed the impact storytelling has on raising awareness on an issue and changing stigmas about a group of people.

In addition, narratives allow audiences to understand the way others perceive an experience (Pentland, 1999). Pentland (1999) explains that there are multiple ways to interpret and share a story. Understanding this concept stresses the importance of listening to an opposing or lost narrative because it allows for a deeper understanding of an incident. Specifically, narratives allow people to understand implicit bias through the stories that people share. Racism and prejudice are not always easily detectable as the implicit association test has demonstrated (Arkes & Tetlock, 2009).

A common experience many Black people have is being followed around a store while shopping. Although there is often not an exchange in dialogue that would insinuate that the store clerk was following the shopper because they felt that they were going to steal, the action of following the shopper did. The attentiveness to Black shoppers as opposed to other shoppers reveals how the Black person is targeted simply based off race. Another individual who does not identify as Black might interpret this experience as the clerk was just being attentive to the shopper. However, when the shopper explains their interpretation, others will be made aware of how the act could be interpreted as prejudiced.

Sharing one's narrative in story form is more impactful because humans are storytelling animals (Fisher, 1987) and we put our experiences in story form to understand and make sense of what has happened. In the example above, the shopper was able to share their experience allowing for their narrative to be heard and to provide a different understanding of that encounter to someone who had not viewed the situation as racist. Pentland (1999) states that narratives can provide additional insight to the social world by understanding the point of view of the storyteller.

While the example above is not health related, scholars believe that narratives can be used to advance health related theory, research, and practice as attention to narratives can help doctors better understand the relationship between experience and understanding (Babrow, Kline & Rawlins, 2005). Lee et al. (2018) used narrative theory to demonstrate the effective use of storytelling on increasing cervical cancer screening and HPV vaccinations in Cambodian Americans. Researchers created a DVD titled “Save My Daughter from Cervical Cancer: Stories by Khmer Mothers and Daughters” and showed it to participants to encourage mothers and daughters to get vaccinated. Through the use of video, women of similar ethnic background to the participants shared their vaccination and prevention stories. Daughters in the narrative intervention group reported higher intention to receive HPV vaccination.

Sharing stories or experiences with a group or to an audience helps individuals who do not have that same experience understand what others go through (Goodman, 2011; Barker & Gower, 2010). The ability to share one’s story also gives a storyteller a sense of agency because narrators can author their own story (Yang, 2016; Boonzaier & van Schalkwyk, 2011). Linguistic agency, having the opportunity to describe the world in the way that one sees it, allows an individual to decide which issues are important, who has power and/or recognition (Bamberg, 2010).

Sharing experiences also brings attention to situations that might not have received consideration otherwise. Japp et al. (2005) argue that narratives have become foundational to public knowledge. They add that testimonies have been used to persuade, evaluate, reward and punish people as these stories lock in listeners by eliciting emotions to get their point across. Within the scope of the present study, narratives are used to shed light and provide insight on health disparities Black women face that often go unnoticed. The sharing of their narratives can

allow the experiences Black women to help identify moments of neglect which contribute to disparities. Much of the current information on maternal disparities simply provides statistical information to support claims that race influences the type of care that a mother receives.

However, previous research has shown that people connect to narratives more than they connect to numbers. (Betsch et al., 2011). Statistical information does not allow audiences to connect to an issue in the same way that narratives can (Zebregs et al., 2014). Identification, empathy and changed behavior is created through storytelling and signifies the important of using narratives to raise awareness about maternal disparities.

In health research, narratives and storytelling have been used in various ways to shape behavior. Although the goal of the present research is not to change the behaviors of Black women, the goal is to change the behaviors of medical personnel. By listening to the narratives of Black women, doctors and nurses can find new and better ways to engage with Black patients. Similarly, narratives could be used as a mechanism to allow Black women to feel empowered and to feel as though they have agency in how they are viewed. In addition, providing a collection of narratives from these women will shift the discourse of health disparities from seeming like an anomaly into a collective of shared or similar experiences faced by many Black women. Sharing more than one story will emphasize the need for change.

Muted Group Theory

Muted group theory argues that subordinate groups have things to say, but they do not have the power to say them (Ballard-Reisch, 2010). Often, individuals within the muted group are disrespected by those within the dominant group and “their knowledge is not considered sufficient for public decision-making or policy making processes of that culture; their experiences are interpreted for them by others; and they are encouraged to see themselves as

represented in the dominant discourse” (Kramarae, 2005, p. 55). Wood (2005) argues that one goal of muted group theory is to bring attention to the fact that voices aren’t being heard and therefore their experiences aren’t being accounted for. In addition to explaining how groups are silenced, muted group theory suggests that words and language are created in order to be inclusive of the experience of the muted group so that the group can be valued (Wood, 2005).

Applications of muted group theory have been used to evaluate and explain the muting of women and minorities. Wall & Gannon-Leary (1999) give several examples of how women become submissive to dominant society. They explain that since language has been created by man, language is therefore controlled by men and because of this, the female voice is silenced. Because of this, women can only express themselves through a male domain (Ardener, 1975). Ardener adds that a muted voice does not necessarily mean a silenced voice, but a muted voice can be a voice that doesn’t say all they need to say when they need to say it. It is explained that women are often characterized as being non-verbal, inarticulate, and veiled where men are verbal and explicit (Wall & Gannon-Leary, 1999).

Black women have also demonstrated this pattern. White society often makes sense of issues for Black society. A recent example would be the discussion around Black Lives Matter. Often times White Americans justify the death of a Black people by characterizing the individual as a danger to society (Smiley & Fakunle, 2016). This narrative is curated by dominant White society and not the Black community which changes the interpretation of events by other groups of people. When Black people do not speak about their interpretations of such experiences, their voices are muted. Another example is Black women who participated in the Women’s March but did not advocate for topics that are relevant specifically to Black women. By marching for issues

that might not be specific to them and not speaking up on the issues that do matter, their voices can continue to be muted.

Another part of muted group theory is understanding the communicative strategies that marginalized groups use in order to communicate within dominant society (Scott, 2013). Scott (2013) analyzed Black women's communicative strategies and notes that Black women shift from speaking in an attitude or tone that is "Black" to "White" or "proper" in predominately White environments. Scott notes that while Black women speak in a way that shows solidarity with other Black women in predominately White environments, there are other instances in which Black women compromise or intentionally use words to allow them to cross cultural borders.

Crossing cultural borders refers to Black women's ability to communicate with those of differing backgrounds, as Black women have a different lived experience and a way of communicating than other ethnic and racial groups, and with other groups, such as dominant White society. For example, Scott (2000) explores the use of – "girl" and "look" – two words often used by Black women. While the use of `girl' indicates solidarity between Black women, the use of `look' is reported as calling attention to differences in identity with those who are not Black and female. Scott notes that Black women said that they not only use language differently across cultural borders, as the words above are used differently in conversation with Black and White women, but Black women see their relationships with others differently in the various cultural worlds.

Other groups also see Black women as different from themselves and Black women are aware that some of these views include negative stereotypes of them. Other cultures sometimes categorize Black women as "too outspoken," which changes the language and tone Black women

use in predominately White settings (Scott, 2013). In an interview conducted in Scott's study, one woman, Marie, shared how she "learned how to shift effortlessly and how to hold [her] tongue and speak [her] mind in situations where it won't harm [her] professionally, academically, or socially" (p. 319).

Understanding how Black women participate in their own silencing by conforming to the way they believe they should communicate in dominant society is important to the scope of the present research because this behavior can be seen in how Black women advocate for themselves during their maternal treatment. I argue that using Black women's narratives will be combative to the silencing Black women. When Black women do not share their stories, they participate in the muting of their own voice. Sharing their experiences will give them a voice. It is also important to note the vocabulary used to describe their experiences because it serves as a way to understand how they communicate their experiences within the Black community and in dominant White society.

Muted group theory is important for the present study because it provides insight as to one reason why the narratives of Black women have not been a part of maternal discourse. Although muted group theory has not been applied to health communication that examines health disparities or Black women's health, this theory is valuable for understanding Black women's voice and narratives.

Black Feminist Theory

Black feminist theory is an approach to help understand the perspective of Black women by listening to Black voices. Smith (1989) notes that:

"the phrase *Black feminist theory* [not only refers to] theory written (or practiced) by Black feminists, but also to a way of reading inscriptions of race (particularly but not

exclusively blackness), gender (particularly but not exclusively womanhood), and class in modes of cultural expression” (p. 370).

Here, Smith argues that Black feminist theory is not only theory written by Black women but it is also a way of understanding the race, class, and gender in culture. This definition of Black feminist theory will be used to understand the significance of the Black female voice.

Particularly, Smith’s definition highlights the role of intersectionality for Black feminism and voice.

Crenshaw (1989) notes that Black women have been theoretically erased. The Black female voice is often not heard and is sometimes erased from discourse because their experience is often reduced to the experience of the Black man or White woman (King, 2016). When learning about marginalization and discrimination, Black women’s experiences are not prevalent, which establishes a need for Black feminist standpoint literature. While there is literature such as feminist standpoint theory that examines the perspectives of women in discourse, it is not exclusive to the Black female experience (Crenshaw, 1989).

Richardson & Taylor (2009) state that feminist standpoint theory has been useful in the examination of sexual harassment of White women in the workforce but has not been applied to examine harassment that Black women experience. When Black women experience a racist or sexist moment, they often have to compartmentalize the experience to only reflect their racial identity or their gender identity. Emphasizing the complexity of Black women is important because Black women often have to choose between being marginalized with the category of race or sex, not both (Lewis, 1977), even though both their race and sex gives them a unique position.

Women like Mary Church Terrell, the first president of the National Association of Colored Women, recognized the “double enslavement” of Black women. She wrote, “Not only are colored women...handicapped on account of their sex but they are almost everywhere baffled and mocked because of their race” (King, 2016, p. 42). Noting this emphasizes the significance of discussing the narratives and perspectives of Black women. Their complex identity and intersectionality of race and sex makes their knowledge and standpoint different than that of the Black man or of the White woman.

Black feminist theory gives Black women the ground to interpret their reality (King, 2016). Under the theoretical framework of Black feminist theory, Black women are also given the opportunity to decide which situations, knowledge, behaviors, ideology, etc. are salient in the understanding of their oppression: “Black feminist thought articulates and makes accessible the knowledge and collective philosophy of Black women, but it also creates new epistemologies and creates new dimension for describing experiences and for liberation” (Hill Collins, 1988, p. 302). The sharing of a Black woman’s experience can add to existing knowledge we have about health equity by raising awareness on health disparities and evoke change within the healthcare system.

In health communication, Black feminist theory has been applied to research that examines the prevalence of HIV amongst African-American women (Lima et al., 2018). In their study, they interview 11 African-American women who have had sex within the past three months with partners that they suspected to have been with other partners in the past 12 months. They found that the women would partake in non-monogamous relationships because of partner availability, gender norms, cultural norms, low self-esteem, loneliness, sexual connection and emotional attachment, etc. To find the themes, they used Black feminist theory to guide them in

identifying themes related to partner nonmonogamy acceptance. Using Black feminist theory allowed them to understand the shared experiences of African-American women and how their experiences can place them at increased risk of diseases like HIV.

Black feminist theory works within the frame of the current research because attention is needed to recognize to the Black female experience. As stated, the Black female experience has been reduced to the voice of the Black man or the White women (King, 2016). Knowing this leads to questioning whether Black women experience healthcare differently than White women or Black men. While that question is beyond the scope of this project, examining the Black women's experience is essential to the current research. Black women have had to learn to navigate within a system that has ostracized them both by gender and race (Schulz & Mullings, 2006).

Standpoint Theory

Standpoint theorizing began in the 1970s and 1980's (Harding, 1998) and focuses on how an individual's life affects how they understand and create a social world (Littlejohn, Foss, & Oetzel, 2017). Standpoint theory values the individual experiences of oppressed groups to help them develop an oppositional or differential consciousness (Kramarae, 2005). Mansbridge (2001) defines oppositional, differential consciousness as a mental state that prepares those within the oppressed group for reform to a system that evokes power over others. Focusing on the individual's point of view of the world allows for this oppositional view to be developed, one that differs from the dominant way of thinking about the world (Ruddick, 1995).

Within standpoint theory, the marginalized way of thinking is the ideology of a marginalized or oppressed group (Longino, 2002). Standpoint theory generally defines women as the marginalized group, making standpoint a feminist theory (Wylie, 2003). Standpoint theory

states that women have a different way of thinking and gaining knowledge about the world than men, but their unique interpretations of the world should be equally valued (Wylie, 2003).

Standpoint theory serves to evaluate how the location of women within a hierarchical social structure impacts how they engage and understand the world. Wylie (2003) describes location as:

What individuals experience and understand is shaped by their location in a hierarchically structured system of power relations: by the material conditions of their lives, by the relations of production and reproduction that structure their social interactions, and by the conceptual resources they have to represent and interpret these relations. (p. 31)

Standpoint theory suggests that people in different social locations have access to different information (Crasnow, 2014) and because members of marginalized groups live within the dominant society and they have knowledge that is not available to those who only live within the dominant society (Riger, 1992). For example, a Black individual understands how to live in a White world in addition to living as a Black individual. Similarly, women can incorporate men's perceptions as well as their own and develop a more accurate and objective set of beliefs about the world (Longino, 2002).

Standpoint theory has been used to help otherwise forgotten groups be heard, widening the knowledge on a given topic. Martin, Reynolds & Keith (2002) used standpoint theory to shed light on the discrimination and unfair treatment, such as sexual harassment, that female lawyers and judges experience in the workforce. They explain how men had reported no issues within the workforce, but women had, revealing gender bias. This research highlighted the differences in the way that men and women perceive the legal field. This research allowed women to share their stories which in turn expanded knowledge on workplace interactions. Similarly, the present

research can contribute to the conversation around health equity by being inclusive of the Black female experience.

Recognizing that Black women experience the world in a different way and make sense of their experience differently than males or women of other cultures can help to understand how to care for Black women. For example, depression and anxiety are mental disorders that are not accepted or recognized in the Black community. Therefore, if a Black woman is seeking medical treatment and is showing signs of depression but has not verbally stated she feel she is depressed, doctors might not treat her for depression. However, a doctor who understands the Black community will be able to diagnose her and explain next steps in a way that she can accept treatment. Examining health equity from the standpoint of Black women will allow for Black women to be a part of the discourse providing a better understanding of the issue.

Standpoint theory is applied to the present research because it provides a way to understand how medicine can integrate the perspectives and ideology of Black women to provide better care to them. The present study explores the standpoint of the Black women by sharing their maternal narratives and using it as a way to inform the way Black women feel in medical settings. It also helps to reveal that Black women do not have the same medical experiences as other racial groups.

I aim to build on the current theoretical knowledge on the importance of Black female narrative as well as answer the following research questions:

1. How do the surviving family members of the Black women who died in childbirth or the women who had near-death experiences tell the stories of what took place?
2. How do these narratives demonstrate power dynamics and inequalities in healthcare?

Chapter 4: Methodology

In order to learn about existing power dynamics and inequities in contemporary maternal disparities and the effect on Black women, I searched for themes in the maternal narratives of Serena Williams, Elise Salazar, Kira Dixon-Johnson, and LaShonda Hazard, four Black women whose health suffered at the hands of medical personnel. In forming the themes, I looked at how the surviving women and/or their family members describe the maternal experience. To find the narratives of Williams, Salazar, Dixon-Johnson, and Hazard, I intentionally searched for media coverage of Black women that were provided with negligent care pre- and post-delivery. I specifically selected these narratives because I wanted to maximize the variation of the treatment, experience, and identity of the women for the sample of which my analysis would cover.

Texts & Sampling

To conduct the proposed study, I analyzed the following maternal narrative texts: Tennis player, Serena Williams' *Vogue* interview, her documentary series *Being Serena* season 1 episode 2, her personal spotlight article with *CNN*, and a follow up coverage piece on her with *CNN*. Serena Williams' narrative was analyzed because she is a Black celebrity who has had a near-death experience post-partum. Including Williams in the discussion demonstrated how Black women of all socio-economic statuses can experience maternal complications and how Black women, regardless of affluence, can receive negligent care.

In addition, Williams was included because, unlike the other women, she had the ability to articulate her complications to her medical team. Williams' preexisting health issues with embolisms allowed her to quickly recognize that one had formed post-partum. While the medical team was attentive to her and ran scans to determine what was causing her distress, when

Williams suggested a doppler examination, which is used to locate embolisms in the body, the medical team did not consider her suggestion immediately. The blatant neglect that Salazar, Dixon-Johnson, and Hazard received was not present in Williams' care.

Additionally, Williams was granted the opportunity to share her story with high profile media outlets like *Vogue*, *CNN*, and *HBO* where the other women were not. Williams' overall maternal experience does not resemble the experience of the women, however, the fact that she is a Black woman who suffered during her maternal care and her quick assessment of her complications were not considered immediately, demonstrates how her maternal experience is fitting for the current analysis.

In addition, I examined Leah Campbell's *Healthline* article that shares Elise Salazar's maternal story. Salazar is a mixed-race Latina who gave birth on a military base in Hawaii. Elise Salazar's story was found through an intentional search of "mistreatment of Black moms during delivery." Salazar's narrative was chosen over other narratives and articles that discuss maternal mortality and/or include the narratives of Black women who have suffered due to medical negligence because the *Healthline* article included several direct quotes from Salazar about her experience. Other sources covering maternal disparities lack in the number of direct quotes from mothers. In a narrative analysis, it seems important to have direct dialogue from mothers to allow audiences to understand how these women felt in their own words.

In addition, Salazar also recounted on her experience as a young teenaged mother which created more variability between the narratives assessed. Salazar was 19-years old in the story she recounts. The other women included were much older than Salazar at the time of they sought treatment. Assessing the narrative of women of various age groups allowed for a more well-

rounded study. In addition, Salazar was the only Black woman who described a traumatic experience during delivery, rather than before or after.

I also analyzed the commentary of Charles Johnson, husband of Kira Dixon-Johnson and Judge Glenda Hatchett, mother in law of Dixon-Johnson, who had a joint interview on YouTube with Kat Harvey who is an African-American social media influencer and the CEO and founder of her own media company. Kira Dixon-Johnson's story was included because of the popularity of her narrative received. Dixon-Johnson's narrative circulated several media outlets that discussed maternal mortality and maternal disparities. In addition, Dixon-Johnson's husband, Charles Johnson, shared their story in front of Congress. The popularity of her story and abundance of information on her experience provided a lot of narrative information about her death.

Further, I analyzed Chuck's (2018) *NBC* news coverage of Congress' The Maternal Health Accountability Act of 2017 which includes dialogue from Charles Johnson about the events that took place at Cedars-Sinai Medical Center. The Maternal Health Accountability Act of 2017 was initially a bill proposed by the Senate that encourages the Department of Health and Human Services to support states in decreasing maternal disparities and pregnancy-related complication and deaths. Provisions of this bill were incorporated into other bills which were enacted. The Maternal Health Accountability bill was incorporated into the House of Representatives 1318: Preventing Maternal Deaths Act of 2018. The Preventing Maternal Deaths Act of 2018 was enacted and signed by President Donald Trump on December 21, 2018

Lastly, I examined LaShonda Hazard's personal Facebook page where she posted about the care she received at Women and Infants Hospital in Providence, Rhode Island. Hazard was a 27-year old mother to be who died of unknown causes. LaShonda Hazard's narrative was

evaluated because she was a young Black woman whose story did not receive the same amount or type of media attention as the other women. Hazard's story trended on Twitter shortly after her death which is how I learned of her death. The unique way in which I discovered her story and mystery of her experience is why Hazard's narrative was analyzed.

Women like Williams have articulated their experiences in the healthcare system with media outlets in order to raise awareness on the current maternal disparities, allowing access to their narratives. Oppositionally, Dixon-Johnson's family has also publicly spoken about the treatment Dixon-Johnson received. The narratives of Williams, Salazar, and Dixon-Johnson were stories that I came across while engaging in traditional media outlets such as newspaper articles, news outlets, and magazines. However, I gained access to and information on Hazard's narrative through new and informal forms of media like Twitter and Facebook.

I intentionally selected these narratives because they are from Black women, all differing in socioeconomic background, geographic location, and levels of networked exposure through media outlets. The variation of stories demonstrates how maternal disparities are not dependent on one factor like economics, nor is a local or an isolated issue. Thus, showing how medical negligence can happen to any Black woman.

Analysis

Thematic analysis is a method for finding and organizing patterns across a data set in order to make sense of collective or shared meanings and experiences (Braun & Clarke, 2014). It identifies a common way a topic is talked or written about and makes sense of those commonalities (Braun & Clarke, 2014). This type of analysis involves identifying themes by carefully reading and re-reading data (Rice & Ezzy, 1999). Researchers find patterns within the

data, generating themes which become the categories for analysis (Fereday & Muir-Cochrane, 2006).

I conducted a thematic analysis to examine the maternal narratives of Serena Williams, Elise Salazar, Kira Dixon-Johnson, and LaShonda Hazard. Doing a thematic qualitative analysis helped to make sense of how the women and their family members made meaning of their experiences and how their experiences were relayed in contemporary media. A thematic analysis also helped to understand how their narratives have been shaped in the discourse surrounding maternal disparities.

In creating the themes, I looked for commonalities in how the experiences between medical personnel and the Black women were described. Media, such as Harvey's interview with Johnson and Hatchett, in addition to Williams' documentary series episode were transcribed. In addition, all direct quotes included in the article coverage of the women's experiences were extracted. Lastly, the comments from Hazard's Facebook page were assessed as a part of the data. I looked for specific terms and language used to describe the negative experiences of Williams, Salazar, Dixon-Johnson, and Hazard. This revealed moments in which women felt dominated and/or spoke freely exercising emancipation from the way historical way in which Black women have been treated in medicine. Not only did I pay attention to the direct quotes and dialogue from the individuals sharing the maternal experiences, but I paid attention to the context in which the narratives were shared. For example, Campbell not only provided audiences with dialogue from Salazar about her experience but also address national issues of maternal mortality and ways to decrease disparity and mortality rates. The surrounding text to Salazar's experience is a part of her narrative which led me to analyze that content.

In finding themes within the narratives, I intentionally paid attention to moments where mothers and/or other narrators described when complications arose during delivery. In these descriptions, I looked at what how quickly medical personnel responded to patients, what procedures were performed, and how were patients describing and recounting the words and actions of the medical staff treating them. After noting these descriptions, I looked for commonalities between the four narratives in order to determine if there were any recurring themes in the feelings described about the treatment they received.

In using the theories outlined above to help uncover themes in the narratives, I paid attention to when the Black women or their family members described moments of power relations by looking for moments in which they expressed concern, when that concern was ignored, and how medical staff responded to disagreement, as well as how these Black women responded to the disagreements. This allowed me to outline the power dynamics in the maternal care that these women received.

In addition, I looked patterns in the language used to describe their experiences. To do this, I identified specific adjectives used to describe themselves or the medical staff attending to them. This helped to determine where power was attributed. In addition, I highlighted moments in which society reinforced the suppression of the Black female voice. Additionally, when assessing the narratives of Williams, Salazar, Dixon-Johnson, and Hazard, I paid attention to which aspects of their narratives were missing. Based off historical documentation in the way Black women such as Anarcha, Fannie Lou Hamer, Henrietta Lacks, Annie and Minnie, and their reproductive organs have been treated in healthcare, insurance coverage/government assistance and identity of medical personnel arose which were contributing factors to the type of

negligent care provided. This led me to question whether similar trends were present in contemporary issues of maternal mortality.

Since these narratives served as case studies for the current research and the analysis would include an extensive look into their stories, a small sample was ideal, as qualitative analyses recommend having small sample sizes (Langlois & Elmer, 2013; Bock & Sergeant, 2002). Only four narratives were discussed because the variability between each of the subjects were showed how women of different economic backgrounds and age are affected.

In addition to finding the themes presented in the narratives, I reviewed the timeline in which these stories were shared in discussions of maternal health in world and national news. Seeing how their narratives have been discussed in media involved examining which outlets shared their stories, what was the surrounding context to the sharing of their narratives and in which ways have the narratives been crafted in popular media. Specifically, I researched contemporary information about what discussions about maternal mortality were being had outside of the experiences of Black women.

Charles Johnson, husband of Kira Dixon-Johnson, shared the tragedy that happened to his wife before The House of Representatives, in support of the Preventing Maternal Deaths Act of 2018. Johnson's testimony was shared through *NowThis*, an American media website that primarily distributes video news content to mobile devices and social platforms. However, *NowThis* did not explicitly share the setting in which Johnson was speaking. From the video, I researched where Johnson shared the testimony and learned about the Act of 2018. I then discovered that the Preventing Maternal Act of 2018 was originally The Maternal Health Accountability Act of 2017. I used The Maternal Health Accountability Act of 2017 as a point of reference for why Williams, Salazar, and Dixon-Johnson, and Hazard's narratives have been

shared in recent media because all of the narratives followed the introduction of The Maternal Health Accountability Act of 2017. Before turning to the analysis, I briefly describe what happened to each of the four women studied.

Case Studies

In 2018, Serena Williams, 37, went into labor at St. Mary's Medical Center in West Palm Beach, FL after her daughter showed signs of distress. Due to complications, Williams could not have her daughter vaginally. Instead she delivered via a cesarean-section. Hours after delivering her baby, Williams had a pulmonary embolism. Williams' reported having difficulty breathing causing her to cough which led to her stitches breaking. Williams was then taken back to the operating room as doctors had to reopen her c-section and re-stitch it. Her medical team searched for blood-clots however, all the test were coming back negative. Williams' explains that because she had suffered from embolisms before, that she wanted the medical team to perform a doppler test/ CT scan with dye and check her lungs because she believe an embolism had formed.

When they did perform the CT scan with dye, they found a pulmonary embolism had formed in her lungs. Eventually, another blood clot had formed in her leg leading her medical team to insert a filter to prevent blood clots from forming and traveling to her heart.

In 2018, Elise Salazar, a mixed raced Latina, recounted her experience as a 19-year-old pregnant teen with Leah Campbell, a writer at *Healthline*. Elise Salazar's identity exemplifies how Black women are not just African-American or decedents from Africa but are women of various backgrounds. Her narrative was assessed because of she is not just African-American but because she exemplifies how Black women of various ethnic backgrounds (Latina and Black) are affected by maternal disparities.

Salazar delivered her child on a military base in Hawaii. Her delivery was painful which led to Salazar to request an epidural. Her request was denied until she demonstrated labor pains to the expectation of her anesthesiologist. During delivery, a nurse on staff told Salazar to shut up because she was scaring other patients. The nurse's instruction in telling Salazar to shut up demonstrates contradictory feedback Salazar received before delivery. The anesthesiologist's wanted her to perform labor pains and when Salazar demonstrated signs of laboring pain, she was told to shut up.

In addition, the medical team did not give Salazar an episiotomy⁶ to prevent the third-degree tears that she endured (which was offered to her during the delivery of her first child). Post-delivery, medical staff left Salazar to lie in blood and discharge for more than an hour. Among the four Black women included, Salazar is the only woman who recounted a negative experience during delivery itself. It should be noted that while the state of Hawaii is shared as the location of the incident, further detail such as which city or specific base Salazar delivered her baby on was not provided.

In 2016, Kira Dixon-Johnson, 39, planned to have a cesarean-section to deliver her second child at Cedars-Sinai Medical Center in Los Angeles, California. About two hours after delivery, Dixon-Johnson's uterus failed to contract (uterine atony) which can lead to or be a symptom of post-partum hemorrhaging (excessive bleeding). Nurses were alerted that Dixon-Johnson's catheter was filling with blood. Within the hour, nurses had replaced her catheter. Minutes after the replacement, the new catheter filled with blood. An ultrasound was then taken and revealed 6cm of fluid had developed posterior to her bladder/anterior to her uterus

⁶ Episiotomy is an incision through the perineum (the area between the anus and the vulva). An episiotomy is performed to enlarge the perineal opening to allow the baby to be born and is done with special scissors just before the birth (West & Isaac, 2008).

suggesting a large hematoma⁷. Dixon-Johnson's doctor was notified of her condition. Dixon-Johnson was then given pain medication and fluids.

About 45 minutes after the ultrasound showed suspicions of a hematoma, labs were ordered showing abnormalities in her blood. A half an hour later, CT scans of her abdomen and pelvis were ordered because another doctor on her medical team believed there to be reason for a surgical emergency. However, Dixon-Johnson was not taken into surgery. Bleeding continued and half an hour after the CT scans, another ultrasound was performed showing the hematoma had enlarged. Dixon Johnson and Johnson were told that although the hematoma appeared stable there was concern regarding the blood in her catheter as she also had no urine output.

Following, imaging of her pelvis and lower urinary tract were ordered and her primary doctor was made aware of her condition. More fluids were provided to her and labs continued to report abnormal blood results. 45 minutes after the new lab results, Dixon-Johnson was seen by a third doctor as Dixon-Johnson had produced little urine despite being given fluids. Blood continued to flow in her catheter. At this point, it was estimated that she lost 1500cc's of blood suggesting acute blood loss anemia which led to her receiving 2 units of red blood cells.

At this time, Dixon-Johnson's primary doctor was aware of all her symptoms. The CT scans that were ordered earlier, still had not been done, which records from the wrongful death lawsuit Charles Johnson filed stated had been four hours after the CT scans had been ordered. In addition to the loss of blood, Dixon-Johnson's blood pressure rose. Thirty minutes later surgical discussion was held, and consent was provided for surgery. However, she was not taken into surgery until 45 minutes later as her primary doctors did not concur with the other two doctors on her medical team that she be taken to surgery. Dixon-Johnson blood pressure continued to

⁷ A hematoma is a mass or abnormal collection of clotted blood within the tissues (Nabili, n.d.) .

rise, and a repeated ultrasound show the hematoma had enlarge and now free fluid had developed in her abdomen. Finally, Dixon-Johnson was taken into surgery however, she was pronounced dead two hours after being taken to the operating room. The autopsy stated that the cause of death was due to hemorrhagic shock due to blood in her abdomen.

In 2019, LaShonda Hazard, 27, sought treatment at Women and Infants Hospital in Providence, Rhode Island. Hazard had been experiencing stomach pain. When seeking treatment, doctors told her that her baby was fine and that there was not anything they could do for her. Hazard and her baby died hours later of unknown causes. The cause of death of her and her baby continues to be unknown. The only information obtained about Hazard's experience has been through a Facebook post on her personal Facebook page. In my attempt to learn more information about Hazard as an individual, I discovered her Facebook and LinkedIn account. Through her social media, I found that Hazard lived in Providence, Rhode Island and worked as a visual merchandiser at Forever21 and/or Zara at the time of her death.

Chapter 5: Analysis

My analysis starts by first highlighting contemporary discussion on maternal mortality held by the Senate in The Maternal Health Accountability Act of 2017. After The Maternal Health Accountability Act of 2017 was proposed the narratives of Kira Dixon-Johnson, Serena Williams, LaShonda Hazard, and Elise Salazar were discussed in various mediums. Charles Johnson spoke before Congress and shared the tragedy that happened to his family to convince Congress to support the Act. In addition, Chuck's (2018) coverage of Congress' support in maternal healthcare research includes the narrative and dialogue from Johnson. Seeing how Johnson's dialogue is intertwined with the Act demonstrates how Dixon-Johnson's narrative has become a part of maternal discourse and why it has been told in contemporary media. Johnson had not shared Dixon-Johnson story with any media outlets before The Maternal Health Accountability Act of 2017. Johnson had only filed the wrongful death lawsuit.

The narrative of Serena Williams also followed the national conversation about maternal health and maternal disparities. Haskell (2018) interviews Williams about motherhood, marriage, and her return to tennis following Congresses initiative to provide better maternal healthcare. I argue that Williams story was strategically placed in conversation about high maternal mortality rates and racial disparities.

In 2017, Elise Salazar recounts her traumatic birthing experience that occurred 20 years prior to the Campbell (2018) article coverage. In an intentional search for more information and dialogue from Salazar besides the Campbell coverage, no additional information on her birthing story was found. This led me to believe that Salazar had not shared her story with any media outlet prior to her speaking with Campbell.

Lastly, LaShonda Hazard trended on Twitter and blogs early January 2019. There is little detail about the treatment she received and the cause of death of her or her child. With that in mind, I believe that discussion about her death received the popularity it generated on informal media sites because of current discussions about maternal disparities.

In addition to using The Maternal Accountability Act of 2017 to reason for why Dixon-Johnson, Williams, Salazar, and Hazard's narratives are being told in contemporary media, I also found that the four narratives were shared in conjunction with statistical information about the disparities in maternal mortality faced by Black women. I argue that the combination of statistics and narrative effectively invokes the ethos, pathos, and logos of an audience allowing for a greater transportation and acceptance in the audience, which is why each of the narratives included both statistics as supporting information and their narratives.

My analysis then discusses three themes found within the four narratives. The first is self-help narratives which are narratives where women, or family members, requested tests or treatments that were not suggested by medical personnel. The second narrative theme identifies feelings of being wronged, which illustrates moments where women were described as not being treated adequately. The third narrative theme involved feelings of being ignored by medical staff. Here, women were described as not being treated at all by medical staff. The difference between the narratives of being wronged and ignored is that being ignored focuses on the explicit neglect that patients received whereas in narratives demonstrating being wronged reveal that care was given but it was inadequate.

Following the explanation of the three themes, I discuss the power dynamics that were revealed through interactions between medical personnel and Black women. Here I discuss instances where physicians asserted themselves over the Black women and when Black women

asserted and advocated for themselves during their care. Following, my analysis includes a discussion on the intersectionality of class and voice. In this section I demonstrate how the hierarchy established in American society allows for Black women of more affluence to share their narratives in a formal setting with more establishment media outlets, in comparison to Black women who are not as affluent or networked. In addition, I discuss how the characterization of the Black women influences the engagement audiences have with the narratives of the four women.

My analysis ends with a discussion of how elements such as the insurance policies, the identity of the medical staff attending to the four women, and several details about Salazar and Hazard's story is unknown and what implications that has in understanding the narratives of these women. The absence of information is equally important as information that is present in the narrative. Here I explain the significance of evaluating missing narrative elements to understand the meaning of a narrative.

Congress's Support in Decreasing Maternal Mortality

A part of understanding the importance of Kira Dixon-Johnson, Serena Williams, LaShonda Hazard, and Elise Salazar's narratives is understanding why they are being told in recent media stories. These women's narratives followed the national discussion focused on improving the maternal health of marginalized groups like Black women. Congress proposed two acts, The Preventing Maternal Deaths Act of 2018 which was proposed by the House of Representatives and The Maternal Health Accountability of 2017, proposed by the Senate, to help decrease the number of deaths caused by preventable complications during pregnancy. The Maternal Health Accountability was incorporated into the House of Representatives Preventing Maternal Deaths Act of 2018. For this analysis, I exclusively reference The Maternal Health

Accountability Act of 2017 because it was the start of Congress's involvement in decreasing maternal mortality. Both the Maternal Health Accountability Act of 2018 and the Preventing Maternal Deaths Act of 2018 directed the Department of Health and Human Services to support states in:

Their work to save and sustain the health of mothers during pregnancy, childbirth, and the postpartum period, to eliminate disparities in maternal health outcomes for pregnancy related and pregnancy-associated deaths, to identify solutions to improve health care quality and health outcomes for mother and for other purposes.

In the Maternal Health Accountability Act of 2017, the Senate (2017) recognizes that the U.S. maternal mortality rates increased 26.6% from 2000 to 2014. They emphasize that the purpose of the act is to share responsibility between states and the federal government in order to identify opportunities for improvement in quality of care and system changes as well as to educate and inform health institutions and professionals, women, and families about preventing pregnancy related deaths and complications.

This bill was proposed May 11, 2017 and Williams, Dixon-Johnson, Hazard, and Salazar's narratives followed the Senate discussion on maternal health. Williams' first media coverage was her *Vogue* interview in which she discussed her traumatic maternal story, that did not surface in the media until January 10, 2018. Kira Dixon-Johnson died in 2016, however, Charles Johnson did not file the wrongful death lawsuit until March 22, 2017. Although this is before the date of the proposed Maternal Health Accountability Act of 2017, the lawsuit follows the Preventing Maternal Deaths Act of 2018 which was originally proposed March 2, 2017, 20 days before Johnson filed the wrongful death lawsuit. Johnson also shared his testimony with the House of Representatives on September 27, 2018 in a hearing on The Maternal Health

Accountability Act. Salazar gave birth 20 years prior to her 2017 media coverage, and her story was shared in correspondence with the recent conversation on the maternal disparities affecting Black women. Hazard died in January of 2019, and it can be implied that her story gained traction in the media because of current discussion on improving maternal health and decreasing maternal disparities.

The Maternal Health Accountability Act of 2017 seeks to decrease maternal deaths for all women, and while it does acknowledge racial differences between which groups of mothers suffer in their maternal care, the focus as a whole is on decreasing maternal deaths. According to the act, the U.S. ranks 50th globally for its maternal mortality rate, and it is one of eight countries in the world where the maternal mortality rate has been on the rise. The act brings up the CDC's report which states Black women are three times more likely to die from complications of pregnancy or childbirth than White women. Out of every 100,000 live births, 42.8 Black women die from maternal complications as opposed to 12.5 White women and 17.3 women of other races.

Inclusion of Statistics to Strengthen Narratives

The inclusion of national statistics in the United States about the maternal mortality of Black women in the media coverage of the four Black women's birth narratives is another commonality that Williams, Dixon-Johnson, Hazard and Salazar's share in common. The articles and other sources sharing these women's narratives continuously highlight the CDC's statistics, and argue that differences in maternal mortality rates and health disparities exist because Black women are not treated equally to their White counterparts in addition to not being listened to by medical staff. Stone (2018), a writer for *Scarymommy.com*, shared LaShonda Hazard's story. In her coverage she not only tells Hazard's story, but states that Black mothers as a whole are

vulnerable to situations where they feel frustrated, scared, and bereft of answers while in a hospital.

In sharing Elise Salazar's story, Campbell (2018) also links readers to articles published by *CNN*, *New York Times*, *USA Today* and *National Public Radio (NPR)*. The intentional inclusion of the additional readings discussing maternal disparities shapes the narrative told by Salazar in sharing her experience in conversation with information on the maternal mortality of Black women. In one specific article, Burns (2017), the author of the *CNN* article linked in Campbell's (2018) article featuring Salazar, not only discusses maternal mortality rates in America, but further explains that because women of color often have poor access to healthcare, experience the overuse of medical interventions, and enter pregnancy with chronic conditions and limited education, they are at high risk of dying during the pregnancy. Burns (2017) also notes that financial, racial, cultural and systemic barriers are reasons women of color and low-income women receive lesser quality care or no care at all.

Tavernise (2016), author of the *New York Times* article, "Maternal mortality rate in U.S. rises defying global trend, study finds," and Martin & Montagne (2017), co-researchers for the *NPR* story, "U.S. Has the Worst Rate of Maternal Deaths in The Developed World," had sources linked from Campbell's (2018) *Healthline* article on Salazar, comparing U.S. mortality rates to various other countries in the world and highlighting the differences in mortality rates by state as they address issues of maternal mortality. Tavernise (2016) argues that obesity is a factor for why the mortality rate is increasing, while Martin & Montagne (2017), note that hospitals are unprepared for maternal emergencies and some doctors entering maternal-fetal medicine were able to complete their training without ever spending time in a labor-delivery unit.

In addition to sharing national and global statistics, Young (2018), writer of the *USA Today* article, “Hospitals know how to protect mothers. They just aren’t doing it,” posits that excessive bleeding and high blood pressure is why so many mothers are dying. Campbell (2018) linked readers of the *Healthline* article on Salazar to the additional resources described above in order to help expand their knowledge on maternal mortality in the United States. In addition, Campbell (2018) also discusses institutionalized racism, lack of access to prenatal care and awareness and maternity leave for reasons maternal complications are so high for Black women. Campbell (2018) suggests cultural sensitivity and awareness as a way to improve these health outcomes.

Similarly, across several mediums and platforms, Charles Johnson, husband of Kira Dixon-Johnson, continuously shares national statistics in addition to addressing the narrative of the tragedy that happened to his wife. Williams (2018) mimics this style of storytelling in her *CNN* opinion piece by sharing her own story—the story of another Black mother who had a tragic maternal outcome—by citing statistics about global maternal issues and ways her audience can help make a change alongside her narrative. Williams (2018) urges her readers to write government officials, healthcare providers and businesses, as well as donate to organizations like UNICEF.

All narratives highlight national statistics as well as share the individual stories in order to emphasize the problem of maternal mortality. They do so to not only share their stories but to convince their audiences to care about the issue through the effective use of ethos, pathos, and logos. Real life stories elicit emotion (pathos) in audiences, where statistical information (logos) provides evidence. The inclusion of statistical information strengthens the reasoning for maternal mortality reform by sculpting the issue to be an ethical dilemma, invoking ethos. Therefore,

allowing audiences to recognize that maternal mortality is a current issue that needs to be addressed now. Each of these women's narratives used ethos, pathos and logos to strengthen their narratives and to get audiences to connect and support change.

Narrative Themes in Maternal Stories

In looking at the narratives separately from the Senate's initiative and CDC statistics, three narrative themes were identified in the analysis of the maternal stories. The first is self-help narratives, which are narratives where women, or family members, requested tests or treatments that were not suggested by medical personnel. The second narrative theme identifies feelings of being wronged which describe moments where women were described as not being treated adequately. The third narrative theme involved feelings of being ignored by medical staff. Here, women were described as not being treated at all by medical staff. The difference between the narratives of being wronged and ignored is that being ignored focuses on the explicit neglect that patients received whereas in narratives demonstrating being wronged reveal that care was given but it was inadequate.

Self-help narratives. Self-help narratives are narratives that demonstrate a narrator's effort in seeking or requesting better care, or more attentive care, regardless of the care that has been suggested or implemented by medical personnel. Serena Williams' maternal narrative strongly reflects self-help as Williams viewed herself as being an advocate for her own survival and care. As previously stated, in 2018 Williams went into labor when her baby was showing signs of distress. Williams was taken to the hospital where she delivered her baby through a cesarean-section. After delivery, Williams reported that she was having difficulty breathing and she believed that a blood clot had developed in her body.

As Williams recounts her post-labor experience in her HBO documentary series, *Being Serena*, she said, “they were doing all these different tests, and everything was negative. And I was like ‘listen, I need you to run a CAT scan with dye because I have a pulmonary embolism in my lungs, I know it, I know it. I’ve had this before. I know my body.’” After repeatedly asking for the CAT scan, doctors ran the test and discovered that a pulmonary embolism had formed. Eventually they put a filter in Williams to prevent any blood clots from forming and killing her.

Across different media platforms, Williams demonstrates how her asking and persistence was imperative to her survival. Although Williams was attended to as what can be inferred as immediately, in her interview with Rob Haskell, a writer for *Vogue* magazine she says, “I was like, a doppler. I told you, I need a CAT scan and a heparin drip...I was like, listen to Dr. Williams!” demonstrating that even with the timely care, the medical team did not listen to Williams. Williams’ dialogue not only shows that she is knowledgeable about medical procedures, but she can effectively articulate her symptoms and ask for care in a way that doctors understand. Her self-advocacy and persistence saved her life. This is seen when she first asks for a CAT scan, but she also tells them to do doppler ultrasound.

Both Williams’ husband, Alexis Ohanian, and agent, Jill Smoller, agree that Williams was fighting for her life and that her personal advocacy saved her life. Ohanian said, “she was undoubtedly battling for her life and I was terrified that she might die. But I was grateful that she had the wherewithal to speak up because she knew her body better than any of us.” Smoller adds, “the enormity of everything was scary but fortunately because she advocated for herself, they ended up taking her in for a CAT scan and they found the pulmonary embolism.”

Self-advocacy is a theme that was not only apparent in Williams’ narrative but also in Elise Salazar’s. In an interview with Leah Campbell (2018), a writer for *HealthLine*, Elise

Salazar, a 39-year-old who gave birth in Hawaii roughly 20 years prior explains that she had to explicitly ask for an epidural to relieve her of labor pains. Salazar shares that her labor was painful, and suggested that doctors were doing little to ease her of pain. Instead of suffering silently, Salazar was proactive in asking for care, as she knew how she wanted to be treated. While Salazar was already in the delivery stage, research has found that Black women are less likely to receive prenatal therapies such as tocolytics and antenatal steroids which are medical drugs used to prevent preterm labor (Paul et al., 2006). Paul et al. (2006) hypothesize that Black women are less likely to receive supplementary medicine like antenatal steroids because of subconscious bias from obstetricians. Noting how Black women are not given supplementary medical drugs pre-delivery can help inform why they are also less likely to receive delivery drugs like epidural. Since Black women are less likely to receive supplementary medicine and are also thought to not being able to accurately report pain (Paul et al., 2009; Schulz & Mullings, 2006) I believe that this forced Black women to be more persistent in asking for particular medical care.

Self-help narratives were one of three narrative types identified in the narratives of the Black women. They exemplify stories in which women have felt like their persistence and request for specific care was essential in their course of treatment. Both Williams and Campbell requested specific test and medicine and through their self-advocacy they got their desire care.

Being Wronged Narratives. Feelings of being wronged by medical staff is another narrative that was evident in the sharing of maternal experiences among the four women. Several of the women whose narratives are being analyzed expressed that they felt as though doctors had not treated them properly and respectfully. Elise Salazar is one example of someone who used this kind of narrative to describe her poor care.

Salazar starts by sharing that her delivery was painful and when she asked for an epidural the anesthesiologist denied her one. She said, “I had to perform labor pain to his expectations before he would authorize the epidural.” Salazar also shares the anesthesiologist that denied her the epidural was not the same doctor to later administer it to her. She tells Campbell that he passed off the task to a medical student who had difficulty finding the right spot to administer it. After four tries the epidural was administered.

Salazar adds to her experience by saying, “after the epidural wore off, I was in the most horrific pain of my life. I was screaming, having trouble breathing, and panicking. A nurse came in the room and told me to ‘shut up’ because I was scaring other patients. By the time I was ready to deliver, I’d been laboring med-free for about an hour and a half.”

Salazar also shares that after she delivered her baby, she was left to sit in her blood and discharge for at least an hour before being attended to. Upon reflection, Salazar recognized that her treatment was more than lack of consideration, it was sheer neglect. Her story ends by her saying:

I was young and naïve. I had no idea that people in that position could be so negligent or just so mean. If I was going through that experience now I would not allow the nurse to ignore us or speak to us the way she did, nor would I allow the anesthesiologist to play God with my pain.

The way in which Salazar describes her caretakers demonstrates feelings of being wronged by the staff. Her adjectives reflect negative emotions towards the practitioners. Not only was she delayed treatment, but she was also ordered to shut up, and was left soiled.

Not all women survive to tell the traumatic experiences they endure during childbirth. Kira Dixon-Johnson is one of many Black women who has died because of medical negligence.

However, her husband and mother-in-law continue to share her story. In 2017, Kat Harvey published an interview on her YouTube page where she talked with Charles Johnson, husband of Kira Dixon-Johnson and Judge Glenda Hatchett, Dixon-Johnson's mother-in law. The discussion recounted the events that took place after Dixon-Johnson's delivery at Cedars-Sinai hospital. Harvey started the interview by asking Johnson to give people a brief synopsis of what happened:

We were expecting our second son [and] we had planned to have routine scheduled c-section at Cedars-Sinai medical center...she walked in there and the baby wasn't in distress and essentially shortly after the procedure they noticed that she was bleeding internally which is not abnormal, completely abnormal for a procedure like that. Long story short...she was allowed, for her condition to deteriorate and to bleed internally for more than 10 hours at Cedars-Sinai while my family and I begged them to do something and essentially she passed away due to their negligence.

Johnson specifically blames the medical staff that attended to his wife: "their negligence." He shows that he feels the doctors are responsible for the death of his wife and that his family's tragedy is a result of the inattentive care Dixon-Johnson received. Judge Hatchett, Dixon-Johnson's mother-in-law, continues the discussion by saying:

This could have been preventable, and it should have been prevented because they knew shortly after Langston's birth that there was some bleeding somewhere. And so, you have to figure out where it is and you go in and fix it. And we know, had she been taken back into surgery earlier she would be alive now.

The feelings that both Johnson and Hatchett revealed through their dialogues exemplified how concerns of patients and their families can go unanswered. Judge Hatchett later adds that, "there

was so many places that they could have intervened, to save her life and they didn't." Again, this puts blame on the medical staff who treated Dixon-Johnson. In telling Kira Dixon-Johnson's story in its entirety, it should be noted that the records from the incident shows that the medical staff said they would perform a CAT scan on Dixon-Johnson; however, those scans were never taken. This follows 'being wronged' narratives because a plan of treatment was established, however, the follow through was not executed in a timely manner to save her life.

Harvey (2017) continues the discussion in the interview by asking Johnson and Hatchett if any of the doctors had come forward to take responsibility for what happened to Dixon-Johnson. Johnson responds to Harvey by explaining that the hospital had refrained from communicating with him. Johnson later adds that something he hopes to come from his family's tragedy is accountability. Johnson's wishes for accountability indicated that he feels as though his wife was a victim and ill-treated.

Poole (2018), a writer for *The Atlanta Journal-Constitution*, wrote a piece about Hatchett and Johnson's fight for the lives of new mothers and addresses the racial component of Dixon-Johnson's situation. In the article, Poole writes:

He wonders if his wife hadn't been African American, perhaps 'she would have gotten back to the operating room an hour or two sooner and that could have made a difference in saving her life.'

Poole quotes Johnson in his belief that if Dixon-Johnson had not been a woman of color, maybe she would have received better treatment.

Both Salazar and Dixon-Johnson's narratives exemplify feelings of being "wronged" by medical personnel. Salazar described her caretakers as being mean and negligent because they were rude and inattentive. Johnson and Hatchett demonstrate feelings of being "wronged" as

they search for accountability from medical personnel at Cedars-Sinai Hospital in the death of their loved one, Kira Dixon-Johnson.

Ignored Narratives. The narratives of these four Black women also demonstrated that the patients, and their advocating family members, felt ignored by the attending medical staff after reports of pain. Elizabeth Chuck, a reporter with *NBC* news also covered the tragedy that happened to Kira and Charles Johnson. In the report, she quotes Johnson as he discussed the response the medical staff gave him as he repeatedly asked for a CT scan for his wife. He says, “The staff at Cedars-Sinai told me my wife was not a priority right now” (Chuck, 2018). Johnson does not provide an explanation for why medical staff did not examine Dixon-Johnson, but he does acknowledge that a CT scan was ordered and to be performed immediately. However, the scan was not given immediately. As stated, his wife was left untreated for 10 hours before scans were run and she was taken into surgery. Assuming that the doctors acted in a way that they thought to be without ill-intent, the story Johnson tells still reveals that Dixon-Johnson’s symptoms were ignored as the amount of time taken to treat her was extensive given the purported symptoms.

Similarly, on January 6th, 2019, LaShonda Hazard posted to her personal Facebook page an image that read, “Women & Infants really sucks and whatever practices affiliated with them” (Hazard, 2019). Her post alludes to the fact that her maternal care was not up to her standard as she explicitly addresses Women & Infants Hospital in Providence, Rhode Island, for what she believed to be poor maternal practices.

When asked by one of her Facebook friends if she was okay, she responds in the comments back by saying, “Nah I’ve I been having excruciating stomach pain cramps and they’re not doing anything about it my whole left stomach is hard and in pain I’m literally

dying.” Her comment demonstrates how doctors overlooked her report of symptoms mere hours before she passed. The cause of death for Hazard and her baby is unknown. Similar to Salazar, Hazard exemplifies how Black women have been delayed or denied treatment because they weren’t showing specific signs of distress.

Hazard’s post received a lot of engagement as friends continued to follow up with her about how she was feeling. She explains that doctors told her that there was not anything they could do for her and the extent of her care involved them checking the baby. The behavior performed by doctors as described by Hazard illustrates a narrative of ignorance because, as she stated, the medical staff at Women & Infants Hospital did not assist her in an appropriate manner when she complained of intense stomach pain. While they did check the baby, the procedure did not alleviate her from pain or prevent her from dying. Because Hazard died, it could be inferred that absence or ineffective course of care contributed to her unborn child’s untimely death.

Ignored narratives represents moments in which women reported that medical personnel dismissed their concerns. This is seen as Johnson reveals that the staff told him his wife was not a priority and as Hazard states that medical staff were not attending to her in the manner the expected.

Narrative Displays of Power Between Medical Staff and Black Women

Examining the experiences of Williams, Salazar, Hazard and Dixon-Johnson also revealed battles of power between the medical staff and the women. In their stories, the narrators share how doctors asserted their dominance over their bodies by delaying treatment or not providing adequate care. These narratives also reveal moments in which the women persevered by asserting themselves and asked for care they knew they needed.

Before I begin the discussion on the power dynamic that lies between medical staff and patients, it should be noted that majority of maternal stories shared do not identify the race of the medical personnel attending to the women. Therefore, I cannot suggest whether the inadequate care Williams, Salazar, Hazard, or Dixon-Johnson was caused because of historical implicit racism, such as White physicians having bias against Black patients. Charles Johnson, however, filed a wrongful lawsuit against Cedars-Sinai Medical Center and names Arjang Naim, M.D., Kathryn Sharma M.D., Sara Churchill, M.D., Stuart Martin M.D., and Benham Kashanchi M.D., as the medical staff that attended to his wife, Kira Dixon-Johnson.

Even though the names of the medical team who treated his wife are provided, I cannot make assumptions about the race or ethnicity of the physicians. While Johnson provides the names of staff who treated his wife in the lawsuit against the medical center, information on the medical personnel who treated Williams, Salazar and Hazard are unknown. However, it is notable that the obstetrician-gynecology field is predominately White (Rayburn et al., 2016). In a later section, I discuss how the absence of information on the physicians treating these women creates gaps in the narratives of these women.

Power with Medical Staff. Elise Salazar's narrative best exemplifies the hierarchical of power within the medical field as medical staff having the most power and patients have less. Again, Salazar explains that she felt like she had to perform labor pains in order to receive an epidural. Her description illustrates the power structure that exists between doctors and patients. Having to "perform" in order to get the desired treatment shows how power rests with doctors. Patients have to convince their practitioners that they are experiencing the distress they are reporting.

The exchange between Salazar and her nurse also demonstrates the existing power structure, as the nurse told Salazar to silence herself when she screamed because of labor pains. In addition, in explaining her regret for not defending herself, Salazar compares the anesthesiologist to God: “Nor would I allow the anesthesiologist to play God with my pain.” In comparing the doctor to God, she attributes a high level of power to him.

In Kira Dixon-Johnson’s narrative, Charles Johnson’s description of the tragedy that happened to his wife also demonstrate the power doctors assert over patients. Johnson felt like he had to beg for the medical staff repeatedly to treat his wife, exemplifying the lack of power that he felt he possessed. It is not unusual for patients or family members to ask for specific treatment or for time to be taken in a busy hospital to treat a patient, however, doing so over the course of 10 hours when the medical staff has been alerted about the deterioration of the patient’s health, reveals how much power is in the hands of the medical staff.

Similarly, the medical staff’s behavior that resulted in the death of Hazard and her baby demonstrates the power structure that exists in the medical workforce. I argue that staff’s superficial examination shows how some doctors follow their judgment over the report of symptoms from the patient.

Serena Williams’ accounts subtly demonstrates the displays of power between doctors and patients as she repeatedly states that she had to continually ask for a CT scan. Williams acknowledges that the doctors were running tests and attending to her, but they initially ignored her suggestions for a CT scan. Williams notes that she has had previous experiences with blood clotting and because of this, she has become more aware of when a blood clot has formed and what steps to take to prevent death. Often, medical staff encourage patients to be aware and share their medical history. In Williams case, she was demanding a doppler test based off her previous

experiences with blood clots. Even as she followed the suggested steps by medical staff as she stated her experiences with blood clots, medical personnel first ran other exams than the one best fit to treat her.

The role of a physician is to care for a patient fairly and justly. In evaluating the relationship between doctors and patients, Pappas (1990) writes:

The physician produces the valued curing, caring and relief of pain. Simultaneously the physician can reproduce trust, authority, control –that is, an entire structure of domination. Doctors are also able to reinforce status hierarchy (p. 200).

The hierarchy that exists between doctors and patients is demonstrated as doctors continue to act superiorly to patients. While it is a physician’s job to treat a patient in the way they best see fit, when doctors ignore the reports of pain or distress by a patient, they make apparent the hierarchical authority in medicine. This is not to diminish the expertise of a physician and the power they hold as a result of their position, but to demonstrate how it is equally important for medical personnel to consider reports from the patient to accurately assess and treat them in addition to the expertise they possess.

Power with Black Women. Having control or autonomy over the course of treatment was not described by many women in the narratives discussed. Women endured inadequate treatment provided by medical personnel with little to no resistance and/or died because they did not argue for better care. However, Serena Williams was one narrator that did assert herself, demanded the care she desired and received the requested care. Williams’ persistence and assertions not only saved her life but gave her power. Williams subtly implies her own power with the statement, “listen to Dr. Williams,” after she repeatedly asks for a CT scan.

By using her own name in third person with the doctor prefix, she asserts that she has the knowledge and knows exactly what she needs. While her decision to refer to herself as a doctor demonstrated that she felt she needed to assert herself the language choice implemented by Williams demonstrated a switch in power from the typical hierarchical medical structure where doctors possess all the power to Williams being the domineering force. She was explicitly telling the doctors that she knew what was wrong and she knew how to fix it. Here she was asserting her power.

Serena Williams was the only woman who strongly advocated for herself. In understanding why Williams was the only mother to assert herself, questions of whether her celebrity influence and the self-proclaimed power she possessed in comparison to the other women are brought into focus. In knowing how much power her status gives her and the level of respect or appeasement medical personnel grant celebrities, Williams knowledge of her existing medical condition and celebrity gave her the opportunity to assert herself in ways the other woman did not.

Power Dynamics Between Society and Black Women

For this analysis, I am not only examining Black women's experiences in direct contact with medical staff, but I am also looking at the narrative characterization of women from various social standings. In doing this analysis, I found a correlation between the volume of news media coverage and the celebrity affluence and/or network of the Black woman being discussed. The larger a Black woman's network or the greater the celebrity or popularity status she holds, the more likely it was for traditional forms of media to cover her experience, thus resulting in the larger her narrative is. Noting this reveals the need for more consideration of individuals of varying lower-levels of socio-economic and social status.

Intersectionality of Class and Voice. In reporting how health disparities affect different groups of peoples, journalists have noted that they struggle to demonstrate how a health issue affects individuals of varying socioeconomic status (Wallington et al., 2010). Van Den Bulck (2017) argues that media focuses on celebrities health for social profit marketing (endorsement) and to influence audience behavior with things like advocacy. To this I argue that if the individual is of affluence, higher social class, or is more connected in the social world, they are able to share their story more frequently and with larger traditional and/or formal media than individuals of a lower socioeconomic status. Arberry (2019) supports my position and recognizes that Black maternal health disparities are mainly told through the celebrity birthing experiences. Arberry (2018) writes:

Although the severity of America's Black maternal health crisis is deserving of far broader coverage, the topic often only breaks through in the context of celebrity birth experiences. For example, in 2018 two high-profile stories involving Serena Williams and Beyoncé exemplified the dire circumstances of the Black maternal health crisis, underscoring that even prominent and traditionally successful Black women are not immune from its impacts.

Understanding how celebrities have been used to allow mass audiences to learn about maternal disparities reveals a different power structure than the one between medical staff and patients. Here, the society's hierarchical power distribution reveals the differing levels of influence that individuals of varying social locations possess. In the present study, media coverage of the four Black women's narrative reveals a difference in detail and description to women of different social status. In addition, the number of sites and types of media outlets that covered the narratives differed. This led me to believe that individuals with higher society

popularity increases the chances of a health issue being shared in the media. More specifically, within the present study, celebrity revealed a difference in the level of detail shared about an individual and their narrative.

As stated previously, researchers have tried to understand why health disparities exist by examining factors such as education and socioeconomic status (Chalhoub & Rimar, 2018; Alexander et al., 1999). While researchers have shown that maternal disparities exist beyond the boundaries of factors like socioeconomic status, celebrity can be gained with increases in socioeconomic status attracting more media attention thus increase the number of large media outlets that will cover a story. Below I will discuss how the hierarchy of society influences how much attention is given to a woman and her story.

Both Serena Williams and Kira Dixon-Johnson are distinguished women and their stories have received much mainstream media attention. Serena Williams, being a world renown tennis player, saturated sports media when she returned to tennis and won the 2017 Australian Open shortly after her delivery trauma. The story of her surviving a near death experience and winning her first post-partum competition generated a lot of conversation about infant mortality rates and maternal disparities. Williams was able to share her story with traditional, more formal outlets such as *Vogue*, *CNN*, *HBO*, and more, potentially reaching millions of people with her story. Williams' fame through tennis allowed her story to be shared for months after giving birth allowing people more insight to her post-partum experience. In addition, Williams' affluence, network and platform allowed her to not only share her story, but to share the story of a woman who did not have access to adequate healthcare in her opinion piece for *CNN* (Williams, 2018). Williams (2018) shares the story of Mary James, a Malawi mother, who lost her baby because her birthing facility was too far away. Williams' celebrity status brought attention to a story that

might not have been told otherwise when she did not have to. Not only does Williams' celebrity grant her the opportunity to share the stories of other, less affluent Black women who do not have the platform to tell their own story, but Williams has been an empowering figure for other Black women who have also had traumatic maternal experiences.

Meadows-Fernandez (2018) also acknowledges the power celebrity has on other women and how it can be used to raise awareness on an issue. Meadows-Fernandez (2018) shares that hearing Williams' story filled her with joy and empathy because she also experienced a traumatic birthing experience like Williams and Williams continues to be role model to other Black women. Meadows-Fernandez (2018) also states:

As a young black mother, I was not given full control or autonomy over my body. Like Williams, I indicated something was wrong and was ignored. Unlike Williams, I did not have the power or influence to convince my local medical team that something was wrong with me...Black women deserve to have medical experiences free of racial bias, and conversations with medical professionals that don't leave them feeling as though they have just been whitesplained. And black women certainly deserve to regain ownership of our own bodies. I hope black women with platforms and power such as Williams...bring awareness to these types of issues. They are spreading information to an audience that does not spend its time researching medical and peer-reviewed journals.

Meadows-Fernandez recognizes that she and Williams are not the same. However, she also acknowledges and praises Williams for using her platform to share her story to empower other women who should have or will need to advocate for themselves in their natal care.

The national attention that Williams' narrative received demonstrates how celebrity can be used to advocate for people who do not have the means to advocate for themselves. Her

narrative also illustrates how other Black women that they can advocate for themselves during their natal care. Their intuitions are important feelings that should be valued in medicine.

Kira Dixon-Johnson's narrative also gained national attention although she did not have the same celebrity status as Williams. While Dixon-Johnson was not as fortunate as Williams to tell her own story, Dixon-Johnson's husband and mother-in-law continue to tell it. As stated, Dixon-Johnson's mother-in-law, Glenda Hatchett, is a judge and because of the resources Hatchett's political status allots, Dixon-Johnson's affluence and success, and Charles Johnson continuous advocacy for Dixon-Johnson and other mother who have had traumatic maternal experiences, Dixon-Johnson's story has been shared across many mediums. Both Charles Johnson and Judge Hatchett have had the opportunity to talk with reporters at *Inside Edition*, *People Entertainment Network*, *NBC News*, *The Dr. Oz Show* and before Congress. While some of these mediums are not as esteemed as *CNN*, *HBO*, or *Vogue*, as they are majority entertainment news, they are mediums that have a lot of viewership.

Hatchett and Charles Johnson effectively used entertainment media, such as *The Dr. Oz Show* and *Inside Edition* to share Dixon-Johnson's story. Judge Hatchett recognizes the importance of storytelling and argues that it can help prevent similar cases like the death of her daughter-in-law, Kira Dixon-Johnson. In the same interview with Kat Harvey she says:

My son who is dealing with unimaginable pain and just the shock of it all. To want the best for his wife, to want this best for his family, and then for her to die under these circumstances is not only unacceptable but it has to be a story that is told because at the end of the day, Kat, we don't want any other family to go through what they have gone through.

Hatchett sees storytelling as a way to prevent similar situations from happening to other families. Through Hatchett's network and platform as a judge, she continues to raise awareness on maternal disparities.

Both Williams and Dixon-Johnson have had their stories shared further than those of Elise Salazar and LaShonda Hazard. It seems that Salazar and Hazard are from middle to low socioeconomic class backgrounds, and their networks are far smaller than Williams and Dixon-Johnson. Both Salazar and Hazard's stories were only shared through fewer and smaller news organizations. Salazar's story has only been shared through *Healthline* and Hazard's story has only been shared through blog sites like *Thatstea.com* and *ScaryMommy.com*. Not only have the stories of Williams and Dixon-Johnson obtained a larger audience than Salazar and Hazard, but the ways in which these women have been described in their narratives vary greatly.

Characterizations of Black Women. The ways in which Williams, Dixon-Johnson, Salazar and Hazard are described in the coverage of the events that happened vary in the amount of detail provided about the life and accomplishments of the woman. When Charles Johnson describes the tragedy that happened to his wife, he describes her as being the most amazing woman he has ever met in his life. He says:

She was absolutely the most amazing woman that I have ever met in my life. We are talking about a woman that spoke five languages, that was an incredible entrepreneur, that was a mother, that traveled the world, who was a licensed pilot, a solo sky diver, ran marathons, raced cars, a phenomenal person. But extremely kind, extremely giving. And somebody that really just changed my life and taught me so much about love, about being a husband, about being a man.

Every opportunity that he gets to talk about his wife, he talks about her accomplishments which humanizes her and make her more real.

Similarly, the discussions around Serena Williams' maternal experience always include her athleticism. Headlines read, "Tennis star Serena Williams 'almost died' after giving birth" and several articles that discuss her delivery also include the number of grand-slams she has won. The media depictions of Williams and Dixon-Johnson continuously remind audiences of their achievements which humanizes them and allows for audience to connect, admire, or sympathize with these women.

In contrast, Elise Salazar and LaShonda Hazard's descriptors are not in the same depth as Williams and Dixon-Johnson. They are not famous tennis players, or overtly successful women in the way that American society depicts as successful. The stories of these women only highlight the racial aspect of their identity. In the *Healthline* coverage, Campbell writes, "Elise Salazar was 19 years old when she gave birth in Hawaii. She was being seen at a military hospital." Campbell does not state whether Salazar is an official in the military, her ranks, educational accomplishments or any other achievements. Similarly, the only attributes given for Hazard in the blog articles is that she was a 27-year-old Black woman.

It is important to note how these women are described in their narratives because it explains how when stories are shared, the narrator humanizes and attributes certain qualities to the characters which allows for audiences to engage and indulge in the experiences of the characters. As stated, the psychological mechanisms implemented in a story allows the listener to immerse themselves into the experience of the storyteller (Lee et al., 2016). Transportation, identification and realism allow the listener to recognize that the experience is real and understand or respect the experience (H. Lee et al., 2016).

In describing the women in such detail, the storyteller created opportunity for the audience to recognize the stories as real and to have deeper and stronger engagement. However, when characterizations are not descriptive and superficial, realism and connections are less likely to be made. The way in which Salazar and Hazard are described reinforces the muted voice of Black women in maternal discourse. In this way, the voices of the less distinguished or affluent Black women in the present study are muted. The superficial descriptions treat them similar to numbers. Without depth, connections between the audience and the narrator cannot be made.

Missing Narrative Elements

In conducting this analysis there were several missing elements in the narratives of Kira Dixon-Johnson, LaShonda Hazard, Elise Salazar, and Serena Williams. One piece of information that is unknown is whether these women were insured and if so, what kind of insurance they had. In addition, the identity of the medical staff treating Hazard, Salazar, and Williams is unknown. Below, I emphasize the significance of having such information in order to have a complete narrative.

Health insurance. Historical documentation of health disparities has noted insurance as a reason why Black women have not received care or was given inadequate care (Sohn, 2016; Noonan, Velasco-Mondragon & Wagner, 2016; Hall et al., 2015; Braveman et. al., 1988; Davis, 1984). Earlier I discussed the government's involvement in the reproductive care Black women receive. There I draw on the story of one Black woman, Sharon Ford, who was left untreated because medical personnel believed that she had been lying about having health insurance (Davis, 1984). Ford gave birth to two stillborn children because of the hospital's refusal to treat her.

From Ford's experience it is clear how insurance can be a contributing factor in the type of care women receive. Examining the insurance policy and coverage of Dixon-Johnson, Hazard, Salazar, and Williams could have led to explanations on why these four women received the negligent care provided. While there is knowledge to be gained by looking at an individual's insurance plan, information on which insurance policy a person has is confidential unless publicly disclosed. In assessing maternal disparities, contemporary researchers have also pointed to insurance as means for improving health outcomes and decreasing such disparities (Hawks et al., 2018). Therefore, the present research could benefit from understanding how the health insurance of these women could have influenced the treatment they received, however, that information is unknown. I believe that information about the insurance policies these women held is unknown to the public because of confidentiality regulations like HIPAA which would conceal that information from the public.

Medical Personnel Identity. According to the U.S. Department of Health & Human Services (DHSS), the Health Insurance Portability and Accountability Act (HIPAA) conceals information doctors, nurses, and other health care providers put in medical records, conversations doctor have about care or treatment with nurses and others, information about health insurer's computer systems, billing information, and most other health information about a patient. DHSS also notes that consent is needed from a patient when information about a patient is trying to be accessed.

While concealing medical information is primarily used to protect and respect the privacy of a patient, it also protects medical personnel. In addition to the medical history of a patient, the names of medical personnel who have treated them is also concealed. Members of the public can only learn the details of a case if the patient themselves or their family members reveal that

information. With the identity of the medical staff treating these women remaining confidential, accountability for negligent care cannot be directed at particular staff, only inferred. In addition, other Black women can also unknowingly be treated by the same staff. This has been seen in majority of the Black women's narratives included in the current study. The identity of the medical staff who treated Elise Salazar, LaShonda Hazard, and Serena Williams is unknown. I believe their identities are concealed due to confidentiality regulations. Since the women, or their family members, did not list the name of the doctors treating them, reporters also do not have access to their names. A clear reason for why the women, or the family members, did not share the names of their medical teams is not provided, however, I believe out of consideration, the women decided to keep the names of medical personnel out of the narratives.

Elise Salazar simply refers to the medical team by describing their occupation. For example, instead of giving the name of the anesthesiologist, registered nurse, or medical student who attended to her, Salazar identifies them by only stating their occupation simply saying, "the anesthesiologist," "the nurse" and "student."

Similarly, Serena Williams only refers to the medical team by their occupation. Williams explains that she told the nurse that she could not breathe and needed an oxygen mask and later says, "After that I remember being wheeled back to the operating room because they had to reopen my c-section and re-stitch it and they had to check for blood-clots and everything. So they were doing all these different test and everything was negative." Again, Williams does not share the identity of "they" or the nurse treating her.

Hazard also does not share the names of the medical team that assisted her. She refers to the medical staff as "them" creating a lot of ambiguity about who provided care to her. Since there is a lack of information regarding the events that took place at Women and Infants

Hospital, audiences are unaware of the identity of the medical staff that provided care, much less whether she was seen by a doctor or nurse.

While this is a matter of how the narrators have reported the information, in my attempt to learn the names of the persons treating these women, I learned that I cannot access that information because of HIPAA regulations. The exception to this is Kira Dixon-Johnson. As stated, Charles Johnson names Arjang Naim, M.D., Kathryn Sharma M.D., Sara Churchill, M.D., Stuart Martin M.D., and Benham Kashanchi M.D., as the medical staff that attended to his wife, Kira Dixon-Johnson. Because of the wrongful death lawsuit Johnson filed, the identity of the medical staff has been publicized. Naming these individuals can create accountability and allow other mothers who plan to deliver at Cedars-Sinai to make informed decisions about which doctors are treating them.

Missing Narrative Elements in Salazar and Hazard's Stories. In addition to not knowing the names of the medical personnel treating Salazar or her insurance plan, Campbell (2018), does not provide any specifics about the location Salazar delivered her child. Campbell (2018) states that Salazar delivered her child on a military base in Hawaii, however, the name of the base is not explicitly stated. There are several military bases in Hawaii for different branches. Campbell nor Salazar provide an explanation for why this such information is not provided. Having access to the name and/or explicit location where Salazar was treated could serve as a warning to other Black women who might be treated there in the future as well as hold that particular center responsible for the negligent care Salazar received.

Narrative elements were also missing from LaShonda Hazard's story. As stated, Hazard and her unborn baby died after she reported stomach pains and medical personnel told her that there was nothing they could do for her. The details audiences have on Hazard's experience is

limited to the comments on her Facebook post. The audience is unaware of what procedure or dialogue was actually provided or said to Hazard, how long it took for Hazard to be seen, whether she was there for a routine or emergency visit, whether a nurse or doctor had attended to her, or the cause of death. The absence of such information leaves Hazard's story incomplete. While the only way to obtain the answers to these questions is through Hazard's family and medical team, statements about her death from these individuals have yet to be made. I believe that part of concealing this information is confidentially regulations as well as respecting Hazard's family privacy as they mourn. However, the absence of such information makes creating change in maternal care for Black women difficult to access and implement. Hazard's incomplete narrative does not pin-point specific dialogue, individuals, or settings.

Chapter 6: Discussion

In medicine, doctors and other physicians are granted a certain level of power over a patient's body. Waitzkin (1984), a physician and sociologist who has studied the relationship between doctors and patients, argues that medicine is form of social control. He writes, "the health care system helps promulgate the dominant ideology of a society and the doctor-patient relationship is a major site where these developments occur" (p. 340). The dominant ideology of Black women in American society has been negative as they have been portrayed as "mammies"⁸, matriarchs⁹, welfare recipients and hot mommas¹⁰" and these stereotypical portrayals have "been essential...to Black women's oppression" (Hill Collins, 1990, p. 97). Black women are also stereotyped as loud-talking Sapphires and crazy Black women (also known as the angry Black woman) (Reynolds-Dobbs, Thomas & Harrison, 2008).

Hill Collins (1990) and Reynolds-Dobbs et al. (2008) remarks emphasize Waitzkin's (1984) as it provides examples for how Black women have been viewed in America's dominant society and how such negative stereotypes could influence the relationship between a Black woman and her physician. For example, if a low-income Black mom who is on welfare and receives Medicaid visits the doctor's office, her caretaker could have implicit bias towards her and microaggressions based on cultural stereotypes. The negative stereotyping of Black people hinders the treatment they receive.

It is important to highlight the underlying social forces that influence the care that patients receive, particularly as medical staff do not always care for patients independent of

⁸ The Mammy is a Black woman who serves as a household servant and caretaker as she filled any role that her master needed in the home. (Sewell, 2013).

⁹ Matriarchs refer to Black women being the head of the household but with negative connotations; "the matriarchal familial structure that exists in the African American family is the key to their problems in society" (Sewell, 2013, p. 313).

¹⁰ Hot mommas are hypersexualized Black women (Emerson, 2002).

social bias which has been seen through the historical documentation of the way Black women have been treated in medicine. Other scholars have examined how White dominance, policies, and negative stigmas of Black women have hindered the way Black women are treated in America (Roper, 2012).

Roper (2012) analyzed how Black women are deemed as unworthy recipients of government social programs as presidents, such as President Ronald Reagan, characterized them as “welfare queens.” Roper’s (2012) analysis is a rhetorical argument against the American social and political economy and uses narratives, feminism and rhetoric to understand the impact negative stigmas of Black women have on the government assistance they receive. Roper (2012) “considers the way narratives and names have been used to mark “black” women and the way dominant ideologies are infused with assertions and assumptions about them as women and as mothers which determine how they are treated by, and within, institutions of power” (p. 33-34).

Black women, the focus in both Roper (2012) and the present research, are used to share an untold story. Roper discusses how presidents like President Ronald Reagan, rhetoric has had on the image of Black women and shares the Black women’s perspective and argues that scholars have an opportunity to shift popular discourse from dominating “whiteness” ideologies to more empowering “otherness” ideologies. Roper does so by demonstrating how narratives write history as they provide alternative stories and perspectives of things that have taken place. Specifically, Roper argues that Reagan’s rhetoric makes Black people responsible for the causes of the racial disparities they face. The white middle-class has been viewed as the norm which is a socially constructed ideology (Roper, 2012). Because of this, other lifestyles (Black, middle-class) are seen as other however, the “other” is not any less norm than white middle-class (Roper, 2012). All in all, Roper suggest that “other” lifestyles and narratives should be evaluated

in discourse because narratives write history and in order to accurately represent individuals in history, other ideologies need to be shared.

While Roper (2012) discusses politics, which is not a major topic discussed in the present analysis, the use of narratives is present in both Roper's analysis as well as in the present study. Roper uses the perspectives of Black women to demonstrate the need for Black women's perspectives to be shared as history uses the narratives of people to create a cohesive story. Similarly, the present study uses narratives to interpret the experiences of Black women to understand how they view their own treatment in medical institutions, to create an alternative perspective about maternal care, and to allow for racial maternal discussions in maternal discourse. In addition, the present research includes Black women's narratives in maternal discourse as a way to not only shift conversations about maternal disparities from being strictly numerical but to also allow the sharing of Black women's stories and allow audiences to connect and empathize and later evoke change in health care.

Although previous research has assessed how Black women have been treated in American institutions and power structures, the treatment Black women face in medical institutions, specifically during the maternal care, is a phenomenon that is new to health communication research. The present study sought to learn more about the treatment Black women endure by analyzing their maternal narratives. In doing this analysis, readers have a better understanding of which aspects of care are important to the four Black women. Through the foregrounding of information, LaShonda Hazard, Elise Salazar, Kira Dixon-Johnson, and Serena Williams demonstrate moments of feeling wrong and ignored and how advocacy and persistent requesting of certain procedures, is essential in the survival of Black mothers. In addition, the present research demonstrates how society participates in the narratives of Black

women as celebrity status and affluence grants more platforms for the sharing of maternal stories and the ways in which Black women are described in their maternal narratives. I hope that through this analysis, in addition to numerical statistical information about maternal disparities narratives are seen as an integral component in demonstrating how significant maternal mortality is among Black women. I believe that through storytelling, changed in health policy can be made to save the lives of Black mothers.

Theoretical Implications

Muted group theory. Muted group theory examines how and why voices of marginalized groups are often not heard by dominant groups (Wall & Gannon-Leary, 1999). As stated, individuals within a muted group are often disrespected by those within the dominant group and the knowledge of the muted group is not considered sufficient for public decision-making or policy making (Kramarae, 2005). The research in the current study demonstrates several ways in which the voices of Black mothers have previously been muted in healthcare, and how in the future, Black moms intend to cease in participating in the muting of their voices.

At the macro level, Black women's voices have been muted in medicine as their thoughts and experiences have had little consideration and inclusion in healthcare. As outlined in the historical section, consent and full disclosure of procedures performed on Black women were preliminary steps that were not given to many Black women. In healthcare, Black women enter centers where their voices have been and continue to be systematically silenced. Black women, such as Rochaun Meadows-Fernandez, have described that they do not feel like they have autonomy over their bodies. Because of these feelings, Black women do not advocate for themselves effectively when seeking medical treatment.

Adding to this, I believe that medical personnel have cared for Black women without considering that their health differs from other groups. The distinction between comorbid health risks between Black women and other racial groups reveal that health conditions such as diabetes, affect Black women at a higher rate and can lead to renal failure. Renal failure is complication that a Black woman can face postpartum. In my belief, Black women are not cared for independent of how other groups are nor is their significant knowledge on the risk factors that should be considered for Black women during delivery. Since Black women have historically been muted and marginalized in health settings, there is a lack of knowledge and awareness in how to readily treat Black women effectively. If Black women's health is evaluated deeper, more precautionary measures for Black moms who have comorbid diseases such as diabetes can be developed. Noting this becomes significant because as muted group theory states, the experience of Black women are insufficient for public decision making, however, contemporary discussions about maternal mortality and maternal disparities has looked to improve the health outcomes of Black women. Highlighting the differences in preexisting health conditions dismantles Black women from being viewed as having the same health and health risks as dominant groups and allows Black women to be assessed on their own.

Explicit displays of muted voice have been seen through verbal assertions such as the nurse telling Elise Salazar to "shut up" or doctors telling Charles Johnson that Kira Dixon-Johnson was not a priority. In this case, the Black female voice is muted. Not only does the healthcare system invoke apprehension amongst Black women while they seek care, but medical staff members have overtly made Black women feel like their pain, symptoms, and feelings do not matter.

However, while medical personnel continue to engage in behaviors that silence the voices of Black moms, some women have been advocating for themselves and others to receive better care. Campaigns like 4Kira4moms, started by Hatchett and Johnson, were created to advocate for better maternal healthcare. Specifically, they aim to educate the public about maternal mortality and to provide peer support to victims' family and friends. Other women who have faced near death experiences have created blogs to keep up the conversation. Timoria McQueen is one of them. On her website she shares her personal maternal story, as she also suffered from post-partum hemorrhaging. McQueen also shares other information about maternal awareness such as the lack of support from the NAACP and Congress on changes in healthcare policy. McQueen also provides a list of resources for women who have had traumatic birthing experiences as a way to build community amongst the surviving women and get them the help they might need.

Giving women support and places to share their stories is a major goal of Hatchett, Johnson, and McQueen. Doing so allows the voices of these women to be heard instead of silenced or ignored. The advocacy created through Hatchett, Johnson, and McQueen allows for Black women's voices to be factors considered when making healthcare policy changes as they have spoken to and wrote to members of Congress. Black people are using their voices to motivate change instead of passively allowing changes in society to exclude them. Black women are not only sharing their individual stories but the stories of other women who do not have the platform to share their own. Doing so helps other Black women learn about the agency they as Black women have, and helps to effectively get medical personnel to pay attention to other Black women who have suffered and who they can help.

As stated, Serena Williams had the opportunity to write and share her experience with *CNN* and in it she not only talks about herself, but she also brings up the story of another African

woman, Mary James, whose baby died post-partum. Williams also addresses the need for more doctors and nurses as 80% of all childbirths are due to preventable causes (Williams, 2018). Similarly, the current research allows for the continuous discussion of LaShonda Hazard's narrative, which could not be further shared through Hazard herself. While death muted Hazard's voice, the potential to continue to share, discuss, and include her narrative in understanding maternal mortality as it affects Black women is a possibility with media like Facebook. Hazard's use of her Facebook allowed her voice to be heard. In using their voices to share their stories and advocate for better maternal care, Black women no longer allowing their voices to be muted allowing for audiences to recognize that their health experiences matter.

Another goal of muted group theory is to bring attention to the fact that voices are not being heard and because voices are not being heard, new language is created to be inclusive of muted groups (Wood, 2005). The phrases "maternal disparities" and "healthcare inequalities and inequities" allow for conversations about discrepancies in health to be had. The language used to describe issues Black women face in health discourse creates opportunities for discussion. The ability to talk about Black women's experiences and to be able linguistically have a classification for their experience, allows Black women to have an outlet to communicate their trauma. Terminology, such as "maternal disparities" and/or "maternal inequities," is language that focuses on the issue of maternal mortality faced by Black women. Having linguistic agency allows for Black women to share their experiences and also allows them to be heard by dominant groups. Because Black women now have a way to articulate their traumatic birthing experiences, conversations about the issue can be had in more concrete ways.

Standpoint theory. In the present study, standpoint is exemplified as differences in maternal stories vary between the four women. Williams' experience is not the same experience

as Salazar, Hazard, or Dixon-Johnson, nor do Salazar, Hazard, or Dixon-Johnson's experiences mirror one another. While each of the women are racially classified as Black and have endured a traumatic birthing experience, they do not have the same shared experience. For one, Williams, a Black woman of affluence and privilege, had more agency and power than Hazard, Salazar and Dixon-Johnson.

Noting that each of these women's experiences varied although they are all Black, demonstrates the different standpoints a Black woman can have. The differences between these women include their socioeconomic status, celebrity, geographic location, age, and profession. These differences helped shape the maternal experiences of these women. For example, Elise Salazar, a 19-year-old, giving birth on military base in Hawaii, has a different reality and perspective than Kira Dixon-Johnson, a 39-year-old, delivering in Los Angeles, California. Dixon-Johnson, a married mother of two and presumed successful woman, had a birthing plan. She knew that she would delivery her second son through a c-section. From the way Salazar describes her treatment, it can be implied that a clear birthing plan was not put in place for her delivery. Again, Salazar described refusal from the anesthesiologist to administer an epidural (Campbell, 2018).

The differences between Dixon-Johnson and Salazar in age, geographic location, laboring preferences, and treatment from medical personnel, demonstrates different experiences which shapes their standpoints. Value in the different forms of Black maternity and knowledge about what complications Black women are faced with and how they are treated when present with such complications can be gained by understanding that the Black maternal experience is not singular. In acknowledging the unique experiences these women have, audiences can recognize that maternal disparities Black women are faced with is not an easily categorized issue.

The present study demonstrates negligent care provided by medical personnel is a contributing factor to maternal disparities and complications faced by Black women but not all Black women experience these factors to the same magnitude. Recognizing that different standpoints exist among Black women can teach medical staff how to engage with different types of Black women such as Black women of celebrity, affluence, low-socioeconomic status, Black women that live in cities, Black women of varying age groups, etc., strengthening communication between doctors and patients. In addition, scholars can learn communicative tactics to Black women of various standpoints and have a better understanding of maternal disparities and its effect on Black women. By not categorizing Black maternal experiences as one singular experience, doctors can learn to communicate to Black women of various experiences because they have recognized differences exist which can tailor the way medical personnel engage with patients.

In addition, standpoint theory seeks to examine the unique perspective individuals outside of dominant society possess (Crasnow, 2014). The intersectionality of Black women provides Black women with knowledge about persons of color and women. Noting this unique perspective is essential in making improvements for maternal care. By listening to Black women and understanding that their experiences are different than any other marginalized group, better communication between medical staff and Black patients can be made. By making apparent the differences in experiences of a Black woman, medical personnel can have a deeper understanding of how a Black woman's experience shapes the type of care she receives. Noting such difference can allow medical staff to treat and view Black patients as individuals rather than a group thus increasing the doctor-patient relationship.

As previously stated, there is a lack of understanding by the dominant White medical community on the health and care of Black women (Freedman, 1998). Since the majority of medical personnel are unable to adopt the standpoint of Black women because they are not Black women, therefore, they do not have the same lived experiences and interpretations of interactions, and thus the communication between doctor and patient is hindered. Speaking broadly, many obstetricians and gynecologists do not have the same lived experience as Black women, as the majority of the profession is White; therefore, difficulty to connect with Black women exist because of the difference in standpoints.

Adding to this, standpoint theory explains that marginalized groups learn to maneuver through dominant society because they understand the hierarchy that exists within society (Wylie, 2003). This is demonstrated in the narratives of the Black women as they demonstrate how they used language and behaviors to get desired treatment. For example, Elise Salazar explained that she when she was experiencing labor pain, the anesthesiologist refused to give her an epidural. In performing labor pains to his expectations, I suggest that she engaged in this performative act because her pain was not being acknowledged, therefore, she performed in a way she knew it would be acknowledged. Standpoint theory recognizes that persons within marginalized groups live within dominant society and because of this, they have knowledge that is not available to those who only live within the dominant society (Crasnow, 2014; Riger, 1992).

The way standpoint point theory has been applied in the current research adds to the theoretical framework because the theory has not been, or rarely has been, used in health communication research. It's important to recognize that there are different standpoints among Black women so that when changes to maternal health such as improving health outcomes and

decreasing disparities, recognition of differing maternal experiences of Black women is presented. For example, a southern and northern Black woman are likely to have different experiences, so they need to be evaluated differently. For health communication, it's important to apply standpoint theory because generally when assessing different demographic groups and the risk factors associated with them, the assessment does not make it past the main categories. Looking at different risk factors deeper than that, from the different standpoints can create for better assessment and improve health outcomes. Doctors-patient relationships can strengthen from this. Patients will feel like individuals and doctors can learn that their communication needs to be focused on who they are communicating with at the present moment rather than as a big demographic group.

Assessing how better care can be provided within a particular demographic subgroup of Black women (i.e. low-income Black women, Black women living in rural or urban regions, Black women with various types of insurance, etc.) can guide scholars in figuring out solutions for maternal complications and mortality among Black women. As previous statistics have demonstrated, Black women are three times more likely to experience pregnancy related complications and have higher mortality rates. Examining maternal mortality by assessing the different experiences and standpoints among Black women can reveal aspects of maternal care that contribute to high rates of complications and/or mortality.

Black feminist theory. The current research also informs the theoretical framework of Black feminist theory. Black feminist theory sees the significance of the Black experience being told and shared by Black women. Black feminist theory says that there needs to be an alternative way of discussing the lives and philosophy of Black women. Not only does this need to be linguistic, but Black women's voices also need to be a presence in what is being discussed. Hill

Collins (1988) notes how Black feminist theory helps articulate the knowledge and philosophy of Black women and creates a new dimension for liberation. The stories and knowledge about the Black experience are often told through mediated forms. Black stories and experiences are often shared by White institutions and people. Woodson (2003), a Black woman who authors children and adolescent books writes that, “the ‘art’ of other people ‘telling our story’ isn’t new, that people have always attempted to do it in literature, radio and film....As I grew older...I learned that no one but me can tell my story” (p. 52).

In terms of health communication, recognizing that Black women may articulate their experiences differently than other racial or gender groups highlights the idea that there needs to be more language that is encompassing of the Black female experience or generate an alternative way of understanding their experiences. This allows audiences to recognize that there is not a singular way of explaining a maternal experience. Going back historically, in the Antebellum period Black female scholars argue that Dr. Sims was racist and performed on slave women without their consent (Ojanuga, 1993), which is an example of Black women narrating their history. At the same time, White men justifies Dr. Sims procedures (Wall, 2005)—two perspectives on the same experience. So, the value comes from seeing that there isn’t one way of seeing things and that equally important is the voice of the Black female narrator. History has demonstrated that when the stories of Black women are retold, it’s often told in a White way.

Black feminist theory seeks to counter this trend by not only allowing Black women to write and share information about the Black female experience but to use their work as a way of understanding race, class, and gender in culture. This serves as a form of liberation for Black women because the narratives shared in media and maternal discourse about maternal mortality as it affects Black women are used to raise awareness of the disparity and is told from the

perspective of Black women. One example of Black women participating in the production of information on maternal mortality in the current research is Serena Williams documenting her maternal experience with *HBO*. In the documentary series episode, Williams is an active voice in the storytelling. Although the documentary is a cultural production, her experience is told from her mouth not from a narrator allowing her a greater opportunity to relay which aspects of her care she felt was important to share. The liberation Williams exemplifies demonstrates how Black women are using their voices to talk about an issue important to their demographic group.

While Williams had the opportunity to be the sole narrator of her maternal experience, other women, such as Elise Salazar, did not. Many times, the experience of Black women is mediated as other people write and share their stories for them. In the current research, there is a range of ways the experiences of Black moms are shared. For example, Elise Salazar shared her story with Leah Campbell, a White freelance writer for *Healthline*. In Campbell's article, only bits and pieces of Salazar's story was shared with few direct quotes from Salazar. While Campbell did share Salazar's narrative on her platform, serving as an alliance to Salazar, I believe that in addition to Campbell's coverage, if Salazar had written an autobiographical piece about her experience, more details of her labor would be available to audiences to learn about her experience which could have highlighted additional issues in maternal health as it affects Black women.

Campbell was motivated to write an article that demonstrated why giving birth in the United States is difficult for women of color. Because Campbell sought to craft an article that would tell the story first-hand, and had limited space to do so, if there was any other information Salazar shared revealing other salient issues with the way medical personnel treated Black women, that part of the narrative would be compromised for the sake of reporting.

Black feminist theory also makes the distinction in allowing for the experience of Black women to be shared independently of the experience of White women and Black men (King, 2016). A lot of maternal statistics about the complication's women face during childbirth groups together women of all racial and ethnic backgrounds. However, all women do not have the same maternal complications. In breaking down the causes for maternal complications by Black women and White women, health risks that are prevalent in these racial groups differ. Carroll (2018) demonstrates that Black women are more likely to experience sepsis, heart failure, renal failure, and eclampsia than White women. Comorbid with renal failure is the fact that Black people are also more likely to have diabetes which could explain why more Black women experience renal failure (Hicklin, 2018). While complications and other risk factors are not the focus of this paper, assessing Black women as a separate demographic group is a focus of Black feminist theory.

Black feminist theory provides an alternative language to analyze marginalized experiences. Currently, the language to denote the material experiences of Black women is limited. In order to increase or broaden how their experiences are described, words directly from the subjects needs to be included in order to get close to understanding their truth. Filtering the Black experience through White media and White voices will not effectively translate their stories because White media and/or voices cannot articulate the experiences of Black women. What is salient to Black women, is not the same for women of other racial groups. There needs to be more Black maternal narratives in order to increase the understanding of Black maternity in maternal discourse. In addition, Black women need have a voice or be a narrator of their story because they can bring forth what's salient or what they want their narrators to take away.

Black feminist theory emphasizes the importance of altering dominant discourse or it will perpetuate the marginalization of Black women. Hearing the narratives of Black women undermines what is considered to be standard. Hearing narratives from Black women demonstrates how language is not static but changing because they have alternate perspectives of maternal experiences.

Narrative theory. Narrative theory has been used to understand the persuasive effect storytelling has on changing stigmas of a group or to influence behavioral change (Babrow, Kline & Rawlins, 2005; Oliver et al., 2012). The current study sought to apply both methods of narrative theory. In allowing Black women to tell their stories, they are providing more depth to their image as they demonstrate how maternal experience is traumatic and preexisting bias and prejudice makes delivery more traumatic. Seeing the way Black women and their family members described their maternal experience informed audiences on the treatment Black women received. Emphasis on negligent care and not survival or mourning made apparent what issues and components of healthcare are important to Black women.

The agency to share which issues of maternal care are important to them, who they feel has power and who deserves recognition in their narratives are all features of narrative theory that these women implemented in the storytelling. In narratives of feeling “wronged” or “ignored” by medical staff, narrators like Charles Johnson and Elise Salazar highlight the importance of having doctors who care for patients respectfully and appropriately. Their narratives also emphasize the importance of feeling heard and having agency.

Another goal of narrative theory is to allow listeners to identify or respect the perspectives of the narrator and characters in the story (H. Lee et al., 2018). Adding to the scholarship of health communication studies, discussing the narrative implications of Hazard,

Salazar, Dixon-Johnson and Williams can continue the discussion of how examining narratives can be used in issue awareness because audiences are able to sympathize, if not empathize, with the experiences of Black women.

Practical implications

In addition to having theoretical implications, the current study suggests different ways to apply the information discussed to everyday life. For one, Black women need more platforms to share their stories. When Black women are granted the platform to talk on about their experiences, only few quotes are taken from their narratives which makes it difficult to understand the full weight of the issue. For example, in an article written by Adriana Gallardo for *ProPublica*, several women such as Heather Dobbs, Asha Ivey-Stephenson, Heather Lavender, Candice Williams and Anner Porter, had the opportunity to discuss their maternal experience. However, only parts of their stories were shared, a few sentences and quotes, and no guidance to seeking additional information or the entire interviews were available. While this is a feature of reporting, other mediums like podcasts, which have become exceedingly popular, can be used to have lengthy discussions with surviving Black women and their families.

After searching “Black maternal disparities” through the Apple Podcast app, only one episode was available. When using the search term “maternal disparities” on the same app only four results appeared. The search terms “Black moms” found 38 results. With the number of podcasts being relatively small, I believe that podcasts can be a great source to generate conversations and allow Black women to learn about experiences of other Black moms as well as gives them a place to share their maternal stories, if any.

Another way to apply the findings of this study is to use the information to change the training medical personnel receive when treating minority patients. By listening to how Black

women experience and interpret their maternal stories, medical staff can see places where they can change behavior, attitude, and language when caring for Black moms. For example, a training session should share Salazar's narrative and ask aspiring medical personnel to identify moments where the staff could have treated her differently. Assessing the narratives of these women will help form better connections between patient's and medical personnel because medical personnel will know what behaviors and dialogue make Black women need feel seen and heard as well as which aspects of care they should pay extra attention to.

Limitations

One limitation of this study is that I was not able to interview Serena Williams, LaShonda Hazard, Elise Salazar, Kira Dixon-Johnson, or their families. My analysis is my interpretation of their narratives. Because these themes were created by me instead of the speakers, it is possible that the themes are overly influenced by my personal exposure to healthcare inequalities and scholarly literature on maternal disparities.

Another limitation with the current research is that the results represent only a small sample of maternal narratives. With the issue being a new and trending phenomenon in the media, there were many stories that have not been examined. Expanding the number and depth of narratives could allow for different themes and discussion to arise.

Future directions

The current research is foundational in learning about medicalized racism in maternal healthcare. In order to further investigate how narratives can inform audiences on the lack of and need for equitable care, future researchers can continue compiling various maternal narratives to gain more insight of Black women's experiences. Hearing more from women of varying ages and locations could help to determine if issues of ageism are present.

Narrative analysis could also be beneficial to look at maternal experiences of women of other racial and ethnic backgrounds. Doing so would allow researchers to establish which areas of maternal care are more important to different racialized groups of women. For example, some women might demonstrate that verbal feedback as opposed to physical touch from medical staff make for more pleasant maternal care. Understanding these distinctions between different racial or ethnic groups will help medical practitioners know how to better connect with patients of various backgrounds.

In addition, future researchers could further the scope of the current study by assessing how Black feminist scholars have discussed maternal mortality in maternal health communication. Since maternal mortality is largely an issue faced by Black women, more scholarship from Black theorist in communicating the ideologies of Black mothers could create different discussions in maternal discourse from what is seen in recent media. Researchers could also further discussions on the intersectionality and standpoint of Black women. Since Black experiences are not singular, continuing to dissect and understand how women of different backgrounds experience things like childbirth could bring forth different ideas about how to fix maternal mortality amongst Black women. Doing so would reveal more ways Black women have been treated and suggest reasons for such treatment.

The present study sought to examine the power dynamic between Black women, physicians, and society by looking at the narratives of four Black women. In health communication studies, narratives are used to provoke empathy, understanding and behavioral change in audiences. Sharing the narratives of Kira Dixon-Johnson, LaShonda Hazard, Serena Williams, and Elise Salazar allowed for more understanding about the lived experiences of Black women which can create more discussion cross-culturally.

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