Felt Inequalities: Race, Culture and Emotion in Reproductive Healthcare

Patrice Christian Wright
Indianapolis, IN

Bachelor of Arts, Political Science & Spanish, Purdue University, 2011
Master of Arts in Teaching, Marian University-Indianapolis, 2014
Master of Arts, Sociology, University of Virginia, 2019

A Dissertation Presented to the Graduate Faculty of the University of Virginia in Candidacy for the Degree of Doctor of Philosophy

Department of Sociology

University of Virginia
August 2023

Allison J. Pugh (Chair)
Isaac A. Reed
Natalie B. Aviles
Gertrude Fraser

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ACKNOWLEDGMENTS

I want to first thank my participants for their time and generosity in sharing their perspectives and healthcare experiences. I also want to thank the birth doula community for welcoming and encouraging me these past 6 years. I have learned so much from all of you. A special note of thanks to the administrators of Foxhill Medical Center[1] that paved the way for data collection. Without the data, there would be no project, but without the keen eye and intellectual rigor of my advisor, this work would not be as great.

I thank my committee for their unwavering support of me as a scholar and of my scholarship. I am sure that I have the best committee to ever do it! Allison, thank you for always nudging me and this work forward with kind words and metaphors. Characteristic of your mentorship style, you made room for me to be a mom, a community member and a scholar. Thank you for making space for me and for the gifts of time, patience, and detailed feedback. Natalie Aviles, thank you for showing me the ropes of medical sociology and always being a sounding board for my ideas. Isaac Reed, thank you for showing me how to incorporate what others, guarding sheep in other valleys, think and feel in my analyses. Gertrude Fraser, your work on African American midwives has been a constant inspiration; thank you for your feedback on my work.

I have been blessed to be surrounded by amazing sociologists at the University of Virginia. In particular, I want to highlight the instrumental mentorship and support from Jenn Bair, Rose Buckelew, Brian Foster, Fiona Greenland, Josipa Roska and David Skubby. I am especially thankful for a cadre of fellow graduate students with whom I have been able to share camaraderie over the years: Kathryn Babineau, Heidi Nicholls, Vasfiye Toprak, Jeon Su Yeone, Lin Yen-Yu, Shao Di and Moriah West. Where would my writing be without the critical feedback and humanizing support of my writing group—Brooke Dinsmore, Bailey Troia, and Shayne Zazlow—and members of our advisee group past and present—Pilar Plater, Nia Baker, Madison Green, and Mike Krieger.

I want to also thank my family, sorority sisters and close friends for their unwavering love and encouragement. I also have to thank my two youngest supporters, Grace and Mia, for giving the best hugs, better than Olaf, and keeping me on my toes. “Mom, how are you a student, I thought you were a teacher?” “I don’t know what my mom does but she’s always talking about something called a dissertation.” I did this for me, but I did it for you too.

Lastly, I thank my mother Kelly and husband Nicholas for being the loudest cheerleaders on this journey. Thank you for loving me in the ways that I needed to be loved.

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[1] Pseudonym

DEDICATION

For Grace & Mia

INTRODUCTION

In a recent Spring, I met with Camilla[2], a Black 42-year-old executive in her office between meetings. I had been following her pregnancy and birth, interviewing her while pregnant and attending a portion of her birth in the hospital. When I had last seen Camilla, I helped wheel her labor bed from the labor and delivery unit of Foxhill Medical Center to the mother baby unit where mothers who are two hours or more postpartum recover before discharging from the hospital. As labor and delivery was busy and short staffed that day, I volunteered to help move Camilla and her belongings from one unit to the other. Before I left her in her new room, post cesarean section and with a brand-new baby swaddled in a baby crib next to her bed, I watched Camilla complain about the condition of her hospital room. True to her characterization of herself as a germaphobe and advocate, I watched as she held a surgical mask over her face as she pointed out to the nurses and myself all of the dust on the ceilings and walls that made the room inhospitable and necessitated a cleaning. As I said my goodbyes and congratulations to her, the nursing team worked to coordinate a new room for her.

What I did not know until our second interview was that Camilla hemorrhaged shortly after I left her side. Recalling that moment she said,

> That's when I was gushing, and I felt blood leaving my body. My mom's like what do you mean? I'm like I'm losing blood. And so that's when she called the nurse and the nurse came in and she called maybe five or more of them [who] ran into the room. And they were like getting blood clots out, doing like everything trying

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[2] Pseudonyms are used in this dissertation to protect participant confidentiality.

> to see what’s going on because there should have been nothing there.

Camilla recounted the moment she and the team realized she was hemorrhaging or feeling blood leave her body. In a calm tone, she continued to explain what happened to her as if she had disassociated from it. The nurses frantically searched for the cause of bleeding. Her mother, a midwife in their home country, yelled at the nurses to measure how much blood she was losing. She lost over 500ccs worth of blood. She lost so much blood that nurses came periodically to help her stand to see if she would faint, an indication that a blood transfusion was necessary.

The experience Camilla described is not an outlier. In the United States, Black women[3] consistently have poorer maternal health outcomes than White women, regardless of socioeconomic status. They are more likely to experience pregnancy complications including: preterm labor, preeclampsia, hypertension of pregnancy, gestational diabetes, membrane disorders, hemorrhage, cesarean section and infection (Shen, Tymokow, and MacMullen 2005). Moreover, they are three to five times more likely to die from these complications (Fang et al 2000). This phenomenon has received media attention in recent years, including a joint publication series by NPR and ProPublica entitled Lost Mothers: Maternal Mortality in the U.S., which won a Peabody Award (Martin and Montage 2017). The increased attention to maternal health also contributes to several pieces of legislation at the state and federal levels that address this public health crisis, including the MOMNIBUS Act (H.R 6142, 2020; H.R. 959, 2021).

Many Black mothers consider poor outcomes to be likely related to the negligence of providers. One sunny autumn day in the fall of 2019, I met with Melody in a local café. We sat

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[3] This dissertation uses the language of women, following how participants referred to each other and themselves. However, the literature on pregnancy and birth has moved towards a shared vocabulary of Black birthing people to acknowledge that everyone who has the physiological capacity to carry a child does not identify as woman.

towards the back in cushy armchairs, far from earshot of other customers, while her newborn baby napped peacefully in her car seat between us. As Melody fiddled with her baby's clothes, she told me about her harrowing two-month stay at the hospital when she was admitted as a high-risk pregnancy patient three months before her due date. In example after example, she described how health providers talked over her but not to her. She said they made assumptions that she was poor, uneducated, and that she "sat around and ate potato chips all the time". When the medicine prescribed by one doctor counteracted the medicine prescribed by a different doctor overseeing her care, she described them as having a "pissing contest" while her health laid in the balance. Although she tried to create a partnership with her providers, she felt her concerns were ignored, and that they were not even really seeing her.

Existing explanations of maternal health disparities all seem to implicate the continuing significance of race in shaping the provision of health care and health outcomes. Health science researchers describe race as a risk factor for outcomes such as preterm labor and low birth weight in babies (Berkowitz et al 1998; Ananth and Vintzileos 2006). Yet the way that health science researchers use race as an independent variable in health research is critiqued by bioethicists for reifying essentialist notions of biological race (Nelson 2016) and perpetuating ideas that belonging to a particular race is synonymous with pathology (Roberts 2011). Other health research indicts implicit or unconscious bias as the main culprit affecting the provision of healthcare and the resultant health outcomes (Spencer and Grace 2016; Hoffman et al. 2016; Matthew 2018). While bias plays a role in health outcomes, the perspective erases the structural nature of race in society and how that stratifies access to resources.

Race is not biological, but a social construct and a social fact that shapes healthcare and health outcomes. Processes of racialization draw symbolic boundaries, create a racial order, and stratify access to resources. These processes also map onto the provision of healthcare whereby hospitals and health clinics in poor, black, and brown neighborhoods are often underfunded and under-resourced (Wingfield 2019) and the medical equipment is older and less reliable (Ansell 2017). While structures of race are external and experienced through various material deprivations, they are also incorporated internally, affecting emotions, increasing stress, causing and exacerbating health issues when competing expectations and cultural scripts collide (DuBois 1903; Anzaldúa 1987).

For racialized others—people that are the negation of hegemonic whiteness—constraints abound concerning how one should interact with the larger world. Emotions signal cultural meanings and social relationships (Illouz 2007), and there are competing scripts and feeling rules that dictate how one should act and feel and stereotypes that are meant to be avoided. Black women are frequently chastised for being angry, loud, and promiscuous. Yet these rules sometimes conflict with norms for expected or sanctioned behavior that prevail in particular settings. For example, healthcare practitioners encourage patients to advocate for themselves, taking an active role in their care. This creates a conundrum: how can black women advocate for their reproductive health when cultural scripts suggest that doing so means she confirms stereotypes? When one of those stereotypes is ‘anger’, how is the emotional tenor of patient-physician interactions shaped by race and racism? In sum, what are Black women’s expectations of maternal healthcare and how are these shaped? How does race shape the emotional landscape of patient-provider interactions? What cultural repertoires become most salient and helpful for navigating interactions and the institution of healthcare, and how do Black women frame racial experiences and the resulting emotions in interactions? How does experience and response vary by socioeconomic class? How do Black women navigate the demands for the “engaged patient”?

I answer these questions through extensive qualitative data including in-depth semi-structured interviews with 56 Black women across class at two-time points, interviews with obstetricians, nurses, and doulas, and 15 months of ethnographic observations of interactions on a hospital maternity ward. I triangulate the data from these three sources in my analysis to confirm patterns in the analysis.

I find that black women's expectations of maternal healthcare are shaped by national media accounts of Black maternal health disparities, local histories of medical racism, and their own previous poor experiences with healthcare. We can best understand how they prepare for healthcare interactions through a *racial safety* frame. Borrowing the term from sociologists of family, I argue that Black women seek *racial safety* or desire to avoid experiences of obstetric racism (Davis 2019). On the other hand, physicians see themselves and their patient care through a lens of *heroic efficiency,* as altruistic providers that utilize medical science to save the lives of mothers and their children, often under time constraints. However, they are facing an authority crisis as the social authority of the physician wanes under the weight of shifting medical authority, hospital business practices, and public criticisms. I argue that how physicians attempt to retain their authority inadvertently shapes the care provided to laboring women and in particular harms Black women patients. I explore the mismatch of expectations of birth on labor and delivery and find that while patients and their providers are both invested in the interaction, they seem to diverge on issues of timing, knowledge, and emotional recognition. As a result, Black women continue to feel unseen and unheard in their maternal healthcare experiences.

These findings have implications for Black women's maternal healthcare. Healthcare outcomes are more than just measures of morbidity and mortality but can also have lasting effects on the women themselves and their trust in institutions (Halbert et al. 2006). Maternal health care is the site of extreme racial disparity for Black women, regardless of their class status. I explore how the extreme racial disparity is produced by the histories, training, and perspectives of Black women patients and predominantly white providers. I consider how patient-provider interactions result in the production of inequalities despite the best intentions of patients and providers. This research is an important first step for eradicating Black maternal healthcare disparities.

This dissertation contributes to race, culture, and medical sociology literatures as it examines the impact of racism on emotions and meaning-making in interactions. It illuminates the emotional dimension of inequality within institutions like healthcare. I add an ethnographic lens on interactions that is unique and allows for a clearer depiction of the conceptualizations of care that drive patient and provider approaches and experiences and demonstrates how interactions go awry. I also demonstrate the continued significance of class as middle-class women's approaches to care do not exempt them from poor experiences.

LITERATURE REVIEW

Race, racism, and racialization have been central to sociology since DuBois. Race, a social structure, and its ideological component racism stratify society into a hierarchy based on phenotype and a color line (Bonilla-Silva 1997; Emirbayer and Desmond 2015). As a social structure, racism benefits and bequeaths some with power while it disadvantages and disempowers others. Processes of racialization perpetuate power differences by mapping ideologies of racism and racial differences onto various other institutional structures, and racism reinvents itself in new ways (Bonilla-Silva 2017; Omi and Winant 2014). While one influential research stream documents the material effects of race and racism by linking practices of structural racism such as redlining, segregation, and employment discrimination to a whole host of negative outcomes such as increased poverty, poorer health, lower educational attainment and criminalization (Ansell 2017, Alexander 2010, Massey and Denton 1993, Wilson 1987, Pager 2003, Pattillo 1999, Young 2004), scholarship also explores how race and racism affect people's inner lives.

Racism gets under the skin and affects the intimate lives of raced people. In qualitative monographs, sociology of race scholars document the experiences of Blacks as they live in segregated and mixed neighborhoods (Lacy 2007; Pattillo 2013), for example, and the struggles and choices they face. We learn what it is like for them to undergo processes of criminalization (Rios 2011), navigate inner city violence (Anderson 2000), and make tough choices about their families and careers (Dow 2019). Through these works, scholars explicate particular ways that racism shapes various areas of social life and how Blacks respond and/or resist (Feagin and Sikes 1994) and this scholarship contributes to our understandings of the nexus between racism and intimate lives. While these contributions are important and vivid descriptions of lived experiences of racism, they do not explicitly explore the heterogeneity of Blacks' interpretation of and responses to experiences of inequality.

Race scholars have called for more work that examines the emotional effects of racism (Embrick et al 2017, Bonilla-Silva 2019). Bonilla-Silva illustrates the intersections of emotions, culture and race with a story of a young Ossie Davis and his encounter with police in the Jim Crow South (Marble 2000:9 cited in Bonilla-Silva 2018:9). As a young boy of six or seven years, he was picked up by the police as he walked home from school. Davis recalls, "…one of them reached for a jar of cane syrup and poured it over my head as if it was the funniest thing in the world. I laughed, too. Then the joke was over. The ritual was complete." Davis goes on to say that he never told his parents, as it did not seem important, although he knew what happened should not have, “Something very wrong had been done to me; something I would never forget”. Bonilla-Silva uses this story to highlight the differing emotional impacts of racism depending on social location: the white officers used the situation as comedic relief to the peril of a young black boy. Yet, this story also underscores what culturally mediated emotional responses and cultural scripts – such as suggesting he go along with his own humiliation, and keep silent about it later – were available and deemed appropriate for a young Black boy in responding to and surviving an incident with the police. The type of experience that Bonilla-Silva describes I call felt inequality, or the emotional experience of racism; this dissertation examines felt inequality from institutional, interactional and individual levels of analysis.

While emotions are in part produced physiologically, their meaning, expression and repression are facilitated by culture, and some culture scholars have delved into the patterns of how people interpret and respond emotionally to racialized experiences. Responses to inequality are heterogenous and depend on several cultural factors, including how individual webs of significance connect to framings of social interactions and are an impetus to action (Small 2004). Some cultural scholars argue that recognition is the way inequality is felt, thus pinpointing the importance of recognition in interaction and the emotional consequences of misrecognition (Lamont 2009). Other scholars theorize the ways emotions are embedded in modernity and affect identities and interactions (Illouz 2007), an underutilized approach to understanding inequality. This current work complements the earlier works of race scholarship that details the intimate lived experiences of racial inequality, and it adds an explicit focus to the patterns of meaning-making processes that shape heterogenous responses.

Despite its relevance for analyzing the interiority of inequality, however, the sociology of culture has a difficult history around race. In the 1960s, alongside Parsonian theories of functionalism, a few sociologists utilized the cultural concepts of norms and values to explain persistent inequality among the poor and racial minorities. In particular, the “culture of poverty” thesis posited that Black norms and values caused them to remain in a perpetual state of poverty (Moynihan 1965, Lewis 1966). Since that time, there have been numerous critiques of that approach. Most often, it is critiqued for placing the blame on the victims themselves for their plight and ignoring the numerous structural and cultural forces that shape their opportunities and life chances (Lamont and Small 2008, Young 2010, Small et al 2010). Because of the legacy of this scholarship within sociology and specifically cultural sociology, in the last 50 years scholars have avoided cultural and causal explanations (Lamont and Small 2008).

Yet some scholars suggest that continuing debates over the “culture of poverty” are an “endless flogging of long dead and buried horses” (Patterson 2014:2), and urge cultural sociologists to once again approach questions that conceive of the causal power of culture, yet with caution to not make the same “methodological, theoretical and ideological mistakes of previous works” (Patterson, 2001). While scholarship in this vein examines the role cultural processes have in producing and reproducing inequality (Lareau 2015; Lamont et al 2014), other work focuses on how culture is the medium through which racial inequality is experienced, as domains of misrecognition (Lamont 2009, Lamont et al 2016), emotion regulation (Wingfield 2010), and mistrust (Clair 2020). Exemplary scholarship centering the experience of inequality uses several cultural tools that illuminate the heterogeneous meaning-making processes of those who experience inequality and connects those meaning-making projects to action (Young 2004).

Cultural analyses allow us to delve into how people interpret and experience race and racism, and the "rules and resources" which govern their responses (Sewell 1992).

Racialized emotions and the sociology of culture

Culture is an apt framework for examining how institutional racism shapes social interactions and emotions. Culture research offers several useful concepts for thinking about the impact and experience of racialized emotions including institutions, cultural scripts/norms, cultural repertoires and frames. Looking at these concepts from the institutional, interactional, and individual levels allows us to make explicit connections between social processes of meaning-making and their effects on the experience of inequality. When we blend these ideas with contributions from the sociology of race, we lay the groundwork for further research in racialized emotional subjectivities.

Institutional Level. Lamont and Small define institutions broadly as "formal and informal rules, procedures, routines and norms, as socially constructed shared cognitive and interpretive schemas, or more narrowly yet, as formal institutions. In all of these definitions, however, they enable and constrain shared definitions and experiences of race, class, and gender." (Lamont and Small 2008:89). For this study, I am leaning on the definition of Lamont and Small and thinking about institutions as organizations with shared cognitive and interpretive schemas including classification and evaluation systems. Within organizations, the built environment is imbued with culture and cultural significance as are the institutional policies and discourses that shape and maintain the classification systems and systematic exclusion of groups; thereby, institutions are able to reproduce themselves. Institutions are the site where people interact and the built environment helps to shape what happens at the interactional level. We might think of organizations as facilitating ‘group styles’ that shape the way people interact (Eliasoph and Lichterman 2003).

Interactional level. Cultural scripts/norms shape interactions, and scholars argue that culture helps to regulate individual emotions through social norms, create identities through discourse and performance, and produce emotions through ritual forms (Illouz, Gilon, and Shachak 2014). “Through emotion we enact cultural definitions of personhood as they are expressed in concrete and immediate but always culturally and socially defined relationships” (Illouz 2007:3). Thoughts, actions, and emotions within social interactions are regulated by social norms and cultural scripts. As race is a structure that stratifies social life, it also shapes social norms and cultural scripts dictating how people, especially racialized others, should interact with society and what emotional responses are appropriate. Adherence to these norms are important as there are social consequences for responding or not responding to a situation in a culturally dictated manner (Briggs 1991). A few of those cultural scripts that shape interactions include feeling rules and controlling images.

Feeling rules dictate how one is supposed to feel in any given situation or interaction—the culturally accepted feeling response (Hochschild 1979). As Hochschild argues, people engage in “deep acting” to manage their true emotions and align them with the dominant, and thus culturally appropriate, feeling rules (1979, 2012). While Hochschild’s work on feeling rules was originally theorized to explain gendered differences in emotion management in the workplace and other settings, it also demonstrates that feeling rules are socially constructed and constrain people’s emotional responses.

Feeling rules are not just gendered but also racialized; they have shaped the way Blacks have experienced and responded to racism, scholars have found. Feagin argued that the emotional options people had in responding to racism were limited. When a black couple was refused service at a restaurant, Feagin described the man as angry and "ready to take the place apart" (1991:105). Instead, he chose to leave, indicating that the emotional expressions available to him were restricted. Lacy (2007) emphasized the agency of middle-class African Americans when they experience racism. She argues that middle-class blacks use public identities to navigate white spaces, sometimes 'getting back' at whites that have wronged them without filing official reports. Yet, she describes that the usage of public identity strategies does not come without emotional tolls. "Even when such strategies pay off, they can be tiring and irritating, exerting a potential psychological toll that informants either are unaware of or tend not to express," and she refers to Feagin's earlier research, "[his] respondents were overtly angry, and it is possible that the blacks in my study are more angry than they realize" (2007:76-77).

More recently, scholars have investigated how feeling rules are racialized in the workplace (Wingfield 2010) and in other settings (Williams, Bryant and Carvell 2019), documenting the racialized nature of institutions (Ray 2019). Black workers experience the feeling rules at their places of employment as racialized and that these restrictions stymie their range of emotional responses (Wingfield 2010, Wingfield and Alston 2013). Other scholars have extended Hochschild's concept of emotional labor to include the emotion regulation undertaken by racialized individuals to acclimate into white virtual spaces and ensure the comfort of whites (Williams, Bryant, and Carvell 2019). The consequences for people of color of not engaging in what Wingfield and Alston (2013) called "racial tasks" or uncompensated emotional labor in the workplace, can lead to "the threat of bodily harm, loss of a job, or loss of cultural capital" (Williams, Bryant, and Carvell 2019:4). These findings indicate that racialized structures of institutions set the cultural scripts and feeling rules differently for racialized others, thereby shaping the interactions that take place within them, and the racialized meaning actors make there.

Feelings rules are racialized, then, and part of the feeling rules for Black women stem from the images that control them. Intersectionality theory suggests that people whose social position aligns along multiple axes of oppression have multiple and conflicting sets of cultural scripts that come together in what has been called “controlling images” (Anzaldúa 1987, Crenshaw 1989, Collins 2000). Tropes like mammies, matriarchs, welfare recipient, and jezebel are ideological constructs that posit U.S. Black women as the other and provide ideological justification for race, gender, and class oppression (Collins 2000:77). These ideological constructs exist at the institutional level to perpetuate gendered and raced hierarchies, and have real consequences for the lives of black women through the legislation and policies they inspire. For example, government officials interpret poor black women as ‘welfare queens’ and ‘matriarchs’ who they perceive are lazy and have children for access to government benefits. This interpretation leads to a host of legislation aimed at population control including: federally funded sterilization in the 1920s and 1930s, public health campaigns promoting long-acting reversible contraceptives in the 1980s and 1990s, and campaigns to prevent unplanned pregnancies in the imagined unwed teenage black body today (Waggoner 2015, Roberts 1997, Bridges 2011, Flavin 2009). These ideological constructs also come with emotional messages – that Black women are “angry” (Childs 2005), “demanding” (Harris-Perry 2011), “stoic” (Mullings 2005) or other emotional stereotypes. In addition to accomplishing institution-specific emotion management, black women must also navigate mainstream cultural biases, and the often-contradictory sets of expectations they generate, placing an enormous burden of emotion management and self-monitoring on an already oppressed group.

Interactions are sites of recognition and misrecognition as actors engage in inter-subjective meaning-making (Lamont 2018). It is the best place to observe the cultural process of racialized emotions and its consequences. Through the interactions of actors with unequal power, cultural processes come to fore as material and non-material resources, including recognition, are exchanged or withheld according to each actor's understanding and assimilation to cultural structures (Lamont et al 2014). During this inter-subjective process, it is possible that one feels slighted or misrecognized and has an emotional response that requires emotion management in that setting (Pugh 2024). Part of that emotional response is shaped by how individuals frame the interaction as well as their aspirations and expectations.

Individual Level. People carry within themselves a variety of cultural repertoires – the taken-for-granted, unarticulated scripts that inform actions (Swidler 2001). Yet toolkits vary by race and class, and the resources of comparative cultural capital with which people can change social structures are unequally distributed (Sewell 1992). Likewise, frames are stories we tell ourselves about the experience, larger institutional explanations that may be applicable in a case (Small 2004, Harding 2007). As Geertz (1973:5) reminds us, "…man is an animal suspended in webs of significance he himself has spun." Therefore, individuals can experience the same stimulus but interpret it differently. Cultural repertoires give us the language to discuss how individuals and their meaning-making are colored by life experiences and exposure to different frames. When experience is framed or interpreted as discrimination per larger institutional scripts, it can bring on a range of emotions tied to the experience of inequality and misrecognition, spurring a variety of responses. The availability of alternate framings or empowering cultural repertoires can sustain resistance or destigmatization.

Culture researchers have also identified an important factor mediating emotional responses to social interaction: expectations—or the combination of aspirations and institutional promises (Frye 2011). Expectations are one link between the self and cultural norms. Emotions ooze as a culturally mediated response to the overlap (or lack thereof) between expectations and experience (Pugh 2015). For instance, being laid off from a job held for many years by an employer who says they value employees is experienced as a painful betrayal. One can feel emotionally hurt when one expects more from the other party. Likewise, if one did not expect much to begin with, one can work to reframe or reduce the emotional toll. For instance, in MacLeod's *Ain't No Makin' It*, the Brothers were poor Blacks who believed in the achievement ideology advocated by the schools and the public, yet after several years, their life circumstances were barely better than the poor white hallway hangers who didn't invest in educational ideology (2009). Being that the Brothers had higher expectations for their life chances, they took the failure hard and blamed themselves. As for the Hallway Hangers who didn't try as hard, they interpreted their failure as caused by African Americans and affirmative action. This internalization of failure on the part of the Brothers, was in part a severe emotional consequence of having high expectations and being let down.

Expectations of institutions vary by class (Lamont 1992, Lamont 2000, MacLeod 2009, Willis 1977, Patillio 2007). The success of 1960s civil rights legislation and the upward mobility experienced by families in the middle class lend some credence for them to institutional promises of equality and equal protection under the law. Because middle-class Blacks have higher education attainment, stable employment, and higher rates of home ownership, their middle-class status shields African Americans from the overt racism that lower-income Blacks suffer in many arenas. The evidence of racial progress in other domains leads middle-class African Americans to have high expectations that institutions will follow through on their promises (Feagin and Sikes 1994). On the other hand, working-class and poor African Americans have fewer positive interactions with institutions. State institutions frequently surveil and intervene in their day to day lives, leaving them with less expectation of institutional aid or support. Thus, while they can feel angry or distressed when institutions fail them, the emotional toll might not be experienced as severe a disappointment (Willis 1977).

What Remains to be Observed

As we view the cultural repertoires embedded in institutional contexts, enacted in interactions and animating individual interpretation and practices, we can see how culture shapes emotional experiences of racism, and how, stemming from that experience, a heterogeneous variety of responses can emerge, especially by class. Cultural sociology offers some promise for decoding the inner experiences of racism, and specifically its emotional component, helping us to evaluate how inequality is both experienced and reproduced. Emotional processing is cultural (Illouz 2007) and dictated by established feeling rules that are different for racialized others. The literature demonstrates how people are constrained by institutional culture, thus engaging in emotion management to avoid social consequences. Yet, there are few works that examine these processes for racialized others for whom the stakes of transgressing cultural norms may be more severe, even though we have plenty of research suggesting that these processes can have important and long-lasting effects. How do racialized others experience and emotionally manage interactions in racialized institutions in everyday life? How do these processes vary by class?

The perfect case to examine processes of racialized emotions, their interpretation and experience is the case of Black women and their experiences of maternal healthcare. There is a robust literature on racial health disparities affecting African American women regardless of class; socio-economic advantages do not appear to protect Black women as much as we would expect from negative outcomes in pregnancy and childbirth (Colen et al 2006). This contemporary mystery, while tragic, also allows for research to compare the effect of class on how women anticipate, interpret and respond to their maternal healthcare, including the emotional processes through which they navigate the institutions and interactions that comprise their experience.

The Case: Black Women and (Dis)Engaged Patienthood

Healthcare as an institution is a white space; according to the American Association of Medical Schools, 56% of active physicians are white (AAMC 2023). Fox Hill Medical Center has a racial history and majority white workforce. It is a unique white space, however, with key differences from corporate or other venues by virtue of its primary business: healthcare. Scholars have argued that this unique mandate makes the institution of healthcare what Rothman (2021) called a biomedical empire, in which the institution certifies the legitimacy of all births and deaths. In this way, all birthing people are compelled under a safety frame undergirded by perceptions of birth as pathological and inherently risky to give birth at a hospital and under the supervision of an obstetric physician and surveillance of the biomedical empire (Bridges 2007; Rothman 2021). While the safety frame decreased the prevalence of midwifery in the 20th century as births moved from the home to the hospital, some births are moving back into the capable hands of midwives attending both homebirths and hospital births in recent years (Rothman 2016; Mckechnie and McIntyre2023). In 2020, almost 2% of births happened at home or in a birth center, a 19% increase in community births as compared to 2019 (MacDorman, Barnard-Mayers and DeClerq 2022) Yet, those who are most able to have home births attended by midwives are white middle-class women (Rothman 2016).

Although Black mothers can also opt into home births, their choice is more susceptible for scrutiny by biomedical empire representatives. Recent news reports document that a Black couple in Texas had their newborn seized by child protective services because of a neglect allegation from their pediatrician (Breen 2023). A few days after a homebirth assisted by a midwife where everything with mother and baby were fine, the couple took their newborn to see the pediatrician for a check-up. At that check-up, the provider diagnosed the infant with jaundice and suggested treatment, which the parents declined as they wanted to confirm with the midwife who attended their birth. The pediatrician, as a representative of the biomedical empire, reported them to child protective services for endangering the health of their newborn. Cases like this indicate that while home births are technically an option for Black women, that choice is often an illusion.

Within hospital-based care settings, patient-provider interactions are key components of positive health outcomes. Positive interactions can improve patient satisfaction, a patient's assessment of their overall health, and health outcomes like blood pressure and blood sugar (Collins et al 1993; Kaplan, Greenfield, and Ware 1989). During labor, support from healthcare providers is linked to lower rates of postpartum depression as well as higher APGAR scores for infants (Collins et al 1993). Scholars suggest that positive relationships with providers encourage patients to adhere to recommendations, increasing healthy behaviors and improving self-care practices that contribute to sustained health improvements long after the interaction (Nicoloro-Santa Barbara et al 2007).

In addition to such benefits for patients, positive interactions also accrue advantages to providers (Pugh 2024). In particular, positive interactions contribute to providers' satisfaction with their work (Menon and Sariego 2022). Likewise, patients who report high satisfaction scores are less likely to initiate a malpractice suit in the event of an adverse medical outcome (Moore, Adler and Robinson 2000; Penchansky and Macnee 1994; Thompson 2007). Thus, both patients and providers have vested interests in the success of the interaction. At the same time, however, multiple factors contribute to making those interactions fraught, difficult or unsuccessful.

Contemporary medical sociologists have identified a changing pattern of clinical expectations for both the clinician and the patient in the rise of what some have dubbed “the engaged patient.” An engaged patient actively advocates for their health and may resist treatments or diagnosis (Timmermans 2020). In response to this trend, clinicians—physicians, nurse practitioners, and physician assistants among others—anticipate and accommodate patient requests, while clinical interactions between patients and clinicians are “more of a negotiation between two unequal parties mutually dependent on each other’s collaboration to achieve health” (Timmermans 2020:260). This transformation of the patient-clinician interaction comes on the heels of considerable evidence that such exchanges can have an impact on health care outcomes (Street Jr, Gordon, and Haidet 2007; Heritage and Maynard 2006; Shim 2010). The rise of the engaged patient and clinicians’ focus on patient-centered care, and the resultant spread of shared decision making, sets new cultural expectations of both clinicians and patients for the clinical encounter. As we shall see below, however, the engaged patient relies on whiteness, as a construct that requires an emotional stance from patients that is not normally allowed for Black women.

The new engaged patient trends also contrast sharply with more than a century of African American experiences of the health encounter, marked by experimentation and paternalistic care. Marion Sims, alleged founder of gynecology, perfected his surgical technique to repair vesicovaginal fistulas on enslaved women without anesthesia (Owens 2017). The enslaved women did suffer from ailments but were unable to consent to treatment nor able to purse alternative treatments they may have preferred (Owens 2017). In the early 1930s, The United States Public Health Service began a research study on the effects of untreated syphilis in African American men (Reverby 2009). In what became known as the Tuskegee Syphilis Study, the participants and their families believed they were receiving treatment, but instead were only monitored for the progression of disease. These are early examples of the lack of honest communication between the patient and clinician and of the clinician making unilateral decisions about the patient’s health and treatment options.

Black women, in particular, have been disadvantaged by paternalistic reproductive healthcare. In the mid-20th century there were forced sterilizations of Black women throughout the south (Washington 2006). In many cases, women went into surgery to repair one medical issue, and awoke to news they had been sterilized (Sacks 2018). When it comes to infertility, some Black women today report being told they were infertile, but not offered any treatments (Wright n.d.). Although comparative rates of infertility are higher for Black women relative to white women (Chandra and Stephen 2010), they are more likely to receive contraceptives and sterilization than infertility treatments (King and Meyer 1997, Griel et al. 2011).

The above examples demonstrate that the history of Black healthcare is marred by racism and inappropriate treatment; they also suggest that interactions between clinicians and Black patients are full of miscommunications at best and flagrant disregard for the desires and consent of the patient at worst. In light of the mounting evidence of medical malpractice, paternalistic communication, and experimentation, it is not surprising that some researchers describe African Americans as having a healthy paranoia of the medical institution (Gamble 1997).

Contemporary African American Maternal Disadvantage

Racialized disparities in health care are epitomized by maternal mortality and compromised outcomes. In the contemporary moment, Black maternal disadvantages persist despite government agencies repeatedly identifying the causes of racial health disparities and naming black maternal mortality as a priority (IOM 2003; CDC 2019). In particular, black women are 3-5 times more likely to die than white women, regardless of class (Fang 2000). Black women are more likely to experience poor maternal health outcomes relative to white women including: preterm labor, preeclampsia, hypertension of pregnancy, gestational diabetes, membrane disorders, hemorrhage, cesarean section and infection (Shen, Tymokow, and MacMullen 2005). Moreover, children born to Black mothers also face higher rates of pre-term delivery and low birth weight (Hoyert, Freedman, Strobino, and Guyer 2001), and are twice as likely to die in the first year of life when compared to white babies (Matthews et al 2003). Health researchers say that much of the morbidity experienced by black women, like hemorrhage and infection, for example, could be prevented. (Mehta et al 2020).

There are three ways in which scholars have explained maternal health care disparities: *social determinants of health*, *weathering*, and *racialization* explanations.

Social determinants of health

The "social determinants of health" approach explains racialized disparities in maternal health by pointing to factors such as poverty, segregation, and access to nutritious food and healthcare. Yet while social determinants of health may explain working-class and poor women's susceptibility to poor maternal health outcomes, it is insufficient to explain how these disparities also apply to middle- and upper-middle-class black women. These women's compromised outcomes, relative to their class peers, highlights a continuing significance of race and racism over socioeconomic status. Moreover, this strand of research traditionally examines such contextual factors to explain low and very low birthweight in babies born to Black women; as such it echoes a culture of poverty framing examining the environment and behaviors of African American women to explain negative outcomes across a host of dimensions (Lamont and Small 2008, Young 2010).

Weathering

As culture of poverty explanations went out of style, a robust literature documenting race and stress emerged, with many scholars embracing the idea that stress, especially stress from experiences of racism, could explain health disparities (Uberson, Williams, Thomas 2014; Shulz et al 2000). This research draws connections between stress and "weathering," that argues that the stress that Blacks experience compounds throughout the life course and causes a higher allostatic load, thus making them more susceptible to illness (Geronimus 2006). For example, anthropologists Mullings and Wali (2001) found substantial evidence linking structural causes such as poverty and inadequate housing to birth outcomes, but they also reported that compounded stress, from continually dealing with structural forces like inadequate housing, poverty and access to food, exacerbated illness.

Stress research also addresses the crucial omission in "the social determinants of health" approach: the continuing significance of race for middle-class Black women's maternal health disadvantages. In addition to structural factors that stratify health, negative outcomes are exacerbated by stress compounded throughout the life course. Scholars posit that middle-class black women are susceptible to even more stress as they traverse white institutions and climb corporate ladders (Mullings and Wali 2001). They find that middle-class black people escape the stressors of living in poverty but exchange those stressors for different ones where they experience racism at work as they climb in ranks within white institutions. The emphasis of stress and its impact on health is important, as stress is experienced emotionally in addition to physiologically (Lazarus 1993).

Racialization

A third influential approach to explaining maternal health disparities is through racialization and racism. Racialization scholars provides an important contribution to our understanding of the case, compared to the first two approaches, by giving greater cultural context to the structural factors that cause disease and exacerbate stress. They highlight the process of racialization, defined as the overlay of racial meaning onto a relationship, group, or practice that was previously unclassified (Omi and Winant 1994), and apply it to medical care, analyzing how it unfolds and shapes health outcomes and clinical experiences.

First, racialization happens through clinical discourse. We know that the way clinicians talk about patients and patient populations at health clinics is important as it shapes how the patients are treated and for which medical conditions they are screened (Bridges 2011). Yet, as theories of cultural scripts would predict, discourses about black and brown patients permeate institutions and affect the way doctors think and speak, constructing narratives about pregnant patients that reify biological essentialist notions of pathology and obstetric hardiness (Bridges 2011, Roberts 1997). These ideas are harmful in the long term, but they also ignore more recent research dispelling the idea that race is biological and demonstrating it as instead a social construct. The prevalence of this discourse also shapes the clinician's expectations of working with Black patients, as it pathologizes them in a particular way.

These discourses also echo and stand alongside controlling images outside of the clinic setting that posit black women, in particular, as jezebels, mammies, matriarchs, and welfare queens (Collins 2000). The controlling images, and the emotional expectations that accompany them, shape Black women's experience in health care, by informing practitioner views and practices while constraining Black women's options for response. When people expect a patient to be "angry" or "demanding," for example, we might predict that it would limit the ways in which she may be "engaged."

While the racialization approach provides us with critical knowledge for understanding how race and racism work to the detriment of Black maternal outcomes, we still need to know more about how Black women themselves experience these encounters. Recent research suggests that Black women resist racialization through self-presentation strategies and a demonstration of health knowledge (Sacks 2018, Wright n.d.), moves that strongly resemble the characteristics of the "engaged patient" that has been transforming the contemporary clinical encounter. Yet Black women's options are severely constrained by the controlling images that inform the racialized patient population discourse, which could lead physicians to misinterpret or view askance behaviors that in white people would be viewed as the "engaged patient" practices. Ultimately, scholars have found that Black women's efforts rarely resulted in improved communication or shared decision-making with the provider, however (Wright n.d.; Attanasio, Kozhimannil, and Kjerulff 2018).

While scholars have examined the impact of environmental factors and stress to explain the disparities, racialization research offers particularly useful tools to consider the ways in which black women are enabled and constrained in their efforts to be an engaged patient. In light of the controlling images and patient population discourses that shape how clinicians think about and discuss their African American patients, how African American patients present themselves in the clinical encounter is restricted. This dissertation then pursues the following questions: What are Black women's expectations of maternal healthcare and how are these shaped? How does race shape the emotional landscape of patient-provider interactions? What cultural repertoires become most salient and helpful for navigating interactions and the institution of healthcare, and how do Black women frame racial experiences and the resulting emotions in interactions? How does experience and response vary by socioeconomic class? How do Black women navigate the demands for the "engaged patient"?

In sum, we know from existing work that racism affects people's inner lives and causes enormous pressure on racialized individuals to avoid confirming an ideological image meant to perpetuate their domination. Cultural scripts and feeling rules vary by institution but pile on top of mainstream controlling images, and black women in particular must navigate institutions and surveil and control their own behavior carefully as to not confirm practitioner biases. There is also work suggesting that the meanings, impact and possible responses to race and racism are shaped by the expectations and resources of class. Much of this work is done in interactions within institutions where — through intersubjective processes of meaning-making – unequal actors award and deny resources including recognition, which can result in emotional turmoil and instant emotion management. This is the process of interest that culminates in the racialized emotions of felt inequality. A perfect case to examine the impact of class on how people experience, interpret and respond to race and racism is in maternal health care, which for Black women is the site of extreme racial disparity, regardless of their class status.

This dissertation project sidesteps the ideological pitfalls of victim-blaming and instead examines how responses to and actions resulting from experiences of inequality are shaped by the experience of inequality itself. It also allows us to wonder or theorize how change may happen in this instance. Work of this type has important implications, including the reinvigoration of culture scholarship that attends to race and the potential to suggest ways to reduce African American maternal mortality and morbidity.

Researching Black Women's Experiences with Maternal Healthcare

In 2018, I attended a community doula training program where I met close to 30 Black women and future doulas who were invested in improving Black women's birth experiences. The midwife who led the training asked each woman her why she was interested in birth work. One by one, each woman told a story where someone she loved, or even she herself experienced what could be described as an emotionally turbulent labor and subsequent birth where it felt as if the patient and provider were not connected, or more colloquially, were not on the same page with the care. They sought to become doulas to be able to better advocate for their sisters, friends and even strangers. By the end of that mission aligning activity, there was not a dry eye in the room. Like those women who set out to gain knowledge in order to improve Black women's birth experiences and outcomes, I immersed myself in a local birth work community.

Since 2018, I have informally explored birth work and considering Black women's experiences with maternal healthcare. I have attended multiple doula trainings and monthly meetings, birth worker workshops, and even presented my work at Black Maternal Health Week events. I have met and befriended Black mothers who, learning of my research, spilled their birth stories into my cup of knowledge and introduced me to their friends and family to hear more stories. Early on in the exploratory phase of this research project, I attended to several Latina women as their doula which has provided and alternate view of patient-provider interactions. This important exploratory work laid the groundwork for my empirical investigation of Black women's experiences with maternal healthcare.

I have formally interviewed 56 Black women and 31 of them I have interviewed more than once about their expectations and experiences of maternity care. Of the 56 women I interviewed, I classify 30 of them as middle-class and the remaining 26 as working-class. I have also interviewed 22 medical practitioners including physicians, nurses and doulas.

Foxhill Medical Center

Moreover, exposure to the birth world shaped both my research questions and access to the field site. My proximity to the birth world bestowed connections with like-minded health professionals, including a hospital administrator with whom I coordinated access to the field site I call Foxhill Medical Center where I observed for 15 months.

Foxhill's Labor and Delivery ward is a locked unit in the hospital and requires either a staff badge or permission to enter. The doors to the unit swing open to reveal a long hallway. A glass sliding wall separates off a designated triage space with four small private rooms often used for people who need to be evaluated before given a regular birth suite or for those who are scheduled for a cesarean. There are eight large birthing suites that form a y shape on the unit. Each private birthing suite has a private bathroom with a shower, a closet with various birthing balls, a couch for a support person and a centrally located birthing bed. The unit also boasts two operating rooms, a resident physician workroom, and breakroom.

I spent much of my time at Foxhill oscillating between the nurses' desk where I had an excellent view of the happenings on the unit, the workroom, triage, patient rooms, and occasionally the operating room. Spending 15 months roaming the halls of the unit provided much needed context for the ways that patients and providers conceptualize birth and their roles in it. Furthermore, I saw those conceptualizations enacted with each other and with their peers.

Overview of the Dissertation

In chapter one, I argue that the preparations for birth by Black women in my study can be best understood by examining them through a lens of racial safety. I trace the emergence of a racial safety frame through the national and local histories of medical racisms and individual healthcare experiences. Building on current conceptions of racial safety, I then explore several common ways Black women prepared for childbirth. This chapter raises the question: if what patients want is racial safety, then what are providers after?

In chapter two, I explore the meaning-making of providers as they conceive of themselves as altruistic providers providing heroic efficiency. Through this lens they justify the embrace of American scientific medicine and care for patients. I argue that they use various strategies to retain physician authority. In a place where they face contestations for authority, I examine how they retain it and argue that they do so through performing competence, insisting on the childbirth monopoly, claiming objectivity, and pressuring patients. The question arises, how does their search to retain authority shape their care of patients?

In chapter three, I consider how both patients and providers are invested in the outcomes of the clinical encounter—the patients for racial safety and the physicians for retaining their authority. With both parties being invested, how then are they going awry? I explore how different dimensions of patient-provider interactions suggest ways that we can understand their interactions, but ultimately what matters are the emotional misrecognitions that result. This chapter ends by asking how the emotional misrecognitions are experienced and navigated differently by class?

In chapter four, I assess how the interactions of patient and providers in the white institutional space of healthcare creates its own sort of emotional healthcare scripts to be enacted that have an emotional toll on Black women patients, scripts I call *affective burdens*. I explore how social class shapes the way Black women patients navigate the patient-provider interaction. This chapter ends by asking how providers of positive healthcare experiences are able to provide them, and at what cost?

In Chapter 5, I examine several positive patient-provider relationships and the impetus for their success. I argue that when providers veer away from hospital policies on time efficiency, their patient-provider interactions improve. They understand their actions through a lens of *connected heroism* that increases their career satisfaction. However, this type of care comes at great personal cost to providers.

In the conclusion, I extend my findings to their implications for Black maternal health disparities and for sociological literatures. It examines the impact of racism on emotions and meaning-making in interactions. It illuminates the emotional dimension of inequality within institutions like healthcare. I add an ethnographic lens on interactions that is unique and allows for a clearer depiction of the conceptualizations of care that drive patient and provider approaches and experiences and demonstrates how interactions go awry. I also demonstrate the continued significance of class as middle-class women's approaches to care do not exempt them from poor experiences.

Conclusion

This dissertation builds on racialized emotions and patient-provider interactions literature by demonstrating how the emotional posture of patients and their physicians shape the experience and outcomes of healthcare interactions. Furthermore, I bring an ethnographic lens to the study of inequality as I have been able to explore how the different conceptualizations of care held by patients and providers interact under efficiency and consumer logics, shaping the experience of care by class and across race.

The findings of this dissertation point to several implications for the provision of healthcare. Neglecting the emotional terrain of patient-provider interactions, or more specifically ignoring the racial safety needs of Black women patients contributes to preexisting medical mistrust. Black women patients are penalized in healthcare settings, when their advocacy appears oppositional to the dominant white cultural logics. Furthermore, the medical mistrust that poor patient-provider interactions perpetuate works to further decrease physicians' authority.

Lastly, I suggest ways that healthcare provision can be improved systematically. The providers in this study whose patients report the best outcomes were partly able to facilitate outcomes through relationships. This underscores the importance of open communication with patients, continuity of care, person-centered approaches to care and genuine empathy for those under your care. It also suggests that providers can be emotionally fulfilled career-wise through this approach, as they accomplish a *connected heroism.*

I argue that in order to address the growing Black maternal health disparities, we must first consider how healthcare inequalities happen and are perpetuated at the emotional level and through interactions. Addressing these emotional inequalities could improve maternal health outcomes through improved patient-provider relationships.

Chapter One

LEAKY BASEMENTS AND RACIAL SAFETY: BLACK WOMEN'S APPROACHES TO HEALTHCARE

Arriving on Foxhill's labor and delivery unit one morning in a recent spring, I ran into a doula acquaintance who offered to introduce me to her client—a woman whom she said needed extra emotional support. After I met Ariana, and told her about my research, she agreed to be followed, saying "The more people on my team the better." A light-skinned woman with sandy brown hair braided into a bun, she reclined in the hospital bed as her doula and I stood just inside of the entryway. Early contractions had compelled Ariana and her partner to arrive on the unit shortly after midnight. Since that time, she had dilated about six centimeters, according to providers during her last cervical check. This left only four centimeters to go before she could push, deliver and meet her new baby.

Despite this encouraging progress, the tenor of the birthing suite for that birth was set by the stillbirth of her son the previous year, an unfortunate outcome that she blamed on physician malpractice. During that pregnancy, she recalled beginning to bleed "pretty heavily" at 20 weeks' gestation. Her partner drove her to their nearest hospital, located in an adjacent town, to be evaluated by physicians. She recounted her experience with the obstetric providers there in our interview.

> I don't think that they took my bleeding concern very seriously. I was having contractions… Um, but they were like still pretty irregular at that point…Um, but the doctor came in there and said, 'you're most likely bleeding… he said you're bleeding and the

> contractions can be induced by sex. This is almost *undoubtedly* due to sexual intercourse.’

Pausing to collect herself between sentences, Ariana described providers as negligent and dismissive of her vaginal bleeding five months into her pregnancy. She emphasized that the doctor used the word undoubtedly, underscoring the effect that word had on her memory of her son’s birth. Its usage also signaled that the controlling image of Jezebel may have influenced the provider’s decision not to examine her; the sexual cause of the bleeding seemed clear to them. Despite Ariana’s and her boyfriend’s insistence that it had been almost 48 hours since they had sexual intercourse and that the heavy bleeding was relatively new, the physician dismissed their concern.

What haunted Ariana is that the physician never performed a pelvic exam. Instead of performing an examination, his diagnosis was based on her self-reported sexual activity and the provider’s judgment. She recalled, “The doctor didn't even check me before he told me that it's most likely due to sex and that I was having Braxton Hicks because of sex and just cut it out for sex for a little bit, and then I'll be fine.” Ariana would actually not be fine. Following the doctor’s orders, she returned home only for her water to break that same night.

Returning to the hospital, the same physician finally listened to her concerns, but it was too late. At 20 weeks’ gestation—four weeks before fetuses are considered viable or developed enough to live outside of the mother’s uterus—Ariana went into labor and gave birth to a stillborn son. “After they finally took me seriously”, she woefully remembered, “all they could say was ‘I’m sorry’.” No apology, however, could relieve the pain Ariana felt from the preventable loss of her son.

The tragic loss at the hands of negligent obstetric health providers culminated in birth trauma that Ariana carried with her through the current pregnancy. Her biggest fear going into labor was of something happening to this baby and, once again, experiencing a heartbreaking stillbirth. To lessen the chance of a poor infant outcome, Ariana enlisted the help of a local Black doula collective. This community-based organization provided doula services on a sliding scale to women of color by women of color in the area. As Ariana received Medicaid, the doula services were free of charge. Planning and preparing for a safe and healthy birth alongside a Black doula alleviated some of Ariana's fears because she and her boyfriend believed racism played a role in their son's demise. For Ariana, having a Black doula as a member of the birthing team with medical knowledge and the ability to intervene if something went awry procured some assurance that racism would not shape the healthcare interaction. Ariana sought what we might call "racial safety."

Like Ariana, many other women I interviewed expressed the same fear, that they or their children would die because of provider negligence. In this chapter, I explore how Black mothers understand and interpret their reproductive healthcare, how the national and local histories of medical racism, patients' previous medical experiences, and current cultural perceptions of Black maternal health converge to shape Black women's approach to maternal health care, and, in turn, how they manage the patient-provider interactions that give meaning to their experience of childbirth.

LONG SHADOW OF RACISM

In the United States, Black life has been devalued and Black bodies have been treated like objects since the time of chattel enslavement. During enslavement, Black bodies were only valued for the work they could do for enslavers and for the U.S. economy. The only interest in

Black life lay in the procreation of the next generation of Black enslaved laborers, especially after the Act of 1808 abolished the importation of enslaved Africans (Franklin 2008). The enslaved were encouraged and often forced to procreate by violence, threat, and intimidation. There was no reproductive autonomy, only reproduction decided by and governed by oppressors. The submission of Black bodies also advanced science, as Marion Sims – a man often deemed the "Father of Gynecology" – perfected his surgical skills on enslaved women under his charge (Wailoo 2018). Black bodies were treated as objects and not embodied people.

After slavery was abolished in 1865, the devaluation of Black life continued into the Jim Crow Era, as the rise of eugenics and population control demonstrated. During this time, women of color, especially Black women, and poor women were discouraged from giving birth to "feeble-minded" individuals (Roberts 1997; Smaw 2021). In 1927, Carrie Buck, a 17-year-old unwed poor white mother, was the first person in Virginia to be sterilized due to being deemed unfit to procreate (Lombardo 2003). The Buck v. Bell Supreme Court case decision upheld the 1924 Virginia Eugenic Sterilization law and paved the way for her sterilization as well as that of more than 8,000 others in Virginia, as it gave states the right to sterilize individuals whose offspring were destined to become "degenerates" (Lombardo 2003). Throughout the South, eugenic sterilization laws went into effect and thousands of unsuspecting Black and brown women were sterilized without their knowledge or consent, including famed Civil Rights Activist, Fannie Lou Hammer. Hammer testified before Congress that during surgery to remove a uterine tumor, doctors in a Mississippi hospital sterilized her without her consent (Early 2021; Smaw 2021). This procedure was frequently done on unsuspecting Black women and was dubbed a "Mississippi appendectomy" for its ubiquity (Bair 2020; Early 2021). Reproductive decision-making was again stripped from Black women.

During the mid-20th century, it was relatively common for health providers to treat Black and indigent people as research objects, as payment for their health care services (Jones 1993; Evans and Beck 2002; Washington 2006). Recall that Black people were often used in research without their knowledge. In one notorious example, Black men who sought care for a syphilis infection went untreated for close to 40 years as public health researchers observed what rampant syphilis did to their bodies and to their wives and families (Jones 1993). Similarly, in the 1950s, doctors at John Hopkins Hospital treated Henrietta Lacks, a working-class Black woman, for advanced cervical cancer. As it was their practice, they biopsied cervical cells from Lacks for usage in their own research, as they sought cells that would regenerate themselves. The cells that were harvested from her without her knowledge and consent were so successful at replication that they were marketed and sold to scientists as a cell line for experiments: HeLa cells, named after Lacks (Skloot 2010). Lacks' disembodied cells would go on to profit pharmaceutical companies for decades. Yet during this time, her family would not know about her cells nor see any financial benefit from their sale (Davies 2021).

Although federal legislation, including the Civil Rights Act of 1964, has been passed to mandate equitable care regardless of race in hospital institutions receiving federal funds, racial disparities in health and the provision of health care remain (IOM 2003). Hospital wards are no longer race-segregated, but racism permeates hospital policies and norms in other ways (Matthew 2018; Washington 2006). Recently, research on the unspoken attitudes of resident physicians has found that often white doctors implicitly believe that Black people feel less pain than white people (Hoffman et al 2016). This assumption is tied to stereotypes that caricature Black people as closer to animals than humans in intelligence and brute strength (Knight 2020). Studies finding implicit bias suggest such attitudes are behind racial disparities in diagnosis and treatment, which then leads to differential outcomes (Hoffman et al 2016; Soluja and Bryant 2021).

In recent years, the maternal health disparity between Black and white women has continued to widen (Njoku 2023; Wang et al 2023). According to the Centers for Disease Control, Black women are more than three times more likely to die from pregnancy complications than white women regardless of socioeconomic status (2023). Of the 1,010 pregnancy-related deaths that occurred within a year of delivery in 2017-2019, about 80% of them were preventable (Trost et al 2022)[4].

The legacies of U.S. racism demonstrate an enduring dehumanization of those racialized as Black. In the contemporary moment, although Jim Crow racism is no longer apparent, new racisms shape the provision of healthcare and health outcomes as racial disparities across socio-economic status persist (Kliff, Miller and Buchanan 2023). The continuing significance of race in reproductive medical treatment nationally is echoed in the local reproductive politics in the city of Foxhill.

FOXHILL'S LEAKY BASEMENT

When I first started interviewing Black women in the city and surrounding areas of Foxhill, I found lurking in their perception of the organization an image of Foxhill Medical Center from a previous era. The personal experiences of family members shaped participants'

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[4] This data is compiled from maternal mortality review committees representing 36 states as reported to the Centers for Disease Control. They determine whether a pregnancy-related death was preventable if there was "at least some chance of the death being averted by one or more reasonable changes to patient, community, provider, facility or system factors" (2022:5). The review committees submit cause of death—cardiomyopathy, hemorrhage, mental health conditions etc.—and do not distinguish between preexisting conditions and those that arose or were exacerbated due to pregnancy or healthcare delivery. They do not specify what percentage of maternal deaths were caused by provider (in)action. To my knowledge, there are no studies or reports that outline what percentage of maternal deaths are caused by provider negligence or inaction and therefore are preventable.

meaning-making and the experience of healthcare at Foxhill (Stacks 2019). The racial history of the city, Foxhill Medical Center, and the personal experiences of their friends and family members molded their opinion of the hospital and their approach to care.

Characteristic of many hospitals in the U.S. South, the legacies of Foxhill Medical Center and its affiliated medical school were forged in a history of eugenics that is both recent and pervasive. Its wide influence can be seen in several academic buildings and hospital wings that are named after eugenicists. Originally built as a school to rival prestigious medical schools in the U.S. North, Foxhill's medical institutions have been ambitious from the start. Yet, their medical ambitions often played out on the bodies of poor Black people in the city and surrounding areas.

Historical accounts of the early days of the hospital suggest that ailing people, "bond or free," could pay 50 cents to be treated by a physician at the end of class while medical students watched to learn (Matthews 1960:10). Black people were considered the best bodies upon which to practice. Medical students also coerced pregnant women in the Foxhill's Black neighborhoods into allowing the students to oversee the women's labor and delivery, either in the hospital or at their homes (Matthews 1960).

At the turn of the 20th century, cadavers for medical research were not in constant supply, leaving Foxhill medical students short on hands-on experiences with surgery and other major operations. It was an understood tradition for medical students to procure their own cadavers for training, often going on "anatomical expeditions" to dig up recently buried Black bodies on whom they could practice (Gates 2017; Matthews 1960; President's Commission on Slavery and the University 2018). The custom of grave-robbing was so ubiquitous, historical accounts note that Black families at times buried logs or other objects and held public funerals over these diversion graves. They opted instead to bury their loved ones in secret to lessen the chance they would be dug up and used by Foxhill students for research (President's Commission on Slavery and the University 2018).

Up until the mid-1960s, Foxhill maintained a separate segregated ward for the care of its colored patients. Unlike the rest of the hospital, which was gender segregated, the racially segregated colored ward was gender-integrated, sending a clear signal that race was deemed more consequential than gender. The salience of race was ever-present for Black patients, who found themselves in crowded hallways and hospital rooms located in the basement of the hospital (See figure 1-1). Not only were they in the basement, but they were also often cared for under steam pipes that heated the rest of the hospital (See figure 1-2). At times, those pipes would leak or drip, creating dampening conditions and a welter of emotions the community did not forget.

In the present day, the Foxhill medical center towers over and creeps into adjacent historically Black neighborhoods. The proximity to Foxhill continues to drive up housing prices and creates a housing crisis, gentrifying the nearby neighborhoods and pushing the historically Black neighbors out of their homes. Foxhill and the land on which it sits are known by Black residents as a place you go to work, or get care, but not a place you are welcome to visit leisurely. The shade of the magnolia trees on its property was not intended for the respite or enjoyment of Black people. Neither was the hospital, as evidenced by the segregated ward in the crowded leaky basement.

"It's Where We've Always Gone"

Given this local history of Foxhill Medical Center as a hospital intertwined with medical racism, it became clearer to me why women expressed a strained and contentious relationship between Foxhill Medical Center and Black Foxhill City residents. Within the hearts and minds of local Black people, Foxhill has historically been an institution steeped in medical racism that has disregarded Black humanity and instead only treated the Black body. Why, then, did the local Black community go there to receive medical care?

Foxhill is currently a well-regarded medical research institution. A "trauma one" public hospital, it is one of the few hospitals in the state that can handle complex care. In addition, many local Black people told me, "It's where we've always gone." For example, Jerrica, a working-class mother, drove over 40 minutes to Foxhill for a scheduled caesarian section, telling me how although another hospital is technically closer to her home, Foxhill houses all of her family's medical records, and that she, herself, was born there. The hospital is where she and her family have always gone, she said.

Nonetheless, previous experiences at Foxhill shaped how women viewed the hospital. One recurring theme in the interview data was that women felt like "just a number" at Foxhill, regardless of the ailment that caused them to cross the threshold into the hospital. The hospital had to provide them care, but apparently did not have to make sure they felt comfortable in doing so. Although many of them recalled some hospital visits where they did not encounter any problems, undergirding their experiences with Foxhill was a common perception that Foxhill had racist tendencies. This impression came through most vividly in participant accounts of their own previous care experiences at Foxhill. In participants' judgment of the care the hospital provided, the history of leaky basements cast a shadow on their accounts of uncaring providers who were uninterested in them as people, and often suspicious of them.

Lisa, a 39-year-old case manager, told me about her experiences at Foxhill Medical Center's Teen Clinic when she was an adolescent. During that time, many Black teenagers went to the Teen clinic because they did not need parental consent to be seen. As Lisa was sexually active at 16, she went to the clinic for birth control and received Norplant, a six-rod fan-shaped birth control implanted under the skin. Lisa recalled being happy with the clinic at first. She was able to assert reproductive autonomy over her body in deciding to get birth control. Yet, her perspective quickly changed after her second-year checkup for the Norplant implantation. She said, “The second year when I went back to get my rods checked, they were frantic. And I was like, ‘What’s going on? Why are you so frantic? Why are you so frantic about what is happening with me?’ My nurse said to me, ‘Well we’re going to have to remove this because we found out that it’s growing into the muscle of people’s arm’.” Lisa expressed fear that she would have to undergo surgery to have the rods removed if the nurse could not pull them out in the clinic. But she was also afraid that she would have to tell her mother, who did not know she had birth control in the first place. She continued, “I think I was disappointed, because I’m like how come you didn’t do research on this before you started injecting this into people?” In our interview, Lisa expressed chagrin as she felt they were experimenting on her with an untested birth control method without parental consent.

Subsequently, Lisa blamed Foxhill and her early Norplant experience for her later infertility.

> “My husband and I, when we had been married for seven years, it had been ten years since I had it taken out, and we didn’t use any birth control. I still did not get pregnant the whole time. So I don’t know if the medicine was still in my body, the reason why I could not, but nobody explained it to me. They just said ‘This is the best birth control. It lasts five years. You don’t have to worry about anything.’”

But Lisa did worry when unprotected sex did not result in a pregnancy for more than seven years until she finally became pregnant. The ordeal caused her and her husband a lot of stress as they planned to build a family, and the backdrop of historical racism at Foxhill and in medical science generally made her apprehensive about the impact of her Norplant experience.

Dorothy Roberts, the Black feminist legal scholar, documented how the state worked to distribute Norplant in poor Black communities in an effort to reduce Black poverty, including making it readily available to youth (1997). Lisa's experience in the 1990s in Foxhill City showed how the national reproductive politics played out locally; such examples continue to make local Black citizens suspicious of Foxhill Medical Center.

Other Black women reported experiences where their providers dismissed their concerns. Terri, a 32-year-old daycare worker, told me of the time she went to see a reproductive endocrinologist to "get her system together" so that she could have children. Although she was having unprotected sex, she was not finding herself pregnant. She describes a condescending provider who asked her if she knew how much fertility treatments cost. Having brought a newborn she was babysitting to the appointment, she recalled the endocrinologist asking, "Oh, I see you have a baby already, so what are you doing here?" For Terri, his flippant question invoked a line of thinking that Black working-class fertility was tied to a drain on the dole. He left the room before examining her and she felt like "he shitted" on her. In turn, Terri did not return to that clinic. Furthermore, the encounter may have had some lasting effects with implications for Terri's health; since that appointment, she reported, she has had a hard time connecting with physicians and following up with treatment for high blood pressure, especially when she feels that they do not care about her.

Some participants described how care at Foxhill, a teaching hospital, seemingly always includes an uninvited medical student, even in the most intimate moments. Tonya, a public health nurse, told me about her struggles with infertility at 40 years old. She had achieved her career goals, was married, and ready to try for a baby, because as she told me, “Janet Jackson did it.” Yet, she was not prepared for the dismissive treatment of infertility providers.

During a visit to a fertility clinic, Tonya was diagnosed with fibroids. As a nurse she felt familiar with the inner workings of medicine and, as she put it, how most conditions have treatments. A doctor came in to perform a transvaginal ultrasound to decipher if the placement of a fibroid would impede a pregnancy, and she was followed by a medical student.

During the very intimate exam, Tonya was upset about the prospect of being infertile and physically uncomfortable while the physician maneuvered a device placed in her vaginal cavity as the medical student observed. Tonya recalled wanting to engage with providers emotionally as it was a hard experience for her. She remembered engaging the medical student:

> I remember saying something like, "Do you want to know what I'm thinking right now? Are you taking notes?" She was like, "No, I'm just here as an observer." I'm like, "When you practice, I need you to know what I'm thinking, not what she's thinking. Not what your attending is thinking." They [physician and student] both were like, “whoa.”

While Tonya was interested in discussing how she was feeling and the potential diagnosis, the medical student’s response indicated they were not there for emotional support but instead to learn to from her examination. Tonya was hurt by her response and made clear how she felt about the medical student wanting to be present without being emotionally involved in the care.

At the time, she told the student, “Because I didn't ask for you to sit in this appointment with me. I wasn't consulted before the student was here, so if you're going to be here I need to tell you how this is going to happen.” Tonya later retorted that you have to be firm at Foxhill because they will always send in a medical student without your permission, there to learn from Black bodies but not engage the person in the body.

Tonya thanked them when the exam was over and recalled silently crying to herself as she waited for the elevator. The medical student walked past, saw her crying, turned on her heels, and went down the stairs on the other side. Tonya took that as another sign that the student did not want to engage her as a fellow human being, feeling that would have been the perfect time to show some empathy.

The community perception that medical providers did not care about Black patients did not apply to Foxhill alone. In Foxhill City, there is also a private hospital that at the time of data collection did not employ any obstetric providers who accepted Medicaid payments. This hospital was a favorite of many middle-class women with whom I spoke as they often juxtaposed the “attentive” care at Oakwood Community Hospital with “dismissive” care at Foxhill Medical Center. For those women who chose care at Oakwood Community Hospital, however, I saw how providers used “concerns about weight” to dismiss or discipline them (Strings 2020).

Several of my participants whose prenatal care was at Oakwood described providers who seemed hostile to their weight. For women whose weight fluctuated in the low 200s, doctors routinely told them if they were to gain any more weight, they would no longer be able to see them as clients. Instead, they would have to move to Foxhill for treatment. For respondents, the prospect sounded like a threat and underscored the sense that providers didn’t see them as people but merely as obese bodies for which they could decide not to provide care.

For Marian, a 35-year-old counselor, having her weight constantly discussed made her interpret their statements to be due to race and not risk. A few years earlier, she had had an uneventful caesarian for the birth of her son. During the current pregnancy, her providers stressed that if she gained any more weight, they would be unable to perform her second scheduled caesarian at Oakwood. Gaining the weight, Marian had to advocate to continue her care there. Although the rest of her patient profile was risk-free, it seemed to Marian as though Oakwood used weight as an excuse to transfer her care to Foxhill and keep their private practice exclusive, and as it happens, white.

In response, Marian elected to approach the Diversity, Equity and Inclusion officer at Oakwood with her concerns and to petition to have her planned second caesarian there, reasoning that her pregnancy was a healthy one, and they had recommended her to have a second caesarian anyway. If she assumed the risk herself, like any other mom regardless of weight, she should be able to birth there. They agreed to allow Marian to have her scheduled second caesarian there. While she waited for her surgery date, however, Marian had second thoughts—what if it was the wrong decision and she was instead placing her baby in danger? The continual dilemma of defending against pervasive racism meant that they had to weigh each incident in which the prospect of racial bias was pitted against possible medical expertise. Deciphering if the hospitals were inflicting racial discrimination or not was an ongoing exhausting battle that possibly extracted its own weathering costs (Geronimus et al 2006).

Setting Low Expectations

In addition to Black women's personal experiences with poor healthcare, as well as the national context in which the care took place, the local politics of birth shaped their expectations of birth. Several of the women I interviewed in Foxhill City became aware of stark maternal health disparities through the local Black doula collective. The community-based doula organization offered programming and social media campaigns aligned with a national conversation about Black maternal health outcomes that shaped their experiences.

The national Black Mamas Matter campaign brought awareness to striking Black maternal health disparities. Furthermore, since 2018, the White House has declared the second week of April to be Black Maternal Health Week. At the community level, several organizations hosted local events such as community baby showers, panel conversations, and viewings of the documentary *Aftershock* which explores the familial impact of the deaths of two Black women from childbirth complications. In 2023, there were two broadly advertised showings of *Aftershock* in Foxhill City during Black Maternal Health Week. These events were amplified by a social media campaign full of alarming statistics and graphs as the local doula collectives advertised their services.

While the broad awareness conversation that these local organizations engaged in was needed and important, I found they also had unintended consequences for Black birthing mothers. Mothers who were previously unaware or unafraid even of hospital interventions found themselves afraid of dying in childbirth. Mallory, a 38-year-old boutique owner, described how she limited her social media intake, as reading about Black maternal health disparities on her timeline increased her anxiety leading up to the birth. When I asked her how she prepared for childbirth, she told me “All I can do is pray.” While respondents were aware of the risk of racism, many of them hoped they would experience compassionate, non-racist providers. The continued media campaigns dampened that hope.

Given the history of leaky basements at Foxhill and the national, local, and personal histories of racism to which they attested, Black women embarked on a quest for maternal health care that prioritized racial safety.

RACIAL SAFETY

Sociologists of family have used the term “racial safety” to denote a set of factors that shape how Black parents teach their children to navigate white spaces. This scholarship marks the additional sometimes-invisible work mothers of color and especially Black mothers do to lessen the chances their children will experience racism (Barnes 2015; Dow 2019; Turner 2020; Uttal 1996). The term racial safety has mostly been used by scholars describing the decision-making of parents of color when it comes to choosing childcare or schools for their children. For these parents, it was vital that they ensure that the culture and policies of an institution that will care for their children eight hours a day was not racist. Uttal (1996) found that women of color were more likely to depend on kin networks for childcare, for example, as that alleviated the racial safety concern. As Uttal (1996) described: “The concern of mothers of color for racial safety addresses their awareness that their children can be targets of racism by a society that has historically devalued their racial ethnic group (55).”

Other scholars document how Black mothers consider their children’s racial safety in the public sphere, hoping specifically to shield them from state-sanctioned violence (Dow 2019; Turner 2020; Malone Gonzalez 2022). In this vein, Black mothers assess how gendered racism affects Black sons and daughters differently, with one gender more susceptible to police violence and the other to sexual violence. Although class privilege, like school choice, may protect Black middle-class children in some areas, it is not enough to shield them entirely from racism and racial profiling. Thus, mothers are compelled to instill in their children a set of rules and norms for behavior in white spaces to avoid becoming victims of state-sanctioned violence, otherwise known as “the talk” (Dow 2019; Malone Gonzalez 2022).

Undergirding the concerns of both groups – those focusing on childcare and those focusing on violence – is the ubiquity of white institutional spaces that their children will have to traverse for access to resources (Anderson 2022; Bonilla-Silva 2017; Ray 2019). In particular, white spaces maintain their whiteness through a culture that centers the white experience and is exclusionary to other racialized experiences (Brunsma et al 2020). Building on this literature, I consider how pregnant Black women approach maternal healthcare including labor and delivery through a racial safety frame. Their preparations for the impending childbirth can be best understood as strategies to prevent or lessen the effects of obstetric racism. These actions are characteristic of a racial safety approach to healthcare.

Healthcare as an institution is culturally a white space; for example, more than 56% of active physicians identified as white in 2018 (AAMC 2023). At Foxhill Medical Center during the time of my research, five of thirty clinicians were racialized as Black while most clinicians and labor nurses were racialized[5] as white. Foxhill Medical Center is a white space as characterized by its past, cultural reputation and current white-majority workforce.

I argue that given the history of racism in the United States generally, as well as in the local region and at Foxhill in particular, coupled with the personal experiences with racism of mothers and their low expectations going into a known white space – these factors all combine to elicit a racial safety approach in their quest for care. And we can further see how this approach permeates their preparations for childbirth by looking at how they prepare.

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[5] Here I highlight how others may assign a racial identity to particular medical providers and staff based on phenotype. I do this because the presumed race of a person shapes how others interact with them. For the staff at FHMC, there were two members who could be racialized one way but identify differently.

Like most moms, the women in my study are mostly excited about meeting their new baby. The pregnant women wonder whom their babies will look like and about their personalities. Many are already reading pregnancy and parenting books. Yet, for these women, undergirding their preparations for a new baby are persistent fears of racism. Their biggest fear echoes the media messages that Black women are not listened to, that their pain goes unaddressed, and that they die at the hand of white providers due to negligence. Overwhelmingly, the women in my study expressed fears of dying. In the face of these fears, when asked how they are preparing for childbirth, women discussed 1) finding the right providers, 2) closely monitoring their health at home 3) preparing to advocate for themselves by seeking more information, and 4) naming an advocate in the event they become incapacitated.

Finding a Provider

As hospital births are near-compulsory, pursuing options for the racial safety of both mother and baby are essential tasks. First among these is choosing a provider, and for many, they look first for a provider of color. Black maternal health pundits and mothers alike often consider choosing a racially concordant or same-race obstetric provider to be one strategy to alleviate racial safety concerns. Psychologists use the concept of “linked fate” to describe the sentiment that people of the same racial group have the same or similar life chances (Simien 2005). If providers have the same life chances as their patients, this similarity should reduce racial bias. Yet, as other scholars have found, sharing racial characteristics with your provider does not always eliminate such bias (Greenwood et al 2020).

Furthermore, common features of the maternal healthcare landscape make ensuring a same-race provider difficult. First of all, like many locales, Foxhill City had a dearth of obstetricians and midwives of color. Second, the maternal health providers in Foxhill City all belong to teams. This team-based approach is excellent for physician work-life balance as they know ahead of time when they will be on call in the hospital attending births for the practice. Yet this approach also means that they will not necessarily be the one to deliver their patient's baby. In the team-based model of care, expectant mothers are encouraged to meet each provider through their monthly prenatal visits so that they are somewhat familiar with the attending physician who ends up being there during their birth.

Yet for many, the Foxhill institution felt like the only option. Many of the working-class women discussed going to Foxhill for care because they were familiar with it. Jayla chose Foxhill, for example, because her sister had gone there when she was pregnant, and as teens, she and her sister both went to the Foxhill teen clinic. And for most working-class patients, choosing Foxhill was the obvious choice, echoing Jerrica above, "It is where [they] have always gone." Some had little choice in the matter: for patients who lived upwards of 40 minutes from Foxhill, the hospital nearest to them no longer had labor and delivery units, only clinics where they could receive prenatal care. For them, the trek into Foxhill City to give birth was really the only option they had.

For middle-class Black women, however, choosing a practice was a little different. Generally, I found that middle-class women who were transplants to the area often preferred Foxhill as the premier medical research hospital for their care. Simone, a 34-year-old pregnant first-time mother, called the Foxhill Medical Center main line to schedule her first prenatal appointment. The operator, learning that Simone's husband was a professor at a nearby university, suggested she seek care at their satellite office, Riverbend. Care at Riverbend guarantees that a Riverbend physician will attend your birth at Foxhill. Locally understood as where the Foxhill-affiliated staff and families go for care, Riverbend was not accessible by public transportation and carried with it a certain prestigious affiliation on Foxhill's Labor and Delivery Unit as opposed to the other Foxhill-affiliated prenatal clinic, located on a public transportation route.

Middle-class women from the area, however, often opted to try Oakwood Community Hospital, the nearby private hospital. The fact that none of its obstetric providers accepted Medicaid increased the number of patients birthing at Foxhill and contributed to a bustling labor and delivery unit there. Oakwood also had a prestigious reputation amongst middle-class women; as one white stay-at-home mom told me, she chose to give birth at Oakwood because of its smaller size. Her risk for complication was also low, she said, and if she did need to be transferred to Foxhill, an ambulance leaving Oakwood could arrive at Foxhill within seven minutes.

For the middle-class Black women in my study, part of the allure of this hospital may have been in the fact that it didn't have the same racial history as Foxhill. It was overall a younger hospital facility, and its small size seemed to promise personal care. The prospect of seeing a provider with whom they might build a relationship and who might treat them as people and not objects was a lure. Yet although they chose Oakwood, Oakwood did not always choose them.

Like Marian, the 35-year-old mother of two who felt racially discriminated against at Oakwood because of her weight, several other women I spoke with that wanted to choose Oakwood were turned away. Monique, a 32-year-old addictions counselor, was pregnant with her first child. Oakwood Community Hospital was a five-minute drive from her home. The proximity to the hospital where she would give birth was appealing to Monique as at the time, she did not have a car. However, her sickle-cell diagnosis made her a high-risk pregnancy and Oakwood refused to treat her, referring her to Foxhill for care. The small, private hospital was not available to many of the women I spoke to due to conditions that themselves were racialized in their distribution.

Self-monitoring health

Another way in which Black women demonstrated the importance of "racial safety" in their childbirth preparations was in their monitoring of their own health. As many medical sociologists will tell you, part of what it means to be an engaged patient in the neoliberal 21st century is to undertake self-monitoring (Timmermans 2020; Shim 2010). Many of the women with whom I spoke monitored their own health and this practice seemed to serve a bifurcated purpose for them. On one hand, they were self-monitoring to make sure that they knew what their numbers were, so that they did not die at home of preeclampsia or other common conditions. Health discourse often posits Black bodies as sicker, so these women monitored their own risks for high blood pressure and diabetes. On the other hand, it often seemed as if they did it so that they could be engaged in their healthcare, both so that they would have something they could talk about with their providers, and also so that they could feel like they were taking some action in the face of childbirth risks they faced. When the main concern is provider negligence, monitoring your health at home yourself becomes more important.

Both working-class and middle-class women engaged in self-monitoring of health conditions. Brandi, a 33-year-old nurse and first-time mother, explained how monitoring her health at home worked to tamp down her racial safety concerns.

> I've been trying not to be nervous because I had an associate pass away after a complication of childbirth—and she was a doctor. So

> not trying to let that, of course, make me fearful, but I did express my concerns to my doctor. My friend had preeclampsia and she had, like, really, real problems… so I've been, I feel better because I've been, like… we check my blood pressure weekly and it's been fine. But just like keeping an eye on that and my weight and stuff like that has made me feel better.

Brandi's concerns for her own pregnancy have been shaped by the loss of a friend whom she thought by education and profession should have been able to avoid death due to a pregnancy complication. If her friend could succumb to birth complications despite all of her class privileges, Brandi was cognizant that she was susceptible as well. Quelling those racial safety fears for herself meant weekly blood pressure checks that she did herself while working as a nurse. Monitoring her blood pressure and weight herself helped Brandi feel safe and on track for a healthy birth.

Preparing to advocate

Besides self-monitoring their health at home during the pregnancy, women also prepared to advocate for themselves in the hospital room. Both working- and middle-class women discussed ways they would advocate in the room to be sure they were given the right treatment. Several of the middle-class moms displayed what I call a middle-class "managerial approach" to advocating for themselves in the hospital. For example, Brandi is a nurse by trade, and told me she was prepared to report any nurse or physician misconduct to the charge nurse and request a different provider. "I have no problem having a conversation with them about like their communication or something like that," Brandi said. "So, I feel comfortable having that conversation with the charge nurse or a manager or something if I feel like it's not a good fit."

Camilla, a 42-year-old executive and first-time mom, practiced her advocacy in early prenatal visits. She recalled an early appointment with one of the Foxhill midwives where she opted against taking a recommended medication.

> I think I'm informed and I demand things that I want to do. I'll give you an example…The second time I saw her, she said given that I went through IVF, my age, and something else, she was recommending baby aspirin just as a precaution for preeclampsia. And I was like, hmm. I don't really like drugs. I don't want to take more drugs I'm already taking all of these…I'm taking prenatals. I'm taking vitamin D. I just didn't want to take more. I was asking all these questions. I was like, 'I'll read it and I'll think about it.' That was my response.

Describing herself as informed and demanding, Camilla saw herself as an assertive person who would advocate for herself during pregnancy and during labor and delivery. As a trained scientist, she was comfortable researching drugs and health conditions in order to make an informed decision and would not take the midwife's word for it. After reading up on it and conferring with physician friends, Camilla determined that although she was not a high risk for preeclampsia, she had several medium risk factors and decided to agree to the medicine at the next appointment.

At the end of the first interview, all of the women with whom I spoke expressed a willingness and desire to advocate for themselves in the birthing suite. They planned to ask questions. Working-class women asserted that they would speak up for their needs. Everyone was on board with communication. Unfortunately, as we shall see in Chapter Three, however, their experience did not always cooperate with their plans.

Choosing an Advocate

The priority of racial safety could also be seen in how these women prepared for the hospital visits through choosing an advocate. The majority of women discussed choosing an advocate in case they were incapacitated and unable to advocate for themselves. Several women across class talked about choosing amongst their partners and mothers for who would be with them in the birthing suite. As this study took place during the end of COVID lockdowns, Foxhill and other hospitals were still under COVID preventative protocols, including only allowing two support people in the room and mandatory face masking. If women were having a caesarian section, however, only one person was allowed with them in surgery. As such, many birthing women discussed the need for a support person who could serve as a strong advocate.

Camilla, the executive, put the concern most plainly. “The only person I am concerned with is [my husband]. And this is why I love him: he’s not going to be forceful. He’s going to be very much like ‘Let’s trust the experts’. I don’t think so. That’s why someone else needs to be there.” Opposites attract, and the mellow nature that attracted Camilla to her husband was the very same nature that concerned her during birth. Instead of someone who would blindly ‘trust the experts’, Camilla sought someone who was willing to be a bit more oppositional, and advocate strongly on her behalf if she were incapacitated.

Ashley, a middle-school teacher, planned for her husband to be in the labor room with her. Since the hospital where she gave birth only allowed one support person, she had to choose between the love of her life and her mother. It was a tough decision; however, she chose her husband and gave him explicit instructions on what to do if there was an emergency and she was unable to advocate for herself. She recalled, “If it was an emergency. If something happens, then he needs to call her. She’s a little bit more vocal than he is. I’m the vocal one in our marriage. I can’t be vocal. I’m going to be down. So, I told him, just call my mama.” Balancing the ideal birth support team and advocacy was a tough decision. Giving one instruction to contact the other seemed like the perfect balance for Ashley’s family.

For some women, this extra support came from a hired doula. In Foxhill City, doulas supported women across class, as one local doula organization provided doula support on a sliding fee scale to women of color, with those receiving Medicaid receiving free doula support. As a birth support person, a doula traditionally guides birthing mothers through several comfort measures. At times they use aromatherapy, soft music, dim lights to make the mom comfortable in the room and facilitate a smooth birth. But for Black women, the doulas offer more than gentle care; they also promise racial safety.

Brandi, the 33-year-old nurse, described why she chose to hire a birth doula. “I feel like I am so tired of hearing, like, horror stories of Black women in childbirth and being in the hospital, and so I felt like extra support—because I will only have my mom in the room—so I feel like just extra support and somebody else who can advocate for me is important.” Her on-going racial safety concern led to her mantra of “extra support” in the birthing suite.

Conclusion

Like Ariana, the woman whose story opens this chapter, many other women I interviewed expressed fear, that they or their children would die because of provider negligence. Their fears were stoked by local histories of medical racism, personal experiences, and a national context of seemingly ballooning Black maternal morbidity and mortality. In this chapter, I argue that racial safety is an apt frame for understanding how Black mothers manage patient-provider interactions. Building on the work of sociology of family scholars, I use racial safety as a frame to denote how pregnant Black women's actions approach to healthcare was in service of deflecting obstetric racism (Davis 2019). They prepared for obstetric racism in myriad other ways, such as choosing their health providers, monitoring their own health indicators, deciding how they would advocate for themselves, and selecting an advocate who would make decisions for them if they were incapacitated,

The lens of racial safety provides a clear indication of how the fear of experiencing racism shapes Black women's approach to healthcare. Their not-unfounded expectations of racism corroded their trust in the white institution where they would be giving birth and in the providers they faced there. That corroded trust meant that medical expertise was pitted against presumptions of racism, so that the women felt they had to interpret and decode medical care often despite not having medical education themselves, questioning physician prescriptions and advice in their struggle for racial safety. Ironically, racial safety seemed to require a vigilance before and beyond even what might be expected for the "engaged patient" that the medical establishment promoted.

This chapter explored how Black women consider their relationship to healthcare and prepare for childbirth. Yet on the other side of the exam table were the obstetric providers, who experienced very different demands and struggles as they prepared for work on the labor and delivery unit. The next chapter considers their story.

Figure 1-1 Crowded corridor on segregated patient ward

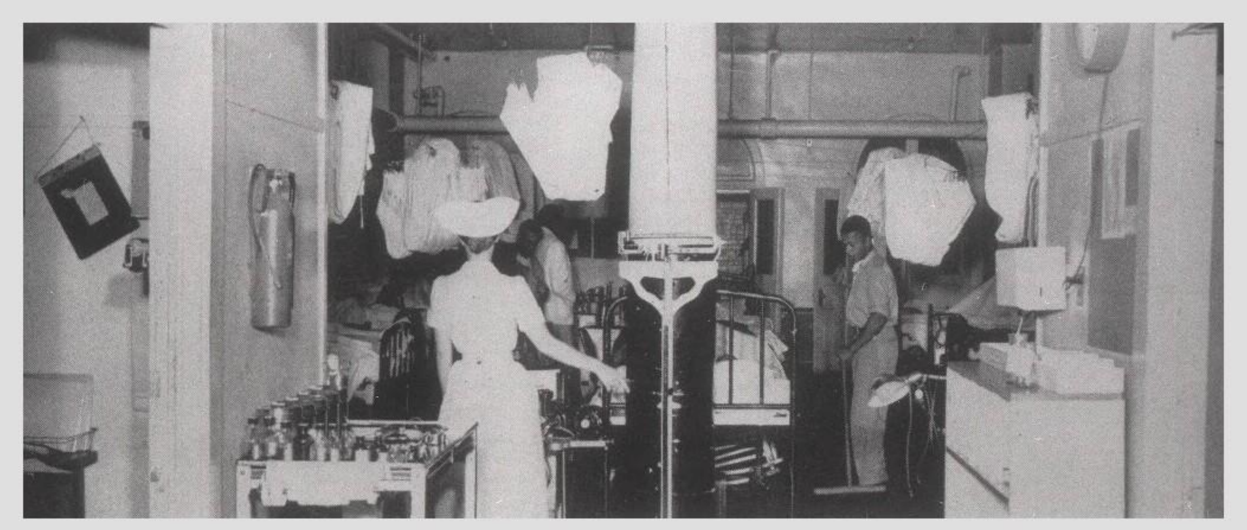

Figure 1-2 Patient bed on segregated ward under a steam pipe

Chapter Two
AUTHORITY UNDER FIRE:
MEDICAL PROVIDERS AND HEROIC EFFICIENCY

One morning, I overheard Dr. Shaw, an Indian woman with darker skin and a confident, even bubbly attitude, encouraging residents to consider specializing in maternal-fetal medicine. She was sitting on one of the loveseats enjoying her breakfast procured from the hospital cafeteria. Behind her, a whiteboard listed the rooms of patients who required circumcisions or birth control counseling before discharge. At the bottom of this whiteboard were several memes disparaging home birth; one proclaimed, “Home deliveries are for pizza.”

Between bites, Dr. Shaw celebrated the practice of maternal-fetal medicine as innovative science when faced with high-risk births. She recounted how the maternal-fetal medicine team collaborated on a high-risk birth of twins where one was born early via cesarean, while the other remained in utero for a few more weeks in a particularly tricky procedure. Describing the melding of creativity and science to treat complex conditions and save lives, she said: “It’s like cowboy medicine.”

Like Dr. Shaw, other medical providers considered birth as inherently risky with consistently complex and unique cases. Using “cowboy” metaphors cast maternal-fetal medicine as on the cutting edge of scientific discovery, like the cowboys who explored new frontiers in the West. The phrase also conveyed that physicians did heroic work— they made hard decisions with the welfare of birthing women and unborn children squarely in their sights. In the birth room, these decisions were best left up to the professionals informed by objective and innovative science.

Dr. Shaw was an expert on high-risk pregnancies and deliveries at Fox Hill Medical Center. As a maternal-fetal medicine fellow, her subspecialty involved education and training that gave her birth expertise exceeding that of more senior obstetricians. She was the one to call for consults on high-risk deliveries, and as a fellow, she often gave advice to residents.

However, not everyone bought into the medical model of birth that positioned physicians as experts and heroes. A few months after I observed Dr. Shaw extolling the virtues of maternal-fetal medicine, a midwife transferred her homebirth patient to Fox Hill. This action signaled to medical providers that the birth was abnormal and out of the midwife's scope of practice; although for the midwife this action may have just been a precaution. At the hospital, the medical team subjected the White laboring woman to the medical model of care—hooking her up to an external fetal monitoring machine that constantly reported her heart rate, the baby's heart rate, and strength and duration of contractions to physicians.

Residents in the workroom who were watching the "strips", or baby vitals as reported by the external fetal monitors, noticed that the baby's heart rate was becoming "tachy", physician shorthand for tachycardia, or that the fetus's heart was beating faster than they would have liked (Bhatia, Burgess, and Skinner 2020). This signaled to physicians that the baby was in distress. Adjusting the monitors did not improve the heart rate reading and increased providers' concerns. Moving quickly to the next stage of assessment under the medical model, a resident physician attempted to perform a pelvic exam on the patient. However, the mother refused and thwarted the providers' attempt to measure labor progress digitally (Scamell and Stewart 2014).

The mother's refusal of a pelvic exam seemed to baffle and frustrate providers who gathered around the monitors discussing what they should do next. Her refusal obstructed them from doing their job as heroes and rescuing her distressed infant. They decided that with the data they had, a cesarean would be the most appropriate next step in the birth if they could get the mother on board.

While there were originally nurses who supported her continued attempt at a vaginal birth now at the hospital instead of the attempted homebirth, their support waned as more medical evidence suggested the baby was in distress. After providers were able to convince her to allow them to perform a pelvic exam, they found thick meconium—the baby's first stool—in the amniotic fluid, which suggested to them that the baby had been in distress for some time. Meconium in the amniotic fluid could cause respiratory issues if inhaled by the baby (Vain and Batton 2017). One nurse who was also pregnant at the time, had originally been supportive of her patient continuing to labor as she herself had a midwife and planned for an unassisted birth. However, apparently stunned by the baby's condition, she repeated the medical assessment twice for emphasis, "tachycardia and thick meconium"; after assisting with the pelvic exam, she said, "that baby really needs to get out of there".

The resident physician continued to try and convince the mother that a cesarean was the best option, underscoring the risks of continuing with what they considered a stalled labor. However, when the physician suggested the infant was at an increased chance of cerebral palsy the longer they waited, the mother again refused the cesarean and countered by asking for the specific risk probability based on her case. This again sent the team scrambling to come up with a plan to convince her to agree to a cesarean or otherwise override her autonomy. Ultimately, they were able to convince the mother to consent to a cesarean section if she went two more hours without giving birth. While the laboring woman was white in this case, her experience captures the collision of the medical model of childbirth with its alternative, and the challenge it provides to hospital providers, a challenge this chapter will show that Black women mounted in other less obvious but no less important ways.

Encountering patients who question the authority and practice of physicians is a growing phenomenon. Scholars credit the consumer and women’s rights movements of the 1970s and 1980s that stressed the importance of patients’ participation in their care. In turn, hospital corporations and insurance companies have set in place a set of standards for practitioners in caring for patients that center on patient-centered care and satisfaction. However, this move to what some have called “engaged patients,” where patients are active and involved in their care (Timmermans 2020), also creates and sustains a questioning of physician authority. The issue is particularly pronounced for Black women patients, because of the constant drumbeat of news about racial maternal health disparities, cases of hospital negligence, and health advocacy campaigns. Black women patients face additional challenges when invoking an engaged patient approach as existing race, class, and gender inequalities come to the fore and stratify their interactions with the healthcare system (Wright n.d.) and have adapted approaches to healthcare interactions. Today, physicians are facing a new type of patient with different expectations of healthcare interactions.

This rise of self-advocacy among patients creates a dilemma for providers. How do they save mothers and their babies when patients can ignore their physician's expertise, and what they consider clear scientific evidence? And on a more practical level, if patients cease to yield to physician authority, what happens to their careers? In this chapter, I explore the dilemmas of authority that obstetric and maternal-fetal physicians face, and – given this backdrop – how they work to retain their authority with implications for Black women’s care.

ORIGINS of PHYSICIAN AUTHORITY

In 2017, more than 98% of births occurred in U.S. hospital settings (MacDorman and Declerq 2018). Although a COVID-19 lockdown ensconced people in their homes unless they were first responders during 2020, the number of births that occurred in hospital settings only declined 1%, leaving an overwhelming amount of births—97%—to hospital-based care (MacDorman, Barnard-Mayers, and Declerq 2022). That mothers, even during a global pandemic, are compelled to give birth in hospital settings speaks to the overwhelming medicalization of pregnancy and childbirth. However, birth has not always been considered a medical event.

At the turn of the 20th century, most births in the United States occurred at home with midwives (Leavitt 1980; Borst 1995). Midwives practicing in the United States at this time were mostly immigrants or Black "grand"[6] midwives in the South (Leavitt 1980). Immigrant women brought with them their midwifery training from European nations while grand midwives were trained through apprenticeship. Birth was considered a natural and healthy part of life for which women prepared by being in community with other women. The midwifery approach to birth was to assist mothers in labor, allowing time and her intuition to guide the direction of the birth (Rothman 2014; Cancelmo 2021). This assumption that births can happen safely and with minimal prodding, led midwives not to judge the progression of a birth based on time progression alone. Instead, they were in tune with mothers, who were in tune with their bodies and could tell when things were on or off track (Davis-Floyd 1994).

The rise of obstetrics, however, signaled the decline of midwifery (Goode and Rothman 2017). It was standard midwifery practice to call a barber-surgeon if birth took a wrong turn,

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[6] Although much literature refers to traditional Black midwives in the U.S. South as Granny midwives, Goode and Rothman discuss the subservient undertones of that language and instead encourage the use of Grand midwives (Goode and Rothman 2017).

and it seemed that the mother would die; only he was authorized to use tools to extract the fetus to save the mother's life (Goode and Rothman 2017). Newly trained physicians who held mostly theoretical knowledge of birth, as opposed to midwives' practical birth knowledge, became fascinated by these pathological cases of birth. With the advent of new tools like forceps—and laws that restricted who could use them—physicians were also able to birth live babies as opposed to only extracting fetuses. A power struggle over birth jurisdiction ensued and some physicians delaying their arrival when called by midwives resulting in the unnecessary deaths of women and unborn children (Borst 1995). This did two things. It medicalized births by casting it as pathological and inherently risky and it increased the desire for the attendance of a physician and their life-saving tools at birth. Physicians gained cultural authority to manage births.

However, physicians were not as experienced in birth as midwives, and in several cities, the infant death rate rose in tandem with the decrease in midwife-attended births (Dawley 2003). As a result, middle-class white women rallied government officials for legislation to protect infant health. Thus, the Sheppard-Towner Maternal and Infant Protection Act of 1921 provided federal aid to state programs working to improve maternal and infant healthcare. A byproduct of this successful lobbying was an increase in public health nurses (Goode and Rothman 2017). Together, public health nurses and obstetric providers pushed out the majority of remaining midwives in a campaign that extolled the virtues of science, education, and medicated "twilight sleep" while demonizing non-white midwives as unclean, uneducated, and unfit to attend births on their own (Dawley 2003; Goode and Rothman 2017; Fraser 1998). The remaining midwives were subjected to 'bag checks' where nurses would examine their midwifery equipment to ensure midwives only used the approved tools; their knowledge and authority were questioned and undermined (Bonaparte 2014). Because of the increase in scrutiny, many of them slowly left the field of midwifery and few grand midwives remained, practicing primarily in poor and black rural areas (Fraser 1998).

Giving birth in a hospital became a class marker, as the middle-class fully embraced the expert care they could receive from college-educated physicians. Obstetricians oversaw many white middle-class births and often put their laboring patients into “twilight sleep” for pain management, although this also meant they were not awake for the birth of their child(ren) (Leavitt 2009). In her seminal study, Fraser found that the black people she interviewed were ashamed to say they were born via midwife because of the class implications of admitting so (Fraser 1998). For a time, the authority of physicians went unquestioned.

However, in the l970s and 1980s, several feminist scholars began to decry the medicalization of pregnancy. They argued that birth was a natural healthy process that need not be regimented and pathologized by medicine (Rothman 1993; Shaw 1974). Furthermore, they argued that it disempowers women in the birthing room as physicians worked only on the body and discounted the woman whose body it was (Shaw 1974; Martin 1987). Despite fierce critiques of the medicalization of birth, risk discourse continues to serve as a linchpin in the argument that physicians should retain authority over and supervise births.

Conceptions of Risk and Heroic Efficiency

A particular conception of risk undergirds physician authority and suggests only births supervised by physicians in hospital settings are safe. Social theorists posit that Western societies are experiencing a period of heightened attention to individual risks, what some call a “risk society” (Beck 1992). Culturally, risk is primarily considered through proximity to dangerous outcomes, regardless of the actual statistical calculation of risk. As birth has become medicalized, mothers may have also internalized the conception of pregnancy and birth as inherently risky, as the high numbers of hospital-based births attest, although there are other, structural factors at play: for example, not all states (currently 34) certify midwives, insurance often does not cover their services, and birth centers that employ them have limited capacity (National association of certified professional midwives 2023). Likewise, American culture inculcates women with messages that they must protect their future children by being risk-avoidant in their pre-pregnant lives (Waggoner 2017).

Medical practitioners follow what Lupton calls a technico-scientific conception of risk (Lupton 1999). They use scientific instruments—like external fetal monitors and other routine testing—to measure and calculate risks to the mothers and the baby (Lupton 2013; Rothman 1993). They cite the data as evidence that a risk is imminent, and treatment is necessary to avoid it. The reliance on data creates a technocratic ordering of birth into stages where physicians then measure how well a particular mother is laboring based on her progress as compared to previous births under the medical model (Davis-Floyd 1994). For the births that fall out of the prescribed laboring timeline, for instance, there are interventions in place designed to address the risks of being outside the “normal” range of birth, as it was previously studied and understood (Davis-Floyd 1994). Otherwise, those “abnormal” labors could lead to adverse maternal and/or infant outcomes at birth—the very risks they work to circumvent.

Physicians are trained with technico-scientific conceptions of risk and supervise births according to a technocratic timeline where timing is integral to conceptions of risk. As experts who are trained and have the authority to use life-saving medical tools and procedures, they embrace the responsibility for healthcare. They see themselves caring for patients through a frame I call heroic efficiency. Through a heroic efficiency frame, doctors understand their role as physicians to be altruistic healers who use a systematic approach to healthcare delivery. Their attention to timing and risk coupled with a scarce skillset is what they think saves lives through quick action, as in childbirth, time is of the essence.

Physicians are heroes because of their service to the profession in light of the demands of the job and the shortage of workers (Zhang et al 2020). They sacrifice their time and health to provide people with the healthcare they need to get well (Nistelrooy 2014; Ribeiro et al 2022). Foxhill physicians most clearly demonstrated heroic efficiency when the births on the floor involved a code—a call to all available providers to come immediately—when a patient faced a life-threatening condition. While codes were infrequent, when they occurred physicians dropped everything and ran to the patient's room. The immediate focus was remedying whatever caused the code using medical interventions and teamwork with other providers. They were there to save the day. Likewise, heroic efficiency could be seen when physicians lost patients, on the unit often referred to as a fetal demise. One recent December, I watched an attending physician break down and cry after leaving the operating room. She paused to gather herself before walking off the ward. A nurse nearby informed me later that the infant she was unable to save in the operating room was her third demise that month—all tragedies she took to heart. She might wonder if she could have saved them if she had more time. Physicians see themselves as heroes because they have the knowledge and authority to use the tools of medicine to save lives—but they have to act fast and efficiently.

CHALLENGES TO OBSTETRIC AUTHORITY

The cultural icon of the physician as a hero is in peril from multiple angles as the public and the healthcare industry question the practices and authority of physicians. The challenges to authority include feminist knowledge critiques, consumer medicine, hospital business models, and poor safety records. As authority becomes less secure, doctors' attempt to bolster it through its enactment becomes more obvious.

Feminist Challenges to Medicine

Technocratic trends were not inevitable, nor are they uncontested as feminist scholars warn that reproductive technologies alienate women from their own pregnancies and births and treat them as nothing more than machines that produce babies and sometimes break down and need service (Rothman 1993). Medical knowledge became the authoritative and thus dominant knowledge over birth superseding women's embodied knowledge (Davis-Floyd and Sargent 1993). Furthermore, scholars contend, the creation and maintenance of these birthing protocols is socially constructed and the research studies that serve as the basis of these protocols are influenced by the creators' conceptions of risk. The protocols employed in advanced industrialized nations diverge, for example, suggesting the "science" is less clear than its proponents maintain (Seijmonsbergen-Schermers et al 2020). Moreover, medical practitioners extol the virtues of science and the reliability of the scientific method while demonizing the lay person for considering risks in different or 'unscientific ways' (Chadwick and Foster 2014).

At the center of the collision between the medical model and its alternatives is the role of time. The technocratic model of birth in the United States plots the duration of birth on a timeline. Each stage of labor has a range of time within which labor is considered as progressing "normally", and there are interventions for those that do not. For instance, the first stage of labor lasts from the time that laboring women begin contractions and lasts until she is fully dilated. The amount of dilation progress labor expected of women in the U.S. is about 1cm per hour for first-time mothers and 1.2cm per hour for mothers of multiples (Desai and Tsukerman 2023). ‘Arrest of progress’ occurs when there has been no change in cervical dilation in more than 4 hours (Desai and Tsukerman 2023) and can be remedied with Pitocin, a medicine to increase the strength of contractions and propel labor out of the ‘arrest’ or ‘stalled’ stage, for example. Yet, this care model resembles a factory model where women progress through recognized stages in an orderly way and are given drugs to make their bodies comply. The clear benefactor in what one might consider to be an industrial model of birth is the healthcare organization that is able to control a wild and idiosyncratic biological process and efficiently manage doctors, nurses and many patients.

Nonprofit hospitals like Fox Hill commodify healthcare and seek a balanced budget in their treatment of disease. And the hospital will want them to see as many patients as they can. This is both a noble thing—having the capacity to care for as many sick people as possible as they don’t turn anyone away—but can also create some challenges as the hospital is still a business.

As an example of the triumph of the medical model at Fox Hill, practitioners there relied on the ARRIVE study to compel women to elect induction at 39 weeks (Grobman et al 2018). In this study, low-risk women who had never given birth before were placed in two groups, one group to be induced at 39 weeks and the other not. The team found that early induction did not substantially reduce risks or adverse events in the infants, and reduced the number of caesarian sections. Physicians at Fox Hill and other hospitals use the ARRIVE study to schedule women’s inductions at 39 weeks because according to the study, doing so did not result in an increased chance of adverse events and ultimately could move most normal births onto the physicians’ preferred timeline.

Although the ARRIVE study is considered evidence-based medicine, a scientifically proven appropriate way to treat patients across populations, that does not necessarily mean that it is appropriate for all women. This was one study of only low-risk women; assessment of who is considered low ‘risk’ is based on providers’ assessment of risk which may vary from patient’s assessment of risk. For women whose sole concern is the safe delivery of a healthy infant, following the expert advice of physicians is the clearest path of risk avoidance, despite high numbers of cesarean sections in the United States and other problematic indicators. The ARRIVE study places birthing women on a laboring timeline that providers are able to monitor and manage to turn over birthing suites quickly and efficiently. Yet while the ARRIVE study demonstrates how the power of technico-scientific conceptions of risk and its concomitant technologies shore up physician power over childbirth, we must also consider how cultural, economic and technological changes have also moved power out of the hands of physicians.

The rise of consumer medicine

One of the major factors eroding physician power has been the rise of consumer medicine. Some scholars believe that physicians are losing their social authority or capacity to direct the behavior of others while medicine retains its cultural authority or influence on meanings of health and illness (Epstein and Timmermans 2021; Starr 1982). Medicalization of pregnancy and other health conditions has been so successful that people have internalized the medical gaze (Foucault 2013 [1963]). Modern medicine thereby has cultural authority that supersedes the social authority of the physician. As such, even as hospitals retain their dominance in childbirth, the physician has become less relevant in the practice of medicine.

Physician authority vis a vis knowledge and tools are beginning to wane as potential patients inform themselves using other non-physician sources of information, such the internet, and can arrange for some tests, e.g. pregnancy tests, themselves by purchasing them over the counter. During COVID-19, for example, you could purchase kits to diagnose yourself with the illness to prevent the spread of COVID by taking precautions at home. Furthermore, markets for do-it-yourself teeth alignment businesses and weight loss aids promote consumer-oriented medical approaches to meet health goals.

Hospital organizations have also begun to orient their practices to a consumer model through the usage of patient satisfaction surveys (Yeh and Nagel 2010). This move has accelerated the prioritization of aesthetics in the hospital and other hospitality touches that may improve the patients' rating of their hospital experiences. Scholars warn that this shift in prioritization of hospitality can come at a cost to patientcare, although the costs are hidden when patients report satisfaction with their experiences (Young and Chen 2020).

The business of hospital medicine

What has become more important for the uptake of medicine, however, is the rise of healthcare organizations, health insurance and pharmaceutical companies. Together these three entities shape how healthcare is organized and conducted. As medicine has great cultural authority, they make for strong businesses. Physicians who work in hospital organizations have to balance their authority as a physician with the hospital’s organizational dictates which can be antithetical to what the physician feels they should be doing with their time. Hospital organizations impose two conflicting demands on their health practitioners: the demand for efficient productivity and the demand for patient-centered care.

Hospital organizations are faced with the daunting task of improving profits, services and patient safety while reducing waste (Borges and Tortorella 2019; Waring and Bishop 2010). In this process, many of them adopt business processes to improve the efficiency of the hospital. This top-down pressure for efficiency creates tension between hospital administrators and the clinicians whose authority efficient practices threaten (Waring and Bishop 2010). It also affects the way that providers can care for patients.

On the other hand, hospitals are increasingly claiming to provide "patient-centered care." In patient-centered care, the patient is listened to, informed and involved in their care. The treatment decisions are made based on what the patient decides is best for them and not necessarily what is proven most effective (Epstein and Street Jr 2011). In practice, patient-centered care means that physicians and patients participate in shared decision-making where there is clear communication about the risks, benefits, and implications of treatments when there is more than one option (Elwyn et al 2012; Zhou et al 2023).

Yet, patient-centered care and shared-decision making are often at tension with provider expertise and even evidence-based care (Engle et al 2021). In a fast-paced environment, like hospital maternity wards, providers may not feel as though they have the time to have a patient-centered care approach where the patient is given the full breadth of options, education, and time to consider (Légaré and Thompson-Leduc 2014; Légaré and Witteman 2013). Resident physicians may feel hindered from sharing power too much in interactions as it may instead be interpreted by attendings as incompetence (Crowe and Brugha 2018). Furthermore, some physicians are leery of following patients' choices when they are not aligned with evidenced based practice for the fear that they could later be sued for malpractice. This amalgamation of social forces shapes how providers interact with patients.

News coverage depicting a poor safety record

In recent years, more attention has been paid to the alarming rise in Black maternal morbidity and mortality—a crisis health professionals seem ill-equipped to handle. According to the Center of Disease Control, over 80% of pregnancy-related deaths in 2017-2019 were preventable (Trost et al. 2022). Despite decades of upward trends in Black maternal health disparities, there continues to be a lack of clear direction from healthcare providers on how to improve outcomes. When I asked providers what they believed caused the trends in Black maternal healthcare, all of them pointed to pre-existing health condition in the mother that caused them to be more prone to pregnancy related health problems. This argument neatly aligns with other public health messages that encourage women to tend to their pre-pregnancy health (Waggoner 2017).

However, there is a difference between pre-existing conditions causing and accelerating Black maternal health disparities and health disparities that are the result of inequalities within the provision of healthcare. Medical providers with all the technoscientific tools to detect, monitor and treat disease seem to hesitate when it comes to detecting, monitoring and treating Black women, at times doubting that Black patients are in pain (Hoffman et al 2016). The trends of Black maternal mortality and morbidity suggest that institutional and individual racism are factors driving healthcare disparities.

Considering the racial safety fears previously discussed, Black women question the actions of physicians. The news that Black women endure maternal health disparities has hit the media. At the time of writing, another Olympian, Tori Bowie, died from complications in childbirth, with her story featured on news outlets (Chappell 2023). Her teammate, Tianna

Madison, took to social media and said, “THREE (3) of the FOUR (4) of us who ran on the SECOND fastest 4x100m relay of all time, the 2016 Olympic Champions, have nearly died or died in childbirth.”[7] As she recounted, three of the four Black women on the U.S. Olympic relay team, Allyson Felix, Tianna Madison, and now Torie Bowie had all experienced pregnancy complications. If Olympians, people who are in better physical shape than most people, suffer such poor outcomes, then the prognosis for birth outcomes for regular black women seem stark, news that likely leads more Black women to question the treatment they would get in hospitals.

HOW THEY MANAGE THE CHALLENGES

Although physicians see themselves as altruistic through the lens of heroic efficiency, mounting criticism from peers and the public place their authority in jeopardy. This context likely shapes the way they approach interactions with patients, particularly Black women maternity patients. Given all these challenges, how do practitioners work to shore up their authority on the ward so that they can get done what they believe must happen?

Performing competence

Doctors attempt to retain their authority by performing competence for each other as well as for patients. At Foxhill medical center, one key ritual I observed on the unit was the so-called “safety round.” At safety rounds, a second-year resident led the entire team—obstetricians, anesthesiologists and nurses—through each case on the unit, explaining potential risks for each one. The practice of doing this solidified the second-year resident as an expert on birth through the approval of attendings for their presentation. Along the way, the language of safety – and the content of risk – also invoked the central tenets on which the medical model relied for authority.

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[7] Tianna T. Madison’s Instagram page, accessed June 27, 2023, https://www.instagram.com/p/CtccVtiS0A0/?igshid=MzRlODBiNWFlZA%3D%3D.

Early one fall morning, I watched as Dr. Taft, a jovial white male second-year resident, led the overview of cases surrounded by thirty colleagues on the Labor and Delivery unit. “Room 3 is a G3 P2 39 and 9…” he began, looking down at his notes and using a shorthand to convey number of previous pregnancies and gestational age, considered key factors in evaluating risk. Occurring four times a day, “safety rounds” provide a chance for members across the care team to weigh in on patient risks and interventions. The first safety round of each shift was always well attended as refreshed clinicians hunkered together for an overview of the day ahead. This particular morning, I fell in behind the huddled mass and leaned against the nurse’s station to see and hear better.

Obstetrics and anesthesia physicians and residents, nurses, patient care techs, and a pharmacist formed a semi-circle around Dr. Taft as they all faced six mounted wall monitors that displayed patient vital signs. As he went on, the crowd – all of them in scrubs – often nodded as they listened and at times referenced folded notes many carry in their back pockets. Dr. Taft began discussing one case by foregrounding the team’s attempt to mitigate risks the patient had embraced: attempting a vaginal birth after cesarean, or VBAC. He emphasized to the crowd that she had been “thoroughly counseled” about the chances of her successfully delivering vaginally.

Flipping through his notes, he reported that the predicted chance of a successful vaginal delivery was 41% and, for reference, the baby’s size was estimated to be in the 91st percentile. Dr. Taft’s emphasis on these numbers signaled his skepticism that a VBAC would be successful. Though he conceded that the team would allow her to attempt, his framing of their interaction signaled to the senior attendings present that the team had tried to change her mind. Several doctors grumbled in agreement that the chances of a successful VBAC were basically impossible, and that her attempt would likely be futile.

Outside of the safety rounds rituals, resident physicians as training doctors are in a precarious position and often take care to make the best impression in front of attending physicians. In his account, Dr. Taft invoked statistics for predicted success and nationally normed baby measurements, but also referred to interactions with the patient; the combination demonstrated physician competence in front of approving senior attending physicians and reified Dr. Taft's authority in front of other physicians.

On another occasion, I observed Dr. Taft search for a piece of information in the patient's chart that was necessary for determining the treatment plan. Unable to find it, Dr. Taft considered either asking the attending physician, who had already met with the patient and would know the information or asking the patient again. He chose to ask the patient saying, "[The attending] is like an angry dad." To avoid rebuke or presenting as incompetent, Dr. Taft went straight to the source for information.

Physicians also must perform competence for patients. Before a scheduled induction, I watched as a chief resident worked to convince a patient that staying for an induction was statistically the safest choice. As Dr. Johnson, a thin Black resident with a short curly afro, perched on a nearby stool, he leaned on his previous life experience as an aeronautical engineer who helped to launch rockets into space. He left a career of engineering to do important work of caring for people in their time of need. Citing his experience, which requires understanding of complicated math and science knowledge, Dr. Johnson established himself as a trustworthy scientist who knew his probabilities—the patient could be sure his advice was correct.

However, physicians' performance of competence was not always satisfactory for patients. Taylor, a Black 28-year-old graduate student, recalled an experience during her second birth. Her baby was born weighing over eight pounds and came three weeks early. At this particular hospital, his height and weight percentile for his gestational age placed him in an at-risk category for hypoglycemia, requiring him to undergo frequent heel-sticks to test his blood sugar levels. However, a nurse mentioned to her that the cutoff percentage for the testing varied hospital to hospital. And at that hospital, had he been born after midnight, which was just several hours later, he would have been an older gestational age and therefore not at risk and not subjected to the testing.

After hearing that there were different cut-offs at different hospitals, Taylor refused to continue his frequent testing. In response, the doctors and nurses sent in the attending physician to speak with her and convince her to continue the testing. “And so then they sent in a doctor and they were like, ‘You need to understand what you are potentially doing to your child, he could die. He could have this. He could have,’ hypo...hyper-glycemia or something,” Taylor said. She explained her reasoning to the doctor. “I'm like, ‘You're just trying to scare me. Let me explain to you what the nurse said before and what I have looked up.” Taylor viewed them sending in an attending to coerce her into the testing as an act of fearmongering, and named it as such to the doctor.

“Home Delivery is for Pizza”: Insisting on the childbirth monopoly

As detailed in the previous chapter, Black women sometimes enlisted the expertise of doulas to vet advice from medical providers. When physicians spoke with mothers about clinical decisions, the doula was not included in the conversation, and any input doulas gave was not well received. I observed a physician speak with Tammy, a Black 22-year-old college student, about starting Pitocin to help her labor along. Seemingly unsure about what decision she should make, she turned to her birth doula, an older heavyset Black woman with shoulder-length natural hair and thick black-framed glasses. Receiving a look from her client, the doula asked aloud for the risks and benefits of Pitocin. Hearing her question and perhaps being frustrated by a third party entering into the patient-counseling portion of the encounter, the provider seemingly responded only to the patient and did not make eye contact with the doula. For several participants, it seemed that the medical providers did not even acknowledge that they were accompanied by a doula—assuming instead that the doula was a family member. This rejection of doula influence minimized the labor support Black women envisioned having on the unit.

Medical providers balked at the idea that doulas wielded any authority in the labor room. While in the abstract Laura, a white nurse with over 17 years of experience as a labor and delivery nurse at Foxhill, was comfortable with the idea of doula support, she strongly objected to their infringement of her clinical expertise. Referencing the difference in classical training, she retorted that their weekends of training did not outweigh her four-year medical degree. In her view, doulas were not trained medical professionals, they were more or less labor coaches. Any advice they could give would not be appropriate given their training. By denigrating doulas, the medical providers rejected challenges to their authority.

While nurses sometimes fended off the doula challenge themselves, however, sometimes the conflict about the medical model of childbirth infiltrated the politics of the ward. Part of retaining physician authority is maintained through the working relationship between physicians and nurses on the unit. While they are on the same team, caring for patients, at times they appear opposed when it comes to issue of authority. Part of this seems to stem from the fact that many nurses at Fox Hill are more aligned with the midwifery model of care than the medical model that gives physicians their authority.

Consider this vignette about patient care. Stephanie, a white nurse in her early 30s, described a disagreement she had with an attending physician in front of a patient. The patient, a woman of color, had given birth to her older children and wanted to again have an unmedicated natural birth. However, at Fox Hill it was a standard practice to administer Pitocin, a medication that induces uterine contractions, after every birth as a preventative for post-partum hemorrhage, a life-threatening condition that affects about 3% of people (Reale et al 2020). When Stephanie explained this "routine" practice to the patient during labor, the patient said that she did not remember having to take Pitocin in her previous births and asked Stephanie to check.

The patient was emotionally invested in having an unmedicated birth, and Stephanie wanted to honor that. However, the unit was busy and Stephanie was unable to steal away for a moment to check her medical records before the birth. As she began to hang the Pitocin bag on the IV pole and begin the drip—per hospital policy—Stephanie explained to the patient what she was doing and referenced their prior interaction. When the patient inquired about the medical records and if she had an opportunity to check, Stephanie told her truthfully, she did not have the time and reiterated why they suggested the medication. However, she also told the patient they could wait to begin Pitocin until it seemed like it was necessary, if she preferred.

Overhearing this conversation with the patient, the attending physician intervened. He chastised Stephanie, telling her that she should not present it as optional; it is a standard of care that all receive. He also offered to help Stephanie – who had more than 10 years of experience taking care of patients – learn how to consent patients through role-playing common scenarios. This condescension contributed to Stephanie's growing unhappiness working on the unit, and less than a month later she resigned. Amidst the tension between the attending and Stephanie over the role of consent in patient care, the patient could see and hear them disagree about whether or not she had to take the Pitocin. If authority were unquestioned, we would not see it so blatantly imposed.

Claiming objectivity and colorblindness

Physicians also attempt to retain authority by claiming professional objectivity and colorblindness. When faced with questions about how their care differs for Black patients given the alarming Black maternal health crisis, several providers mentioned that they "did not see color." This rhetorical move distances providers from inequitable care. Any healthcare inequalities are instead positioned as naturally occurring in the population and not due to provider (in)action. This claimed distance from existing racial structures is akin to the naturalization tenant of Bonilla-Silva's colorblind racism (2018 [2003]). Instead, providers positioned themselves as heroes that treated whatever health condition that walked through the door, without prejudice.

When I asked providers how they shape their practice to care for Black women, they emphasize the colorblindness of their care. Speaking with one doctor who has practiced at Fox Hill for over 20 years, she told me she could not tell which race her patients were from their chart. For added emphasis, she turned her laptop towards me to show her planned schedule for the clinic. Of the ten patients she was scheduled to see, none of their charts seemed to list demographic descriptions. She used this as evidence that she practices "colorblind" and treats all of her patients the same.

Similarly, when I asked a nurse who was also a long-time employee of Fox Hill how she might treat Black patients differently because of Black maternal health risks, she became defensive and claimed that she treated everyone the same. The morning after our interview, she sent me a long text message as a follow-up where she detailed each step they take when any mom is at risk for a cardiac event including leaving a crash cart outside of their room. The text demonstrated some of the pressure she felt to ‘clean up’ the record and portray Fox Hill in a non-racist light.

As I spent more time on labor and delivery, I looked for evidence of race in the provision of care, yet this form of colorblindness seemed to be ubiquitous. There is a patient board on the unit which tells the status of each patient in labor. Using the letters of first and last name, room number, age, number of previous pregnancies, gestation of the fetus and a host of other labor progression data, the electronic board is a convenient snapshot of patient progress. Yet, I found it curious that no information about the race of the patient appeared on the board. This was especially surprising for Latinx patients. Birth lore on the ward suggests that Latinx women who have previously bore children progress faster than other laboring women and often with less assistance. Nurses and doctors frequently referred to these cases as “Spanish multips” when estimating how long women would labor and how they planned to allocate labor so that someone could be there to assist. Even though Latinx is considered an ethnicity, because of this relevance of the ‘Spanish multip’ in unit conversations and planning, its absence was striking in both the writing on the electronic board, as well as in answer to my questions about explicit racial policies.

After months on the unit, I gathered that race played a larger factor in how providers approached care heuristically. For instance, as I recruited participants in the prenatal clinic one day, I asked a white health coordinator who screened patients for me how she knew which patients were Black and therefore qualified for the study. Calling me over to the computer, she hovered her mouse over the name of a patient and a yellow rectangular box appeared with their descriptive statistics—age, sex, race. Her ease of showing me how to find out race seemed to contradict the providers at Foxhill who use the same electronic health records system as they are in the same network. However, the risks of pinpointing race to a researcher studying racial health disparities are quite different for someone screening eligible patients than for someone who might be characterized as the perpetrator of racism. Because of those risks, I suspect medical providers avoided talking with me explicitly about how race shaped their care, although it did in patterned ways. Furthermore, although providers claimed objectivity and colorblindness, the way they cared for patients did not always seem colorblind.

Pressuring patients

Resident physicians are under pressure to perform as competent physicians guiding their births away from risky situations—like the attending enforcing Pitocin for all. Pitocin, an artificial hormone that causes the uterus to contract, is often given to mothers whose dilation progress is considered slow, and is a common tool physicians use to augment the speed of labor. Yet, some laboring women refuse Pitocin and thus unknowingly place the resident in a predicament in which being patient-centered and obeying medical dictates conflict. This contradiction comes into focus especially for patients whose labor is considered stalled.

On more than one occasion, I witnessed a resident coerce a patient into using Pitocin. While observing on the unit one day, Dr. Givens came out of a patient room and leaned over the nurses desk to have a conversation with the patient’s nurse. She described how she told the mom that while her water was broken, she wasn’t making a lot of progress dilating and that that created a higher risk of infection and infection carries a four-times greater risk of the baby developing cerebral palsy. “The lack of labor progress” is a metric that the US medical establishment has decided creates a risk to the unborn that is not followed in other countries with better infant outcomes (Seijmonsbergen-Schermers et al 2020). Hearing this, the mom agreed to begin Pitocin, desiring to avoid placing her baby in harm's way, and Dr. Givens was informing the nurse to begin the Pitocin drip. Dr. Givens wanted to speed up the labor process and allowing the patient to labor for hours and hours was an impediment to the progress of births on the unit as a whole. Her decision to nudge the mother with a scary cerebral palsy statistic was in service of flow of patients on the floor and not patient preferences. It was in service of hospital efficiency and retaining the authority of physicians by having their patients adhere to evidenced based medicine.

In another instance, I observed as the same doctor handled a Black patient's anxiety after she informed her they would consider a cesarean section if she did not continue to dilate. The patient began discussing wanting to avoid it, asking what they could do. Dr. Givens explained how they would attempt other interventions first, but if they were unsuccessful, they would recommend a cesarean, saying although a cesarean section might not be what she wants, the baby "can still come out healthy" and she may need to "reassess her priorities". Dr Givens was attempting to reason with her patient while clearly communicating where the birth is potentially going. However, her approach seemed cold, distant and to the point—I see what you want, but this is what we want, and although our way might prevail, at least we can ensure the baby will still be healthy.

In these two examples of Dr. Givens interacting with patients, we see that she is not harming the mothers or the babies, instead she is guiding them towards a medical model of childbirth that physicians maintain would minimize risks to infants and their mothers. Moreover, as the expert, she privileges heroic efficiency as the baby can still come out healthy while she can still perform as a competent physician.

Black women's suspicion of physicians is an additional blow to physician authority following the consumer health movements of the 1970s which challenged whether or not doctors should be the sole deciding factor in which treatments, including births were allowed. Like the laboring woman in the opening vignette, Black women also try to thwart the efforts of providers to get them to take a medicine or do a procedure that they do not want. However, unlike the white woman in the opening vignette, black women are bound by affective burdens that shape how they act (Wright n.d.). They work to avoid controlling images that might cast them as angry Black women, characteristics that could incite obstetric violence against them.

Conclusion

In this chapter, I have explored how medical providers make meaning of their work on labor and delivery. Physicians see themselves as altruistic healers who use a systematic approach to birth through a heroic efficiency lens. Conceptions of themselves as heroes are threatened by growing challenges to their authority from feminists, consumer medicine, healthcare business models and their poor safety record caring for Black women. They handle these attacks on their authority by performing competence for each other and patients, insisting on a childcare monopoly, claiming objectivity and colorblindness, and pressuring patients.

I argue that in their pursuit of authority that maintains and upholds conceptions of heroic efficiency, their actions are particularly detrimental to Black women that may be enlisting strategies like doula support or self-advocacy. It compounds onto existing raced and classed inequalities that prevent marginalized people from advocating for themselves in the first place while portraying the care they provided as colorblind.

While we have seen how conceptions of authority and its maintenance contour the provision of healthcare from providers point of view, the next chapter examines how heroic efficiency interacts with racial safety.

Chapter Three

"SHE'S NOT IN LABOR UNLESS WE SAY SO": THE CULTURAL MISMATCH OF RACIAL SAFETY AND HEROIC EFFICIENCY

I met with Raven a little over a week before her scheduled cesarean section. She sat on the couch propped up by several pillows. As we began our interview, she shifted around in her seat until she found a comfortable position. We chatted about what had transpired in her pregnancy since our last interview and how she was anticipating the scheduled cesarean. She was feeling a little anxious. After years of infertility and an almost one-year-old conceived by IVF, Raven could not shake the feeling of nervousness that shrouded this pregnancy, her first unassisted by technology in many years.

At this late stage in her pregnancy, her nerves focused in on her inability to breathe. Not only was reclining or laying on her back uncomfortable, but it also constricted her respiration. Although she acknowledged that carrying a baby made internal organs crowd, she explained that "It almost feels like I'm losing my breath, like I just can't breathe. It's just very uncomfortable." Raven had discussed this concern with the physician that would perform the cesarean section.

> And so, when I saw her last week, I told her that was one of my concerns, that I know I'm going to have to be on my back for this [surgery] and that feeling of not being able to breathe gives me a little anxiety. And so, she just kind of went over, like, what they can do and how quick the process would go. Because once the baby comes out, I'm sure it's going to open up some space and I won't have that feeling, but I did just, you know, I really explained to her that it does give me a little anxiety.

Raven underscored that she told her provider that she experienced “a little anxiety.” Her repetition of the phrase “a little anxiety,” however, combined with her prior history with infertility, suggested that she was actually more than a little anxious. After years of infertility, she was fearful something would again impinge on her incipient childbirth. She had begun to believe her body was unable to carry a baby to term without some sort of medical assistance. Media accounts of rampant Black maternal health disparities further fueled her apprehension going into the planned procedure. Raven shared this building anxiety with the medical provider who would be on-call and thus the assigned surgeon to her cesarean section, a provider with whom she had no previous relationship.

In response to Raven’s expressed angst, the physician did not speak directly about her incapacitated breathing, nor did the doctor address Raven’s underlying concern about her body’s birthing competence. Instead, the surgeon explained how quickly the cesarean would be performed and how the internal pressure would be relieved with the baby’s birth. The doctor also reassured Raven that she would give her extra oxygen, to help make sure she was getting the necessary oxygen to her lungs. Leaning into her expertise as a surgeon and a physician, the doctor offered a clear and efficient medical solution to respond to Raven’s concerns.

Yet the intended comfort of “extra oxygen” was not well received by Raven, who noted in our interview, “I don't know if that’s going to help! It’s a lung thing. I mean, my lungs aren’t expanding the way that they should.” The doctor’s clinical orientation to the interaction and the upcoming cesarean may have generated her response, but it did not assuage Raven’s building worry, as was evident in her comment to me about her lungs not expanding. The pair seemed to talk past each other, with Raven expressing anxiety about living through the cesarean and the physician expressing expertise and authority over cesarean births. However, after the doctor’s reference to extra oxygen, Raven did not further push the issue. Although her medical anxieties were unmet, Raven did not take it further because of her “affective burden,” her concern about how she would be perceived as a Black woman, being too pushy or demanding; and how that might penalize her with poor or improper care (Wright n.d.).

Providers often reported a dissonance between their experience of a given childbirth and the patient satisfaction surveys they were given. As the last chapter argued, clinicians approached their work with heroic efficiency. They provided the best evidence-based care they could to their patients under the constraints of market approaches to healthcare. Appeasing both the hospital administration through efficiency and patients through patient-centered care was an increasingly daunting task for physicians who at times seemed like ‘double agents’ (Boyer and Lutfey 2010; Waitzkin 2000).

The hospital used survey scores to evaluate the patient’s happiness with their healthcare experience (Yeh and Nagel 2010). While the unit enjoyed an 86% patient experience rating, according to the goals board affixed near the nurses’ station, patient satisfaction was not unanimous. “You ask people to their face if they are satisfied, some aren’t comfortable and then gripe on the survey,” said the medical director. His comments exemplified how both the hospital’s administration and doctors did not understand why some patients were dissatisfied with their care and what hindered them from sharing this dissatisfaction during their hospital stay. Moreover, his usage of the word “gripe” had a negative connotation, signaling that he thought they should complain while the unit had a chance to address it instead of waiting and reporting their dissatisfaction on a third-party survey. Yet as Raven demonstrated, many patients did not feel like they could confront physicians with their queries and disputes in the moment, and without confrontation from patients during the labor and delivery, physicians were left in the dark.

The dissonance between patients and providers, illustrated by the tension between Raven and her provider in the above vignette, is the focus of this chapter. While almost all birthing patients express anxiety, patients like Raven harbor particular anxieties due to their own previous medical histories and/or legacies of racial health disparities in treatment and outcomes. As we have seen, they seek racial safety. In particular, Raven fears that a new provider with whom she does not have a connection may be less concerned about her being able to breathe, with the end result of Raven's health slipping through the cracks. She seeks reassurance that the provider will take the correct steps. Meanwhile, medical providers like Raven's doctor provide their patients with the most medically accurate information and care whilst embracing efficiency. As both are invested in positive outcomes of the interaction, how do patients and their providers continue to talk past each other?

EXPLANATIONS OF DISSONANCE

There are three compelling alternative explanations for why patients and providers are speaking past each other in these interactions. One vein of scholarship considers how the commodification of healthcare shapes patient-provider interactions (Reich 2014). Hospitals are embracing business models that invoke patients as consumers with consumer choices (Lupton 1997). Some medical practices, then, cater to a niche patient population to bring in more revenue, a practice that has been quite successful in other countries through a bustling medical tourism industry (Skountridaki 2019). However, hospital care subjected to market forces also creates opportunities for inequality, as some medical options or procedures are financially out of reach for some (Reich 2014). Patients of lower economic status may then experience constrained choice as the medical organizations and/or medical insurance they have access to may not afford them a wide range of healthcare options. Commodification might suggest that the amount of time and resources providers can give patients varies by insurance or ability to pay. The dissonance could be a reflection of class inequality.

Other scholars have considered increasing standardization in clinical practice as a factor in creating dissonance between providers and patients (Timmermans and Almeling 2009; Timmermans and Berg 1997). One hallmark of standardization practices is the institutional uptake of evidence-based medicine (Engle et al 2021). Evidence-based medicine provides a guideline practice for care based on randomized clinical trials that purportedly show how a population responds to this treatment. As a standard practice, it is efficient, and in some cases improves patient outcomes (Engle et al 2021). However, some scholars criticize evidence-based medicine for being "cookbook medicine" and stress its limitations, particularly its applicability to ethnic minorities (Huey et al 2014; Knaapen 2014; Timmermans and Angell 2001). Often standardization practices on a medical ward are exemplified by the usage of checklists to screen patients more efficiently and streamline their care—similar to how an automotive company might streamline its manufacturing process for quality and consistency (Waring and Bishop 2010) Yet, this assembly line approach to patient care can hinder connection in patient-provider interactions (Pugh 2024).

Yet, some inequality scholars point to differences in cultural health capital as the cause of persistent inequality in patient-provider interactions (Timmermans 2020,Van Ryn et al 2006). The leading explanation of these interactional inequities is cultural health capital theory (Shim 2010). Cultural health capital is the set of "cultural skills, verbal and non-verbal competencies, and the interactional styles that can influence healthcare interactions at a given historical moment

(Shim 2010:3).” Shim and colleagues and other cultural health capitalists insist that cultural health capital facilitates open communication and buy-in from both patients and providers where the negotiation of the health encounter can take place (Shim 2010; Dubbin, Chang and Shim 2013; Gage-Bouchard 2017). Those without accumulated cultural capital are simply unable to advocate. However, this vein of research is inadequate to explain the continuing significance of race for middle-class Black women that experience maternal health disparities.

Recently, medical sociologists have considered how emotions influence patient-provider interactions (Gengler 2019; Menon and Sariego 2022). Moving away from previous conceptions of patient-provider interactions that implicitly portrayed physicians' emotions as absent, newer work reflects on how the emotions of providers shape their care (Cottingham, Johnson, and Erikson 2018; Gengler 2020; Seim 2020). Physicians may use emotions as tools in their care for patients leading to smoother interactions (Menon and Sariego 2022; Pugh 2024). Some physicians lean into the realm of emotions to aid in shared decision-making with patients (Gengler 2019). While utilizing emotional labor in their care for patients may lead to higher job satisfaction, however, some scholars allege that it also increases the chance of provider burnout (Larson and Yao 2005; but see Pugh 2024). For example, in a study on paramedics, the author found that “legit” medical cases reinforce paramedics' satisfaction with their jobs while “bullshit” cases disenchant them (Seim 2020). This emotional view of their work through the prism of medical cases illustrates that medical providers are emotionally invested in their work and that in difficult cases their emotions bubble to the surface as they wrestle with their identity as professionals. Considering how emotions shape the emotional dimension of patient-provider interactions suggests that while on the surface what patients and providers say to each other appears clear, the meanings attached to their words on an emotional level can be misunderstood.

The Terrain of Dissonance

Instead, I find that dissonance emanates from the emotional terrain. Exploring the emotional dimension of patient-provider interactions also uncovers emotional misrecognition. As we have seen, women of color are dismissed and gaslit in patient-provider interactions (McLemore et al 2018; Fielding- Singh and Dmowska 2022). Gaslighting and other emotional harms are most prevalent when there are existing power imbalances, especially on the axes of race, gender, or other structural/institutional inequalities (Sweet 2019). Within the emotional dimension, the effect of legacies of medical racism on patient-provider interactions and the resulting power imbalances and 'feeling rules' (Hochschild 1979) is clear. Through considering emotions, we might see how expressed racial anxieties go unaddressed by providers who are not even looking for it, or more precisely, are "colorblind" and therefore utterly unaware (Bonilla Silva 2018). The commodification and standardization approaches to care miss them importance of interactions and the intersubjective meaning-making that contributes to experience. Moreover, the cultural health capital approach is unable to explain the persistence of disparity across class.

In the previous chapter, I explore how providers use various strategies to retain and exert physician authority. I suggest that although they may be successful, that success comes at a cost for Black women who may be using strategies of their own in a quest for racial safety. The clash of their two different approaches to care can be seen on several dimensions including the emotional terrain. At Foxhill, the mismatches between patients and providers were characterized by three dimensions: timing, knowledge, and emotions. These fissures are important places to explore how mismatches shape patient experiences.

"The Clock is Ticking": Timing Mismatch

At Foxhill, hospital time often clashed with the planned schedules of birthing moms. Sometimes this meant that a mother arrived at the labor and delivery unit only to be turned away—a miscommunication of her scheduled time. Most often, however, it was simply a common daily occurrence stemming from the way the unit was organized. One of the many jobs of the charge nurse is to assess the state of the floor—how many mothers are laboring, who will deliver soon and thus move to the next unit, who is scheduled to come in for an induction, or who might come in after the prenatal clinic has closed for the night. The presence of too many birthing women on the floor creates a safety hazard for the babies—will there be enough hands to care for infants if something goes wrong? Managing the flow of patients on the floor is a key concern, and thus pushing back the arrival time of inductions is a routine practice.

At “morning safety rounds,” the attendings, residents, nurses, anesthesiologists, and occasionally the pharmacist discuss the current cases on the floor, staffing, and spacing on sister units. Afterward, the charge nurse then contacts scheduled inductions that need to be delayed. Because the site was a regional hospital, many of its patients came from as far as an hour away. Often, the charge nurse remarked that they were trying to call people before they left their house. However, they were not always successful, and sometimes women were already on their way.

Delaying inductions meant that women often had to make new arrangements to cover their existing responsibilities, often for childcare or other needs. While middle-class women could often bide their time when their inductions were delayed, relying on paid employees or other supports, for working-class women it was much more stressful to rearrange coverage, revealing the more patchwork nature of a precarious network of support. I observed the frustration of one woman who arrived a full day before her scheduled induction. Full-term and wearing a grey t-shirt that did not cover the bottom of her belly, a white-appearing mom raised her voice in frustration outside the triage bay. Accompanied by one support person, she showed the nurse the note on her phone that says she was supposed to be induced that day. Through tears, she described the preparations to be there on that day—coordinating transportation and childcare for her other children. These were now all plans that she had to renegotiate for the following day.

Like the woman outside of triage, Vonne, a 27-year-old Black hairdresser, vocalized her irritation with the charge nurse who called to push back her induction scheduled for 8 pm. While she was able to re-coordinate care for her children to come in the next morning, that meant that her partner had to leave midway through the labor to relieve the support person who agreed to watch the children on short notice. The delay pushed the labor past the nighttime babysitter's availability. While a nighttime induction is not inherently different or better than one occurring in the daytime, Vonne had appreciated its benefits. A support person who agrees to watch children during the night while they are asleep may also be willing to watch them for a longer time than if they were awake. This overnight care would allow a support person to attend to a mother's labor longer, but when Vonne's case was delayed, it made that impossible for her.

Mothers who find themselves without childcare but in labor are also often bound by hospital policy that children under seven are not allowed on the floor. This practice further disadvantaged poor and working-class women whose support systems were already burdened by multiple needs and reciprocal arrangements, and thus did not have the necessary give that could buoy them in a time of need. When in labor with older kids, they often had no other choice but to bring them; in other cases, their support person was absent because they were home caring for older children. During my observations, I saw some nurses bend the policy. Vanessa, a seasoned nurse with over 30 years of experience, occasionally allowed older children to come and spend a few hours on the unit. Vanessa seemed more understanding of the demands of motherhood and the constraints of social support. Newer nurses, however, possibly motivated by career aspirations or without the authority to bend the rules, often enforced hospital policies that limit children and other visitors on the unit, even if it increased the stress of a laboring patient. Hospital time clashed with the prior planning that often goes into birth and was especially detrimental to working-class and poor women.

Hospital time also clashed with the expectations of middle-class women. Simone, a 34-year-old social worker, was disappointed when the nurse called to push back her 8 am induction to a later unspecified time. Simone originally planned to go into labor naturally with her doula. However, a week prior the nurse practitioner at her last appointment informed her she was dilated to four cm—almost halfway to full dilation. This was Simone's third pregnancy and the first time she made it to the third trimester, after experiencing two prior miscarriages. The excitement about the baby's impending arrival began to build and she assumed because of her stage in dilation, an induction would speed the process along, and in no time, she would meet her new baby girl. She was disappointed but understanding when they called to delay her arrival time. However, she had the resources to bide her time and instead opted to go out to brunch. When they did call her in, around 4 pm, Simone arrived on the floor stunningly. She wore a loose brown sundress, gold leaf earrings, and a face featuring carefully blended makeup. Her entourage – including her husband, mother, father, and grandmother – were in tow and had made plans to stay overnight, rotating in and out of her room. It was clear that this was an important day for all six of them, including the baby.

After settling into the birthing suite, a resident came in to check Simone's current stage of dilation so that they could begin the induction. As the resident, a young Black doctor with a short curly afro put on gloves for the examination, Simone explained how she was already four cm at her last appointment and has not been feeling any of her contractions. That was a week prior, so she may have dilated more since then and the baby's arrival closer than what they thought. Simone and her husband waited patiently for the resident to finish his examination and report her current dilation. His assessment? Just "fingertip" or about one cm dilated. Simone was confused, how could she be fingertip this week when she was four last week? Her chart corroborated her story, reporting a 4 cm dilation. But the resident held firm, and he challenged and trumped the previous dilation claim made by the nurse practitioner, signaling his authority over birth. He explained that although she was effaced, meaning the cervix was very thin, the cervix was still mostly closed. To her dismay, Simone now faced a decision. Did she stay for induction from 1 cm or go home and wait until her body spontaneously went into labor and progressed naturally on its own?

Simone originally thought she was progressing in labor without being able to feel her contractions as indicated by the previous 4 cm dilated assessment. Fearing the birth would transpire too quickly and she would not have time to get to the hospital and under the safety of the medical gaze, Simone agreed to be induced at 39 weeks. Confronted with the fact that her labor actually had not started, Simone considered going back home to wait out labor like she originally wanted, but it was too late. Her family and support system were already in place.

Simone's induction raises another common theme amongst women's birth experiences. I found that many women could not disentangle whether the recommended inductions were medically indicated or purely elective. For patients like Simone, being confronted with a medical discourse that suggests you need to hasten your labor and delivery time can be unsettling, especially if they wanted or planned a natural birth. Providers attempt to reorient their priorities by counseling them that ‘they might not have the birth they imagined, but that what matters is that it is a healthy birth.’ But while they use the language of safety to soothe mothers, they impose an industrial model of childbirth time that collides with the unpredictability of women’s bodies.

Hospital time does not account for mothers' personal circumstances or support needs and is almost always out of sync with actual childbirth. Many days the floor is overflowing with birthing patients, causing people like Vonne and Simone to adjust their plans to accommodate hospital time. However, there are days when the floor is mostly empty, and the charge nurse calls in inductions scheduled for the upcoming week to see if they can come in early. While natural childbirth is something that cannot be timed, scheduling inductions regiments the flow of patients onto the floor. The way providers treat patients is analogous to an assembly line—speeding up births where possible and slowing down when one cannot. The disembodied mothers are only carriers of the work, the birth that needs to be monitored and controlled.

“She’s Not in Labor Unless We Say So”: Knowledge Mismatch

Medical providers and patients often clash at the nexus of medical knowledge and experience. One day I watched the unit coordinator, Maggie, manage patient calls to Labor and Delivery and direct them to the triage nurse. As we sat at the desk one day, a patient called and reported that she was in active labor and her contractions were close. When she arrived at the hospital, her behavior aligned with what labor nurses called “singing the songs” or vocalizing with a moaning voice, a behavior many moms exhibit when they are close to delivering. Hearing this call, the charge nurse opted to skip the triage bay and offered to her in a regular birthing suite. Soon a resident emerged to perform an exam on the patient and assess her progress towards delivery. He reported her dilation to the charge nurse—and the rest of us overhearing at the desk—to be only “fingertip” or about one cm dilated.

Hearing this, Maggie was frustrated and said something about not having room for drive-by babies. When I asked what she meant, she explained that she needed to keep labor rooms open in case a mom comes in off the street fully dilated and ready to have a baby. That mom should get a birthing suite and not a triage bed, she thought. Maggie was annoyed and felt as though the vocalizing mom had exaggerated her stage in labor and was then a drain on limited resources, the birthing suites. When the next unscheduled mom arrived at the hospital in labor, I could hear Maggie retort to the triage nurse, “She’s not in labor unless we say so.”

As scholars of medicalization note, physical experience does not become a medical issue until a provider evaluates it as such (Conrad 2007). Diagnosing a body as in labor falls squarely into the realm of physicians’ authority and expertise. For patients in the labor and delivery unit, their concerns were not always taken seriously, until they could be verified by a doctor. The patient’s own assessment of their condition was not to be trusted outright as they could be misinformed or exaggerating. Competing claims to knowledge – and the priority physicians give to their own judgment – can leave many potentially life-threatening conditions hanging in the balance, but also led to an acute dissonance between the patients’ and the physicians’ perspectives.

The women in my study also encountered what I would describe as uneven information sharing. For instance, Vonne, the 27-year-old hairstylist, spoke softly during our first interview. When I asked about her interactions with her health providers during this pregnancy, she responded with frustration, and told me a story. She and her boyfriend had traveled to New York City for a boxing match early in her pregnancy. When it was over and people were leaving the stadium, she heard gunshots, ran, tripped and fell on her stomach. At four months pregnant, Vonne was concerned about the baby and wanted to make sure they were all right. In calling the hospital, Vonne encountered who she describes as a "nosey nurse" who kept asking about the circumstances of her fall: had she been chased? what made her fall? Frustrated, Vonne hung up to prevent harshly criticizing the nurse. "She was pissing me off. It doesn't matter what I was doing, [I wanted to know] should I be worried about my baby?" After this difficult interaction, where Vonne felt the nurse was preoccupied with things other than the health of the baby – asking questions that felt to Vonne like an interrogation into her own behavior or environment – Vonne decided not to go in to the clinic but instead to self-monitor, which meant watching for signs of miscarriage like cramping and bleeding. Ultimately, the medical knowledge she sought felt like it would have come with a hint of judgment, hindering Vonne from further pursuing medical evaluation and treatment.

Other mothers experienced doctors who shared information, but ultimately not the information they were looking for. Recall Raven, whose story opened the chapter. While the doctor's response to her concerns about breathing was reasonable –assuring her that she would be given oxygen – they did not satisfy Raven, who needed a bit more explanation. What was missing was an attempt to assuage her feelings as the emotional level was where her anxieties lay; the clinical truth of oxygen could not reach the terror of not being able to breathe. The response she got from her provider showed a privileging of medical knowledge over her lived experience.

While we might anticipate there to be some discord between working-class patients and their providers, we would expect middle-class patients to have cultural capital that would enable more positive experiences with their providers. However, income, education, and status did not prevent mismatches of severity/knowledge. Lauren, a 37-year-old middle-class first-time mother, prepared baked salmon and roasted vegetables as we debriefed about her delivery experience. In our post-birth interview, Lauren told me that she had a frustrating birth. At 8 months pregnant, she and her husband were vacationing in Atlanta when she decided to get a 3D ultrasound of the baby. This service was marketed by a private vendor to expectant parents as a way to "see" their baby before birth; however, it offered no additional medical value over a traditional 2D sonogram. The sonographer doing her 3D scan alerted her to the growing baby's size and suggested she speak with her providers as the baby was measuring big. Lauren obliged and brought it up to her provider, who originally asked her to email him the scans. Once she had the scan files forwarded to her providers, however, they told her that because the sonographer was not a medical provider, they could not use the scans.

Lauren was confused about why they refused to perform another scan, although she provided proof that it was necessary. But the baby's portentous size was not a medical condition until the doctors said that it was. And for a healthy mother whose 20-week scan was normal, there was no medical need for additional scans. So they refused Lauren's request for subsequent growth scans for the baby.

In our first interview, Lauren had told me she was open to having a cesarean section because her husband was a big guy and weighed 11 pounds at birth. When she heard the baby was big, she was further convinced that a C-section was the best course of action, and wanted one to be scheduled in advance for her. Nonetheless, she did not have success advocating for herself. Instead, she ended up laboring for 39 hours only for the baby to fail to come down the canal, and ultimately, for him to be in distress. After having endured a full course of labor, Lauren was then rushed to the back for an emergency caesarian section. Telling me the story in her post-birth interview, Lauren said what upset her most was that the pain of labor could have been avoided because she had originally been prepared for a cesarean. Her providers encouraged her to labor only to be unnecessarily surprised by the baby's size; her labor ended on the surgical table.

"Something's Going on With Her": Emotional Mismatch

Emotional displays are directly tied to perceptions that a patient in difficult, I learned from Angela, a relatively new nurse practitioner in her first year on the job. As one of the two Black providers at her clinic location, she said, "Patients that are more difficult, they kind of hand them to me. I don't know. But then, they end up not being difficult at all. That's why I don't really bother [preparing for a difficult patient]."

Angela gave an example of a patient with whom she ended up having a great relationship but who was labeled by others as difficult. She told me: "…I remember the nurse came and was like 'something's going on with her. She has some attitude. She was very short with her answers'." On other occasions that I observed, a nurse's characterization of a patient as one "with an attitude" frequently led other providers to be closed off and defensive before entering the exam room. In this case, Angela did find the patient to be short but attributed it to her personality—straightforward—rather than a grumpy or preemptory attitude.

While some people have their attitudes discussed by the nurses, other patients have their bad reputations pinned to a chart. Angela described how patient characterizations were communicated to other providers. "So, we have these little snippet things in their chart, and it talks about if they are a doctor or if they are a nurse or if they are whatever importance to Foxhill in any way. And that is listed at the top for them. And then it also talks about if they've had marijuana use or drug use or needed treatment for chlamydia in the first [trimester]." Previous providers collect these notes and put them in the patients' charts to guide future patient-provider interactions. These notes also shape how providers will provide care.

These notes can often prime providers for a difficult patient. I was on the unit, waiting for Vonne to arrive the day she was induced. When I got on the floor, the nurses were already abuzz with how "nasty" she had been on the phone with Suzanne, the charge nurse from the night before. Vonne was supposed to have been induced the previous night at 8 pm. However, because of spacing on the unit, the charge nurse had to call her to push back her arrival. That call met a frustrated Vonne who voiced her discontent with them on the phone.

The week before, I asked the unit coordinator to confirm Vonne's scheduled induction time with me. As soon as she opened Vonne's chart, a red flagged text box appeared: a note about her being a behavioral concern. The note was from a fall 2020 encounter where Vonne refused to wear a mask at her prenatal appointment. She made a comment that she would "set it off in here" and security was called. Two years later, that interaction followed her into her subsequent pregnancy and birth as nurses braced themselves for a bristly patient. The charge nurse called in a part-time nurse to take care of her, briefing her beforehand that they have some "behavioral concerns".

Yet, after all their preparations for her to be difficult, she was to their surprise, not difficult at all. In fact, Vonne was very quiet and often spoke in a soft voice to her nurses and doctors. I followed Maria, the PRN nurse called in to provide care for Vonne, as she recorded her medical history and began her IV drips. Maria spoke in an optimistic voice to Vonne. When Vonne responded, however, she spoke so softly you had to strain to hear her and she avoided eye contact with the nurse and the providers. Vonne's behavior was so different than what was expected from her chart and the nurse scuttlebutt, Maria asked me if she was always like that—

not speaking unless spoken to. The contrast of Vonne's characterization as a difficult patient and her unit behavior was illustrative of a mismatch, wherein the providers misread her behavior as a challenge to their authority instead of her advocating for herself to be seen by physicians.

In truth, there were only two situations where I saw providers actively consider the emotional needs of their patients: in the cases that end in fetal demise, and in those cases in which they anticipated a difficult patient with a negative emotional display. When a family experiences a loss, called a fetal demise, the grief protocol goes into play. A Black butterfly magnet is placed next their door for providers to see before they enter, a reminder to change one's emotional display and verbiage to match the emotional tenor in the room. The assigned nurse makes sure unnecessary visits to the room do not occur. They provide the family with a cooling bassinet and a hand-knitted hat and scarf set for their sacred time with baby. A chaplain is paged to provide direct emotional support and resources to the family. The nurse or patient care tech prepares a keepsake teddy bear filled with sand to match the exact weight of their baby. Lastly, a grief tray of complementary refreshments is ordered to the room, with a card signed by the providers. In what is one of the worst days of these families' lives, the unit has a system for showing them that they acknowledge their emotions and that they care.

The only other time the unit officially acknowledges the emotions of a patient – and acts in accordance to those emotions – is through their treatment of patients who have received the label of being "difficult." As we see with Vonne, the care for so-called difficult patients is often passed from one provider to another. The day charge nurse wanted to protect her regular full-time nurses from Vonne's potential disruptive behavior, instead assigning her care to an on-call PRN nurse who only works a few days a month. Similarly, in other cases, I saw the care for patients being passed down the totem pole in terms of medical hierarchy—attendings passing to residents, or other care teams, residents passing to nurses, nurses passing to patient care techs. One day I was observing in the doctor's work room as Dr. Taft, a second-year resident, talked about a discharge. In a note left by the attending, it said to check with vascular before she was discharged. However, Dr. Taft did not find any record that the patient had ever been seen by vascular. He noted aloud, this was clearly because the attending did not want to see this patient again, but what was less clear is why they suggested she be seen by vascular. This passing of "the buck" is reminiscent of other work that details how impoverished, homeless and mentally ill people are often passed from one care team to another as teams try to avoid confronting their fundamental needs (Seim 2020).

When patients did have emotional outbursts or showed emotions that went against hospital feeling rules, they were rebuffed. Recall Ariana, the 27-year-old working-class mother who previously bore a baby stillborn. When we met her in chapter 1, she agreed to let me stay for her labor and delivery reasoning the more people on her team the better. After several hours in the hospital, Ariana was finally at the pushing stage of labor when she realized something was off. The physicians called a code PINK—which signals an infant medical emergency and calls available pediatric providers to the room—resulting in multiple doctors and nurses rushing into the room to assist. Ariana screamed from the hospital bed, "Let me see my baby! Let me see my baby! Give me my baby!" while providers continued with several maneuvers to pull Ariana's baby from the birth canal. In a stern voice, the nurse assigned to Ariana took her hand and told her to be quiet; the doctors couldn't hear each other.

The last few moments of Ariana's birth were experienced very differently by Ariana and the medical team. For the medical team, this was a routine case of shoulder dystocia for which the standard procedure was followed. For Ariana however, it was a chilling experience. Although she was weighed down by previous birth trauma shaping how she experienced this birth—and what she sought from her medical team in a moment of terror – the providers handled her with heroic efficiency and clinical empathy.

Conclusion

While patients and providers are each invested in a positive birth, their interactions are often characterized by a significant dissonance. Existing work suggests that commodification, standardization or emotional misrecognition are to blame for that dissonance. However, each of these accounts explains the experience of one side of the interactions – either the patients or the providers.

Instead, I found that the dissonance relies on three kinds of mismatch between providers and patients. There are three recurring themes that illustrate where and how Black women patients and their clinicians talk past each other: timing, knowledge, and emotions. Hospital practices –such as delaying inductions, not acknowledging medical concerns until they can be confirmed by a doctor or labeling difficult patients – stem from organizational priorities that might feel race- or class-neutral, but that have acute racial and class implications. When such practices negatively affect patients, providers are often ill-equipped to respond appropriately.

This mismatch feels almost inevitable, brought about by the clash of their positions that are each so firmly generated by their positionality in these institutions with racialized histories.

This chapter paints a bleak picture of cultural mismatch in patient provider interactions, but this is not always the case. The constrains of racialized and classed policies within the hospital remain—inductions are still postponed and being seen by a physician can often take time—but there are some staff members who are willing and able to connect with patients in a meaningful way. Who are these staff people, and how do they manage to do this?

Chapter Four

AFFECTIVE BURDENS:
CLASSED STRATEGIES OF BEING

Recall Jerrica from chapter one, a Black working-class mother who drove over 40 minutes to Foxhill for care and said of the commute, “it’s where we’ve always gone.” I observed her scheduled cesarean section early one morning. When she and her partner arrived on the unit that morning, she was wearing a short-sleeved camo shirt with “MAMA” written in capitalized letters on the front. We chatted briefly before the surgery as her partner napped. She spoke softly and seemed to consider each word she said carefully. She told me she was afraid of needles, and that concern was at the forefront of her mind leading into the surgery.

A little while later, I joined Jerrica and the team in the operating room as they prepared for the surgery. When I entered, Jerrica was sitting on the side of the operating table with her feet firmly planted on the seat of a chair as the anesthesiologist attempted to quell her fears of the spinal anesthesia stemming from her fear of needles—especially the large one the anesthesia team used. The Anesthesiologist explained the process. First, they would use a small needle to numb the area. Then, after she was numb, they would use the larger, longer needle for the anesthesia medication. He told her that the first injection would burn and feel like a bee sting, but that would be the worst part saying, she “shouldn’t feel any pain or anything” after that.

One of the nurses went over to comfort Jerrica. She alternated between holding Jerrica’s hands and rubbing her leg. The anesthesiologist administered the first medication, the one that was supposed to sting. Jerrica began crying saying, “oww oww oww”. She seemed really scared. A resident physician came over to help the nurse comfort her and was telling her reassuring things. The anesthesiologist followed with the larger needle containing the anesthesia medication. Jerrica complained louder, “Ow it HURTS!” and she began sobbing. The nurse took both of Jerrica’s hands looking her in the eyes and said, “It shouldn’t feel sharp, if it does, tell me left, right or center, okay?” Jerrica did not respond to the instructions through her tears, but shouted out, “Ow!”. “Is it sharp?” asked the nurse. “YES!” responded Jerrica. The nurse asked her where. Jerrica told her exasperatedly, “The right!”. The nurse yelled over Jerrica’s shoulder at the anesthesiologist, “Sharp on the right”. A few seconds later, “Oww that hurts! In the middle!” “Sharp center.” After at least three different attempts, the medication was successfully administered.

Jerrica, however, seemed traumatized and continued to sob quietly to herself on the operating table. During these moments before a major surgery, Jerrica is faced with one of her fears—needles. As she explained to me before, she had always been afraid of needles but the size of the one they would use for anesthesia seemed especially daunting. As her fears were realized—the needle causing pain – Jerrica cried. As she was comforted by a nurse, the providers continued administering the medication through her tears and pain complaints. After they finished, she quietly cried to herself. Although a nurse attempted to comfort Jerrica, she still felt real fear and may have wanted time or even reassurance that she would not be injured or paralyzed by the needle in her spine. Yet what she did was cry and tell them where it hurt her.

In this chapter, I consider the emotional fallout of healthcare where the interests of the hospital and providers and the emotional needs of patients are not in alignment. In particular, I explore the mechanism(s) that shape how Black women comport themselves and interact with whites in healthcare settings. I ask how does class shape the way Black women navigate experiences of racism in healthcare?

RESPECTABLE, ENGAGED PATIENTS

Healthcare as a "white space" also stems from its prevailing cultural ethos. Certain behaviors and attitudes are widely expected of patients that neatly align with middle-class culture, including having cultural health capital (Shim 2010) and being an 'empowered' (Andreassen and Trodsen 2010), 'expert' (Fox and Ward 2006), or most recently an 'engaged' patient (Timmermans 2020). The engaged patient literature indicates that shared decision making, and patient-centered care have become 'best practices' and key aspirations for patient-provider interactions (Légaré and Witteman 2013; Stivers and Timmermans 2020). Certain behaviors and responsibilities are now expected from patients, e.g. self-surveillance, health promotion and disease management (Shim 2010), and an expectation of what others have dubbed an 'engaged patient' (Timmermans 2020). According to Stefan Timmermans, the patient-clinician interaction is now a "negotiation between two unequal parties mutually dependent on each other's collaboration to achieve health (260)." An engaged patient is one that is "*more active in advocating for their health* and ha[s] a greater responsibility to advocate for health" (Timmermans 2020:265, *emphasis* mine). Expecting pushback or ongoing negotiation with patients, clinicians engage in persuasion tactics (Manzar and Bell 2022; Stivers and Timmermans 2020). This vein of research suggests that health providers expect that patients will be invested, involved and even potentially contrary in their healthcare encounter.

On the other hand, research in sociology of race and ethnicity points to an important contradictory cultural dictate affecting Black Americans in particular. This research posits that politics of respectability have long been an institutional strategy used by Black Americans to navigate white spaces and interactions (Barnes 2016; Dow 2016; Grundy 2022; Higginbotham 1994; Malone Gonzalez 2022; Turner 2020). Respectability politics urge Black Americans to adopt white middle-class cultural practices to access social mobility and social inclusion and to abandon social practices that are reminiscent of an iconic Black working-class background (Gray 2016). At its core, "politics of respectability" were strategies of the Talented Tenth to undermine notions of Black inferiority with clear evidence of Black exceptionalism (Higginbotham 1994). Middle-class Black people may use public identities like conventional language conventions, mannerisms and clothing to prevent or lessen the extent of racial discrimination and signaling membership in the middle-class and belonging in a white space (Goffman 1963, Lacy 2007, Lamont and Molnar 2002). Strategies to vie for respectability by explicitly countering "the controlling images" conflict with the demands of the engaged patient, however.

For their part, working-class Black people may teeter between proffering performances of respectability and leaning into stigmatized identities, like the 'cool pose,' to gain respect in white spaces (Jackson 2018; Jackson and Wingfield 2013; Majors and Billson 1993). This research suggests that in white institutional spaces, both middle- and working-class Black Americans will attempt respectable identities to counter negative stereotypes of Black people but with different intentions: the middle-class will seek belonging, and the working-class will seek respect. As Black women continue to have the worst maternal and infant health outcomes relative to other racial and ethnic groups, the intersection of race and class in Black women's experiences is rife with contradictions.

In a white interactional space like healthcare, Black women patients must weigh the benefits and consequences of self-presentation with competing cultural expectations. As engaged patients, they are expected to ask questions, pose alternatives, and otherwise negotiate with their healthcare providers. Yet, politics of respectability dictate that they do not act in ways that are suggestive of the ‘iconic ghetto’ or other ‘controlling images’ like the angry Black woman etc. (Anderson 2022; Collins 2000).

Respondents encountered and responded to experiences of racism in the white institutional space of healthcare. I also found that they faced affective burdens, or racialized emotional directives, that shaped how Black women felt they could comport themselves in the setting. These affective burdens influenced how Black women of all backgrounds navigated healthcare encounters. While respondents across class reported discriminatory experiences in the healthcare encounter, they varied in the strategies available to them to respond, with some strategies widely available, and others mostly used just by the working- or middle-class.

In what follows, I will first explicate what it is like to be a racialized person in a white institutional space. Using participant vignettes, I show how various raced and classed assumptions shape the experience of healthcare for Black women. Then, I illustrate the concept of the affective burden, and demonstrate how it is shaped by the experience of living in white spaces and by real and imagined consequences. Because of these consequences, Black women across class approach healthcare settings with strategies to navigate the raced and classed emotional directives of the institution, that I dub “strategies of being.” Lastly, I review how Black women across class navigated patient-provider interactions using these strategies of being.

LIVING IN A WHITE SPACE

Within healthcare, a racialized institution, Black women across class reported encountering negative judgment from providers. While this feeling is not uncommon for many patients (Derricks and Earl 2019; Fernández et al 2021), the judgments that Black women perceived were often rooted in controlling images (Collins 2000) steeped in racism and classism, such as of being poor, uneducated, undisciplined or on drugs (Sacks 2018). At other times, women felt judgement but were unclear why they were being judged. Experiencing racism was a fact of life for many of the women, one that they accounted for in preparing for and navigating healthcare visits. In this section, I outline how some clinical encounters conveyed common raced and classed tropes facing participants —tropes that then shaped what acceptable behaviors they felt they could exhibit.

One assumption respondents faced is that their providers believed they were impoverished, on government assistance, and uneducated. For instance, Courtney, a 42-year-old program director, gained much weight during her second pregnancy although she was not eating differently. As the pregnancy progressed and she gained more weight, the provider's approach to the unexplained weight gain was to address Courtney's eating habits. Courtney described how she came to realize that her provider was making raced and classed assumptions about her being on government aid.

> And as I was getting bigger, she would say things. She'd examine me and stuff like that, and she was like, 'You're going to have to do something about your weight.'… She was like, 'You got to be careful when you drink all that WIC[8] juice, because that WIC juice has a lot of sugar in it, and it will make you heavier.'

While Courtney did have Medicaid insurance, she was not enrolled in the WIC program, and was offended by the doctor's assumptions that she was unaware of sugar in juice. In fact, Courtney had a PhD; at the time of the clinical visit, however, she was unemployed and in need of short-term assistance, although she was certainly aware of basic nutrition facts. She described this as one example of derogatory comments made by the doctor, and she perceived these slights to be

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[8] Special Supplemental Nutrition Program for Women Infant and Children (WIC) is a federally funded nutrition program that provides food vouchers/subsidies for pregnant and postpartum mothers and their children.

caused by the doctor assuming her education and class background based on her insurance status and race.

> You can tell that she had these assumptions. She didn't know that I had a PhD, she didn't know that I had been to grad school. She didn't know any of that stuff because she never asked me. I'm not one of those people that goes around boasting about it or whatever.

Because Courtney did not talk about her level of education, the providers seemed to have assumed that she was uneducated and poor and treated her as such. For Courtney, this interaction also reflected the lack of patient-provider relationship—that the doctor did not know she had a PhD and would have likely be aware of the sugar in juice.

Other respondents shared experiences of blatant racism and classism with their providers. Amber, a 32-year-old childcare worker who was receiving Medicaid, recalled a visit to the endocrinologist in her early 20s. Wanting to “get her system together” so she could have children, Amber went to the appointment accompanied by her infant nephew she cared for during the day. Describing her interaction with the doctor, Amber said, “He comes in, doesn't even look at me, just says, ‘Oh, well I see you got a baby already, so what you're doing here?’”, his statement signaling to Amber that poor women who already have children did not need fertility services. After explaining that she was babysitting and her care for him was separate from her own desires to “be a mom” and “be healthy”, Amber continued:

> He said, ‘Okay.’ Never looked up from his little pieces of paper in the pile. And then he's silent for about two to three minutes. Nobody said a word and he just comes out and says, ‘Well you know, a procedure like that cost $10,000. Do you have $10,000?’

At this point the provider gathered his things and left—never having examined her nor making a treatment plan. Amber was demoralized by his apathetic response to her health concerns. To Amber it seemed that the first and only pressing issue on this provider's mind was her ability to pay, and because her insurance was Medicaid, he assumed she could not be his patient.

For others, their healthcare experiences were shaped by providers' judgements that they were undisciplined. Melissa, a 36-year-old college professor, gave birth unexpectantly at 33 weeks due to a serious pregnancy complication. During her hospital stay, Melissa found herself annoying the nurses but was unsure how or why.

> I just was constantly, I kept seeming, I kept feeling as though I was not complying, that I was like non-compliant, but I like could never figure out why I was not compliant. I mean, and like my blood pressure wasn't going down, um, that was annoying …doctors, you know?

That the nurses were annoyed with her high blood pressure perplexed Melissa; this is a common condition they must encounter and treat all the time.

Although Melissa herself was ill and recovering in the hospital, she continued to visit her baby several times a day in the neonatal intensive care unit (NICU). As days went on, she could tell the nurses were irritated with her, but she did not know why until the morning she was discharged. Apparently, she had been missing from the floor each time she was scheduled to receive a new dosage of medicine, frustrating the nurses who then had to double back. An exasperated discharge nurse pointed her to the scheduled times written on the whiteboard, times that no one had deigned to explain to her. During her hospital stay, she repeatedly felt like she was not being the patient the hospital wanted but could not figure out why on her own. While not hewing to the schedule could be the mark of an “annoying” patient of any race, being “undisciplined” or “unreliable” is a racist trope that Black and other nonwhite people face, and may certainly have informed their treatment of Melissa.

Of course, we do not know if such a trope informed their treatment of Melissa, but that uncertainty is itself a characteristic of racialized experience. One of the enduring costs of racism is that within white institutional spaces, Black women are never sure if their poor treatment is because of racism or something else. As one participant remarked, “Was it just because of my profile, and I'm a young, Black woman?...Would you have [treated] somebody else like this?” Experiences like these shaped the expectations respondents held for healthcare encounters. In turn, these expectations of experiencing racism shaped how they prepared for healthcare visits. They conjured emotional scripts for how Black women were supposed to act in these spaces.

Affective Burdens

When they struggle with experiences of race, participants face what I call affective burdens, racialized emotional directives for behavior and comportment in white spaces. Participants expected to experience racism, and those expectations were accompanied by an emotional dimension, perceived as racialized emotional directives. Examples of such directives include “the dance” that Black people are at times required to do for White institutional gatekeepers to maintain access to that space (Anderson 2022), racialized feeling rules in the workplace that Black workers abide by to keep their jobs (Wingfield 2010) and “submissive civility” practiced by Black men in the presence of the police to lessen the chance of being arrested or shot (Rawls and Duck 2020).

These affective burdens are often internalized. In expressing their concerns about healthcare visits, many respondents either referred to historical mistreatment of African

Americans, an older relative's poor experience, and/or their own personal experience when they did not receive appropriate care. Those previous experiences reify the impulse to protect themselves via managing their emotions to accord with perceived expectations (Hochschild 1983). Moreover, race and culture scholars note that when faced with racial discrimination, many Black people begin with a "careful assessment" of the situation and the personal costs of response (Feagin and Sikes 1994; Lamont et al 2016). I argue that for Black women, their careful assessment of the situation includes a determination of which emotional directives are at play, and how their emotional displays may be received and acted upon. Words like "perceived" and "internalized" should not be taken to mean that affective burdens are entirely imagined. Instead, there are real and imagined consequences for not submitting to these emotional directives.

Affective burdens hinder agentic emotional displays as the consequences may be severe. For example, Rawls and Duck write about the Black men involved in the racist Starbucks incident in Philadelphia (2020). The men reported being afraid for their lives. If they had tensed up and displayed anger and frustration, that could have triggered a response of state-sanctioned police violence and potentially death. Interpreting the emotional directives of the officers and choosing to respond with "submissive civility" were perceived as their best option for walking out of there physically unscathed.

In the healthcare setting the imagined consequence is most often not receiving proper care. Respondents recounted experiencing racism in healthcare, and some reported enduring inappropriate care as a consequence of that racism. Although most participants did not experience blatant disregard for their welfare while under the care of health providers, given this backdrop, the threat of such treatment loomed large, shaping their experience of and response to the care they did receive. As such, most respondents were careful to avoid upsetting their healthcare provider to prevent poor healthcare.

The threat of harm coupled with a white institutional gaze shaped how respondents approached the healthcare encounter and interactions with their provider. In my research, respondents across social class faced affective burdens generated by their expectations of racism. They navigated those burdens with a variety of responses that sometimes struck to the heart of their everyday lives; thus I term these responses "strategies of being."

STRATEGIES OF BEING

Affective burdens shaped the way women approached interactions with their providers. Women in my study leaned into strategies of being—ways they decided were the best for navigating a hostile environment. These included: mental preparation, reluctant acquiescence, self-censure, care switching, direct confrontation and opting out. Some of the strategies were available to all women, regardless of class, while others were limited by class.

Shared Responses Across Class

Middle-class and working-class respondents shared some responses to affective burdens. For instance, both mentally prepared in advance for the healthcare encounter, although the type of mental preparations was slightly different by class. Similarly, both working and middle-class respondents utilized protective withdrawal when faced with affective burdens.

Mental Preparation

Respondents of all backgrounds reported "mentally preparing" for racism before going into a healthcare space. They were cognizant that race could be a factor in how they were be treated, and before they even arrived at that space, they were steeling themselves to experience racism. For example, Morgan, a 34-year-old insurance claims adjuster, described how she got ready for doctors' visits. "Mentally, you prepare. Even though I'm seeing a doctor that I like today, let me just get my mind right for any foolishness that may occur, is sort of how I prepare for that." Even seeing a provider she liked did not necessarily protect Morgan from experiencing racism, for which she used the gentler catch-all: "foolishness."

She continued: "That's horrible, but not unlike what I would do if I were doing other things, like shopping in a certain store or preparing for a meeting with a higher-up. I feel like that's what I've been trained to do, that's what I do." Black women are trained to expect racism in their encounters with powerful others, Morgan reported; why should healthcare be different? In describing how this was something she would do in other settings like shopping or preparing for a meeting, she identified racial indignities as ubiquitous, and the strategies she would have used to address them were the same. This sentiment was echoed by several middle-class respondents.

The mental preparation for Morgan included anticipating how they might perceive and treat her, and thinking forward to how she might respond. Much of what she described as a mental preparation is reminiscent of a DuBoisan double-consciousness, whereby her preparation for the visit was based on how she thought she would be perceived and treated by White providers as a Black woman. Her expectation of how they would treat her cannot be simply dismissed as entirely conjecture, but is instead based on previous experiences with healthcare providers. While her then current provider treated her with respect, she alluded to other providers who did not. Those prior experiences – in healthcare and beyond – meant she felt she had to be ready for racism, shaping her mental approach to seeking care.

LaToya, a fast-food worker, provided an illuminating example of how working-class respondents prepared mentally for an interaction with a healthcare provider. A year into being prescribed anti-depressants, LaToya reported repeatedly telling her providers that the medicine did not work for her, that instead it made her feel worse. Their usual response to her complaint was to either increase the dosage or tell her it took a while to take effect, LaToya said. As a result, she stopped taking the medication and her depression went untreated.

During this period of impasse with her providers, LaToya remembered how she mentally prepared for a visit, when she expected the doctor to not heed her concerns about medication. “I'll talk to myself on the way, on the bus. I'm like, ‘Yep.’ And I'm going to be like, ‘Yeah. We're going to say this, this, and this.’ And it's always exactly what I say.” On the way to the appointment, LaToya mentally ran through the interaction with the doctor that she expected, crafting her approach to the encounter in tandem with anticipated responses of the doctor. It was a rehearsal of an acceptable script and something we might also see in other domains, like that of student and teacher. But part of this preparation stemmed from LaToya feeling like her doctor did not actually care or was too busy to care that the medicine did not work for her. “And she don't care. They want you just to go. Like, ‘Oh, okay. That's fine? Everything's fine? All right.’ They don't really care though,” La Toya said. As a result, she decided to suppress her reports of her own health situation. “So just tell them everything good,” she said. “They'll have you out there in minutes because they want to get to the next person.”

The fast pace of the clinical encounter and the doctor’s previous dismissal of LaToya’s complaint collided and resulted in LaToya feeling like her provider either did not or could not care about her individual issue. The history of dismissiveness, and the perception that the provider did not care, added to why LaToya practiced what she would say in their brief interaction before they moved on to the next patient.

The fact that respondents discussed mentally preparing for healthcare visits is indicative of the type of emotional interactions they expected to encounter. They expected emotional inequality, with the provider's feelings and emotional comfort prioritized and the patient's feelings and experience diminished. Yet, in order to access healthcare services and good care, Black women had to mentally prepare for what we might consider the emotional fallout of racism.

Reluctant Acquiescence

A second way Black women across class responded to their affective burdens was by reluctant acquiescence, or a push back that remained gentle even when the encounter violated their own sense of what was right. For example, Simone was a 33-year-old social worker who experienced some conflict after her baby was born, although she had earlier predicted that the communication between she and her providers would be smooth in the birthing room.

Recall Simone from chapter 3. I interviewed Simone five months before she gave birth to her first child, when she chatted energetically about her expectations. She was confident that when and if the time came, she would be able to effectively advocate for herself and her needs, she said. "I really have like zero communication issues. As a social worker, I have a lot of experience with like, you know, talking to people about feelings."

Yet, the communication between Simone and her providers was not as smooth as she hoped. Two hours after the birth, the nurse taking baby's vitals alerted Simone and her husband that the baby's temperature was too low. The low temperature could indicate a condition that would necessitate the infant being transferred to the neonatal intensive care unit (NICU). Before making the decision to send the baby to the NICU, the nurse wanted to confirm the core temperature via a rectal thermometer. Yet Simone did not want her newborn subjected to a rectal thermometer and sought alternatives to this intervention.

When I walked into the room, Simone held the baby skin-to-skin while her husband stood at the end of the bed. Seeing me, her eyes widened, and she asked me directly for assistance. “Help me advocate! They want to get a rectal temperature on the baby and I don’t want that.” Simone was clear, she did not want the nurses to insert a cold thermometer into her newborn’s rectum, but she was encountering resistance from the nurses that she did not anticipate. Looking for a strategy that would work, she requested help from me, the researcher, whom she knew was observing on the unit.

I responded in a low but serious and concerned tone. “You can always say no.” At that point, her husband weighed in, saying in a soft voice, “It’s not that deep, we should get the rectal temperature, make sure everything is okay.” Her husband, an engineer by trade, wanted to follow the advice of the professionals by listening to the data; he worked to convince Simone it was best for the baby.

When the nurse returned, Simone ignored her husband and assertively asked if there was anything else they could try before taking a rectal temperature. She offered suggestions gesturing with one hand, “warm blankets on the baby, putting me under warm blankets.” The nurse cut her off and insisted that the only course of action was a rectal temperature. Simone felt pressure from both the nurse and her husband to proceed with rectal temperature checks on her newborn, at this point less than three hours old, although she herself found it intrusive and worried it would be uncomfortable for baby.

After two attempts at swaying the nurse with alternatives, Simone acquiesced. She agreed in a slow, soft voice, “Okay.” Still unhappy, she made soft whining noises as the nurse took off the baby’s diaper and inserted the thermometer; in turn, the baby let out a strong cry. “Aww, it’s hurting her...” Simone whimpered weakly. Possibly not hearing, the nurse continued without any response.

Simone had predicted she would not have any problems communicating with healthcare providers. Yet, when she did let them know her wishes, they were rebuffed, as providers dismissed alternatives. Simone perceived that the risk of not following the directives of the provider was that her baby would land in the NICU. Considering the consequences, her voice and body language shifted from assertive to weak. As the provider continued to take baby’s vitals, Simone’s concerns about it hurting her were ignored.

This vignette certainly embodies the tension between hospital best practices and the worries of a new mom. On the one hand, all parties involved wanted what was best for the baby, although how to arrive at what is ‘best’ was contested. Rectal temperatures are indeed the most reliable measure of core temperature, and having that data was probably best practice for determining whether or not an infant should be escalated to NICU. The nurses likely followed protocol in caring for Simone’s baby. However, there were other ways the providers could have both checked the temperature and attended to Simone’s concerns. For instance, they could have comforted Simone as a first-time mom and explained in greater detail what would happen. Perhaps they could have even allowed Simone to insert the thermometer and/or tried one alternative for a few minutes before opting for its use. Instead, they did not heed nor address her concerns. Rather, they ignored them.

More important for our purposes, however, it also illustrates the impact of the affective burden, that then shapes the responses available for Black women. Simone changed her posture from the assertive refusal of an intervention she knew she did not want to reluctant acquiescence given the consequence of having her baby transferred to the NICU and the unyielding posture of the practitioner (and possibly her husband's input). Although she ultimately consented, her quiet yet persistent remarks demonstrate how she did not agree with the decision but felt unable to fight it. Reluctant acquiescence is an emotional capitulation by women who are unable to give full voice to the angry defiance that reflects how they actually feel.

Self-Censure

Several respondents across class recounted a practice of self-censure when healthcare providers negatively responded to their emotional display. For example, Ariana, a 26-year-old student recounted the final moments of the birth of her second child. After experiencing a stillbirth at 20 weeks with her first pregnancy, Ariana was quite reasonably concerned about bringing a healthy living baby into the world. During the final pushes of labor, doctors called a 'code pink' for a shoulder dystocia[9], which solicited both emergency pediatric and obstetric teams to the room. The flood of additional doctors and nurses into the room petrified Ariana, who had no idea what a "code pink" was, and all the activity signaled to her that her worst fears were being realized. "Like, I was freaking out because, I mean, her shoulder just gotten stuck in that chaotic scene," Ariana said. "It just happened. But then after that, I wasn't able to like see her. Like I wasn't able to hold her."

The doctors called a code and the baby was whisked away, while Ariana lay there unable to bond with baby and unsure if baby was okay. Without immediate skin-to-skin or hearing baby's cry, Ariana said she "freaked out," expecting the worst.

> And when I was like 'give me my, I wanna see my baby, give my baby!' Um, the, one of the nurses was like, '[Ariana], you need to be quiet' because I mean, they were trying to

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[9] Shoulder dystocia is when the baby's shoulders are stuck behind the pelvic bone during birth. It is considered an emergency, but can be resolved with several maneuvers to get baby out safely. In less than 0.4% percent of the time, does a baby die (Dajani and Magann 2014).

> console me normally, but then she was like, '[Ariana], you need to be quiet because they can't hear each other talking.' And nobody was like answering me. So of course, I'm gonna keep going. You know what I mean?"

Although her visceral emotions of terror and anxiety were valid, they were deemed intrusive by her nurse as they impinged on the ability of the doctors to communicate. So, while Ariana acknowledges that they were trying to calm her normally, in that moment no one reassured her that the baby was okay. Instead, her pleas for more information were stifled. The only way to ensure she and the baby received the proper care was to give in to the reigning emotional dictates. She went on to say,

> In that moment I had to be quiet. I had to like reel myself in by myself almost. I had to like, um, I had to put my brave face on just so that they could figure out what was going on. And so that I could try to hear something of what was going on myself.

Recall that this new mother had given birth to a stillborn one year earlier. Her anxieties were neither casual nor unfounded. In response to stonewalling by the healthcare providers, however, she suppressed her own emotional response – "reeling herself in" – to fit in to the emotional culture of the hospital environment. If she remained loud and emotional, the implicit consequence would have been lesser quality care for the baby. For Ariana, complying with their request that she be quiet at the moment felt like the best way to continue to be involved in the birth and understand what was happening with her baby.

Working-class Responses

On the other hand, there were also some strategies that seemed to be off limits to middle-class women and were mostly utilized by the working class. Middle-class women often had classed resources that allowed them to shape healthcare experiences. Without those classed resources, working-class women leaned into other strategies to navigate racism in healthcare.

Defensive Rebuke

Several working-class women discussed ‘telling off’ or ‘cussing out’ providers after experiencing an indignity. A noteworthy example of this comes from one woman’s experience with the emergency department. While participants were asked specifically about reproductive healthcare experiences, at times participants shared particularly salient experiences within other branches of the healthcare system.

Wendy, an unemployed 55-year-old, had brought her daughter to the ER due to extreme ear pain. When the doctor examined the daughter, however, he announced that the pain was caused by an insect in her ear, which he identified as a roach. Wendy was appalled.

She discussed the indignity of an emergency room doctor wrongly diagnosing the pain in her daughter’s ear as caused by a roach. “That just made me feel real bad,” she said. “Because in the emergency room they had other people on the [other] side only drawn by a curtain, which means they can hear everything. And for him to say, ‘A roach.’ That was just so embarrassing.” The fact that other people could hear the doctor accuse them of living in proximity to roaches was humiliating to Wendy. “And he didn't apologize or anything. That's just what he's said, ‘Oh well, it isn't a roach.’ It was a gnat. A baby gnat. And he just automatically assumed it was a roach. And I just flipped out.” If the misdiagnosis of a roach and the cultural assumptions that come along with that characteristic was not enough, Wendy was livid that he did not apologize. In response, Wendy “flipped out”. Like Wendy, several working-class respondents discussed cussing out providers who treated them poorly.

In another example, LaToya sought pain relief in childbirth and would not allow the nurses to place a catheter before administering pain medicine. This annoyed her nurse, and LaToya advocated for her right to receive pain medication. "The medicine wore off," La Toya recounted. "So she was trying to put the catheter in, and I wouldn't let her. I'm like, 'No, you cannot do that. I'm hurting too bad. You got to do something. I'm going crazy.'" LaToya openly protested the catheter before pain medicine, imploring the providers to act because she was in so much pain.

> "And after she gave me the medicine, I kind of calmed down. And she waited a second, but I heard her. I can hear her, and she said, 'That's why...', and she was trying to put a catheter in. And I don't know if she was having a hard time or what, but she's like, 'That's why I wanted to do this before you took the pain medicine.'"

LaToya's insistence on pain management before the placing of a catheter made its insertion harder for the nurse. Although the nurse respected LaToya's wishes, she expressed annoyance with the difficulty of insertion. LaToya understood from the nurse's tone that she had upset her.

> You're mad? Because I was like, 'Well, this is my body.' I remember saying, 'This is my body. You have to do things how I want you to do them. I'm in pain. This is me, and it's your job.' She's like, 'Yeah, because it's easier for us.' I don't care. *I'm not trying to be rude*, but I really don't care at that point. (emphasis added)

LaToya was in the throes of childbirth when she demanded pain medication before being administered a catheter. The decision made it harder for her frustrated nurse to insert the catheter, something we know because the nurse was comfortable verbalizing her own preferences. LaToya reacted to the nurse's suggestion that an easier catheter placement was more important than her pain relief. However, even in that moment of chastising the nurse, LaToya mentions that she is ‘not trying to be rude,’ signaling a continued awareness of the affective burdens in that space. At that point, LaToya still needed valuable healthcare treatment from the hospital staff. While she made clear she was not trying to violate an affective burden, like being rude, however, she was able to be quite forceful in expressing her desires.

Opting out

Working-class respondents were also more likely to discuss opting out, which in this environment meant withdrawing from seeking healthcare all together. Amber reflected on the endocrinologist who walked out of her appointment without examining her or giving her any next steps in her infertility journey.

> I sat there for a good five minutes trying to figure out what just happened, is he coming me back, what's going on? One of the nurses had to come in and get me and they didn't tell me that he was done with me. I cried and I went home and I just never went back. I didn't want to try anymore. He really shitted on me. I just stopped.

In addition to her healthcare need going unaddressed, Amber faced embarrassment and disappointment as the nurses had to inform her the appointment ended. Poor healthcare experiences, like the one Amber had, do not end that day or with that provider. For Amber, her dreams of being a mom were placed on hold as she stepped away from pursuing medical diagnosis and treatment for infertility. Thus opting out imposes very real consequences. However, opting out of healthcare protects working-class women like Wendy and Amber from experiencing further indignities at the hands of healthcare providers who are supposed to help.

Middle-class Responses

While mental preparation, reluctant acquiescence, and self-censure were strategies that were available and utilized across class, middle-class respondents had another option for navigating affective burdens. Because of their middle-class status and resources, they were able to switch provider and even healthcare systems. This option was not always available to working-class respondents whose choices for healthcare were often stymied by location and insurance constraints.

Consuming Choice

Consuming choice was a middle-class response where people pull away from their health provider or practice and move their care elsewhere. Recall Courtney, the PhD whose provider assumed she did not know the sugar content in juice. That interaction led Courtney to seek care from a different provider, one whom she felt could better understand her and not preemptively judge her based on assumptions. Her response is a classic example of withdrawal for middle-class women who have the resources to easily switch healthcare options. In a joyful turn to her story, she told me her new doctor sang Barry White during the final pushes of labor.

Through various strategies of being, Black women navigated the white space of healthcare. In their decisions to self-censure or reluctantly acquiesce to providers recommendations, we can see the weight of affective burdens shaping how they handle interactions with providers. Yet for some, defensive rebukes, opting out, or consuming choice were preferable alternatives to enduring racially fraught interactions with their providers.

Conclusion

Within white spaces, Black and other people of color are prompted to perform emotional labor that upholds the primacy of whiteness as a condition to remain in the midst of environments that are often well-resourced. This chapter builds on existing research that details how white spaces maintain a culture of whiteness and research, by examining the emotional fallout of Black people who traverse these spaces and contributing a mechanism that connects institutional culture and emotion management. The theory of affective burden allows us to conceptualize emotion directives—internalized and external—as the connection between competing cultural expectations in a space and the emotion management and subsequent behavioral comportment of women. Affective burdens shape how black women feel they can and should comport themselves in white spaces, for safety and for continued access to resources.

The competing expectations clinicians have of black women – including the ‘engaged patient’ as well as ‘controlling images’ like angry black women, welfare recipient or undisciplined women – act as conflicting cultural frames to which the women feel they must respond. These competing cultural dictates, coupled with the call for respectability and the imagined consequences for responding inappropriately, form affective burdens which stymie the way that Black women comport themselves when they encounter racism in interactions.

In practice, affective burdens shape women’s experiences with healthcare differently. Working-class Black women respond with defiance when faced with racism in interactions—by “cussing out” and “telling off” their providers and opting out of healthcare—actions that in the short term ensure their dignity and secure respect for themselves in the moment. Unlike working-class women, however, middle-class women did not describe using a defensive rebuke strategy with their providers. Many expressed being agitated or “pissed”, but none confronted providers in the same way as working-class respondents. This finding is in line with what we might expect given the demands of respectability politics (Malone Gonzalez 2022) and suggests that middle-class women then are constrained from using all of the strategies of being at their disposal. Because of their access to resources, middle-class Black women are often able to secure positive healthcare experience through consumption, however. Nonetheless, it is unclear how using consumer power instead of two more defiant strategies available to working-class women – defensive rebuke and opting out – shapes middle-class women's sense of dignity and retribution.

The concept of affective burdens contributes to the literatures on racialized organizations and racialized emotions as it offers a key mechanism in connecting institutional cultures to the performance of racialized emotional labor. Moreover, considering how racialized others must confront multiple competing directives in white spaces builds on literature to further explicate the monstrous emotional toll of everyday racism. The next chapter considers the actions of a few providers who patients describe as cultivating a positive patient experience.

Chapter Five

TALKING OVER THE CURTAIN: HOPE FOR PATIENT-PROVIDER INTERACTIONS

One day in a recent fall, I observed an unusual exchange between a patient and provider during a cesarean section surgery. Rochelle, a 38-year-old Black mother of two invited me to attend the scheduled surgical birth of her son. I obliged and arrived early on the unit to slip on a 'bunny suit' protective overgarment over my street clothes and shoe covers before the 8 am procedure. Outside of the operating room, an assisting surgeon carefully scrubbed her hands, wrists, and forearms at the handwashing sink. Inside the operating room nurses, a scrub tech, and the anesthesia team laid out their instruments and materials as they prepared for the surgery. When I entered, Rochelle was sitting on the operating table and leaning forward over a chair where her feet – in fuzzy, mismatched black and grey socks – rested on the seat before she was being anesthetized. She seemed a bit nervous and reserved as Dr. Ira Moorehead, a resident physician, stood behind that chair and held Rochelle's hands as he comforted her before the surgery.

As the surgery began, a thin blue surgical drape at chest level separated Rochelle, her husband, and the anesthesiologist from the surgical field. On the other side of the curtain, Dr. Moorehead was the lead surgeon and donned a blue shark-patterned surgical cap. He and a surgical tech who handed him instruments on command flanked the left side of her abdomen. Two physicians and an observing medical student flanked her right. The surgery ahead of them was relatively intricate. Scar tissue from a previous surgery complicated their approach. Instead of making a low transverse incision done in 98% of cesareans, they would instead make a vertical incision, which is commonly known as a classical cesarean section (Patterson et al 2002). Classical cesarean sections are more difficult and less common. This was also an unintended pregnancy for Rochelle as she was using an IUD implant for birth control—a device that had gone missing since she found out she was pregnant. After the cesarean, the team would perform a bilateral tubal ligation which removed part of each fallopian tube as permanent birth control. Lastly, they would try to locate and retrieve the missing IUD device that could be implanted in the uterus. This surgery which involved multiple steps and procedures would take time.

Over an hour into surgery, Dr. Moorehead and his team continued their work, having already delivered a healthy baby boy, when Rochelle called out to Dr. Moorehead. Her amplified words seemed to go up and over the surgical curtain and into Dr. Moorehead's ears. "Ya'll found the IUD yet?", she asked. "No, not yet", Dr. Moorehead responded back to her from over the curtain.

What may seem like a simple of act responding to a patient's question was actually quite extraordinary. It was rare to see conversation across the curtain, typically two conversations emerge—one between the patient, her support person, and at times the anesthesiologist, and the other amongst the surgeons, nurses, and surgical tech. However, their conversation across the curtain signified a deeper relationship and trust between Rochelle and Dr. Moorehead, a relationship that improved her experience of healthcare. How was this relationship feasible? This chapter explores positive patient-provider interactions for the ways that physicians have been able to build rapport and relationships with their patients despite waning physician authority and organizational time constraints.

FROM SUSPICION TO TRUST

I first met Rochelle one week before her scheduled cesarean in the hospital room she had called 'home' for over five weeks. The previous month, she was admitted to Foxhill's antenatal ward for uncontrolled blood pressure and diabetes. The preexisting conditions placed her and her baby at an increased risk which necessitated full-time medical observation and medication to control. When I joined her one afternoon, she sat on the sofa and get-well cards aligned the window ledge behind her. She pointed out a whiteboard in her room where a nurse wrote with an expo marker "Almost there! One week until 33 weeks!" She and the medical team were counting down the weeks until her scheduled surgery and her impending departure from the hospital.

Despite the purported medical risks to her and the baby, Rochelle had long wanted to leave the hospital against medical advice. A Foxhill City native, Rochelle also worked at Foxhill Medical Center where she registered patients in the emergency department for over 18 years. Despite her enduring relationship with the institution, she was skeptical of the maternal healthcare she received. At the core of her desire to leave the hospital during this pregnancy was a mistrust of the hospital's maternity ward because of her previous care experiences with them.

Two particular issues shaped her previous maternal healthcare experiences at Foxhill: a lack of communication and a lack of empathy. Rochelle recalled the birth of her daughter five years prior in a cesarean delivery. She was accompanied by her husband, a mechanic by trade, who sat beside her during the surgery. After their daughter was born, he left the surgery early so that he could retrieve their oldest child from the school bus. Both she and her husband assumed that everything was fine and that the remaining steps in the surgery, to stitch her abdomen back together layer by layer, would go smoothly. Rochelle experienced complications, however, and was placed under general anesthesia for the rest of the procedure. Hours later, she awoke alone in a hospital room with a scratch on her face and bruising on her legs. To her dismay, no one had called her husband to disclose her complications, and family members who called the hospital to check on her were also not informed. Rochelle tried to make sense of what happened to her and inquired of a doctor where the bruising and scratches came from, asking if they had dropped her. Medical providers dismissed her concern and denied dropping her or otherwise mishandling her body while she was under anesthesia. Yet, her bodily experience and their account were incongruent and led to her mistrust of Foxhill maternity care providers.

Her previous care team failed to inform her family of her worsening condition during surgery, failed to communicate a clear explanation for a scratch and bruising, and failed to demonstrate empathy when she questioned the bruising. Luckily, however, the previous physicians she mistrusted were “long gone” and the new team treated her very well. Rochelle compared the information-sharing with the current team to the lack of communication with her last birth. Dr. Moorehead was the first person to explain to her what happened during the surgery and why they planned to perform a classical cesarean. From a family of doctors, he frequently wowed his coworkers with his medical knowledge and self-confident swagger. He was the provider who actually sat down with her and explained what all occurred in the previous cesarean section that resulted in her being put under general anesthesia and waking with unexplained injuries. Although the scratch and bruising were not in the post-operation report in her medical chart, he was also able to explain why the medical team wanted her to remain in inpatient care and had scheduled a classical cesarean for 33 weeks’ gestation. The anticipation of scar tissue shaped the providers' decision to perform a classical cesarean section and they wanted to perform it earlier to decrease the chance of uterine rupture (Kan 2020).

During one of Rochelle’s attempts at leaving against medical advice, Dr. Moorehead took the lead and made several appeals to convince her it was in her own best interest to stay. Dr. Moorehead was able to connect with Rochelle in a way other providers had not, not only convincing her to stay but persuading her that staying was the best option for her and her family.

Building an ongoing relationship and the trust that it entails, Dr. Moorehead frequently visited her and carefully explained medical concerns. Rochelle told me that even though they were from different backgrounds, they got along really well. In her account of her extended hospital stay and this pregnancy, he was the hero.

Empathy that does not need heroes

More than the sum of any individual provider, I also observed the whole unit come together on cases to provide time and space for exceptional patient care. One such case involved a member of the labor and delivery team. Kelly, a short southeast Asian who frequently wore her jet black hair in a messy bun, was a labor and delivery nurse who had worked on the unit for over 12 years. She became pregnant with her first child during my fieldwork. Kelly was a valuable source of information and leadership on the unit as she was tasked with coordinating the training of all incoming nurses. In fact, during her pregnancy she was singlehandedly onboarding 13 new nurses to the floor—a tremendous responsibility but ultimately a favor to the unit's management and her longtime friends. Usually, she only worked one day a week on the ward as she taught nursing at the university the other days of the week. However, she picked up more hours to help the unit. As a pillar of the nursing staff, Kelly welcomed me and answered all of my questions about the unit and maternal care and often shared her concurrent prenatal experiences. As her pregnancy progressed, I listened as she explained her choice of providers including a Foxhill physician with whom she had become friends over the years. Kelly really trusted this provider who also came into triage one day to review Kelly's labs with her. As an experienced labor and delivery nurse and someone with obstetrician friends, Kelly was one of the last people I would expect to experience pregnancy complications.

When I arrived on the unit one morning, it seemed very tense on the unit as people worked with more urgency than usual at 8 am. It was then that I found out Kelly had gone into early labor, and they had been unable to stop the labor from progressing with medication. The baby was also showing signs of distress on the external fetal monitors. It was clear that Kelly would give birth to a premature baby born at 34 weeks' gestation and the team decided it was best to deliver the baby via cesarean section. The gravity of this maternal outcome seemed to weigh heavy on the team—an outcome they try to prevent in their patients was now happening to their friend. The unit, however, rallied together to provide Kelly with the best patient experience possible. Kelly's longtime friend and obstetrician came in on her off day to be the lead surgeon on the cesarean. I watched as this physician scurried onto the floor from the back door in her street clothes and within minutes went back into the operating room wearing surgical scrubs and other protective gear. Kelly's best friend who happened to also be the nurse manager handled a few patient care concerns on the floor before throwing a bunny suit over her professional attire to serve as the baby's nurse in the operating room after he was born. She would be the one doctors handed him to immediately after birth and would help the NICU team evaluate the premature infant.

At each step of Kelly's labor and delivery on the unit, her colleagues worked together to give her the best experience possible—whether it was her friends stepping in to care for her and the baby in the operation room, or the unit coordinator who reserved the largest room for Kelly and her family. They demonstrated a level of care for her that did not suggest there was one hero going above and beyond, but that the unit as a whole had the capacity to provide patients with exceptional care.

Rochelle and Kelly's care experiences on Foxhill's maternity ward are clear examples of excellent medical care and healthcare experience. Their care teams seemed to go above and beyond for them. In chapter three, I explored how emotional misrecognition led to poor patient-provider interactions and ultimately patient experiences. In this chapter, I argue that what improved the experience of healthcare for Rochelle and Kelly were relationships and their impacts on the emotional dimension of care. In what follows, I consider the essential components of this type of quality care including 1) treating their patients like members of the care team, 2) providing continuity of care, 3) person-centered care, and 4) authentic empathy.

Members of the team

One-way providers make their patients feel comfortable is by treating them like part of the team. Kelly was already a part of the labor and delivery healthcare team and her associates rallied around her labor and wielded support in myriad ways. They displayed a sense of community and she was included in her own healthcare decisions. This is an ideal type of healthcare that all women should receive regardless of employment or prestige. There are two fundamental ways providers can help their patients feel as part of the team—sharing knowledge and attending to emotional concerns.

An essential part of being on any team is sharing knowledge and information. Although Rochelle was a Foxhill employee during the earlier cesarean with her daughter, she was not treated as part of the team. As I have seen the unit similarly rally around the care of doctors or doctor's wives from other units in the hospital, I suspect her positionality as a registrar on the first floor and the limited prestige it offered did not translate to prestige and team membership on the obstetrics floor. However, in this pregnancy, Dr. Moorehead included Rochelle and made her feel involved in her care and centered her decision-making power as he worked to convince her to stay. Reviewing her health history and home life, Dr. Moorehead explained why the team thought, and he concurred, that she should stay as an inpatient until her son was born. He highlighted the medical risks of her returning home and her diabetes and blood pressure returning to uncontrolled states. More importantly, given her previous experiences, he walked her through the plan for the upcoming cesarean section and promised to be there, even if it was his off day. Dr. Moorehead's inclusion of Rochelle in medical decision-making and promise to be there for her even on his off day set the stage for a positive birth experience for her, even if it included a challenging surgery.

Like Michelle, other participants also felt it was important to know what happened or would happen to them. Those who feel Black women's questioning of providers' actions and choices as an attack on their authority, engage in a fundamental misreading of women who want to make sure that they are receiving appropriate healthcare and not be dismissed or forgotten about. This assurance is even more important in the context of national and local histories of medical racism where Black people are rendered inappropriate treatment. Furthermore, clear communication is a cornerstone of positive patient-provider interactions. Doctors like Ira Moorehead were clear in their communication with patients and that made a natural bridge of trust between them. As other scholars can attest, clear communication increases patients' adherence to treatment plans and can have a positive effect on their future health behaviors (Street, Gordan and Haidet 2007; Lerman et al 2007).

Continuity of care

Another way providers care for patients is through continuity of care. The unit was able to smooth over a particularly difficult labor and birth for Kelly by bringing in people with whom she had an on-going care relationship. The doctor that she chose came in on her off day to lead the cesarean and deliver Kelly’s son. The birth of Kelly’s son, although unexpectedly early, is marked by the presence of consistent care partners. In contrast to team-based approaches to birth where whomever on call delivers the baby which can feel like an assembly line, continuity of care embraces the personal significance of birth. Some doctors are able to convey a personalization of care with patients, increasing their satisfaction.

One day I shadowed a provider in a rural area, a Dr. Heather Evans, an older white woman with long greying hair and gold wire-rimmed glasses. The rural community clinic was housed in what used to be a carpet warehouse, and according to clinic lore had a tendency to flood after heavy rains. The clinic was set up with two major hallways on which different medical services shared clinic rooms, albeit on different days. Every Thursday, Dr. Evans, a nurse, and a rotating nursing student cared for 10 obstetric patients. Using a high hallway counter to set up their two laptops—one for the Foxhill electronic medical record system and one used by the community health clinic—Dr. Evans and her small team stood to chart between rooming patients and draw labs. The small group of dedicated practitioners tag-teamed caring for patients, the nurse rooming the patient, the nursing student collecting urine samples, the doctor seeing the patient, the nurse or assistant cleaning and flipping the room for the next patient—all on a hall of five medical rooms. Using two different electronic health record systems slowed them down and required that the doctor prepared for the patients she would see at home.

This continuity of care also meant that providers made themselves available to patients. I first came to shadow Dr. Evans because of her reputation amongst nurses on labor and delivery at Foxhill. They told me that she was the obstetrics provider at the women’s prison and the only provider out in the county. Therefore, for a large swath of women, she is their sole provider.

Some women, like Alexis, a Black 28-year-old student, told me she enjoyed seeing Dr. Evans as she has been her obstetrician since she was 18-years-old. As it was a small town, Dr. Evans knew her family and had delivered her older daughter. Having a personal relationship with the provider made everything better, she said. Although Alexis was nervous as she neared the end of her second pregnancy that a complication might arise necessitating a cesarean, she was comforted by the idea that Dr. Evans would be a familiar resource. In her previous experience, if she called the clinic with a pregnancy concern, Dr. Evans would call her back, personally.

The personalization moms get from continuity of care harkens back to the fact that for women birth is a special occasion, a high-risk ritual of motherhood, not just an everyday procedure. Having a provider who is there from positive pregnancy test to the actual birth was important to some women in completing that ritual from beginning to end. For these women, birth was an intimate experience, and they wanted to share it with someone close to them.

Other scholars have found positive outcomes from continuity of care. It improves the quality of care, decreases hospitalization and emergency department utilization (Cabana and Jee 2003). Continuity of care creates opportunities for relationship building which then translates into women of color being more satisfied with their care (Altman et al 2020).

Person-centered Care

Recently scholars have considered what it means to center the whole person in patient-provider interaction. As opposed to patient-centered care, person-centered care considers what gives a person a meaningful life over a functional life (Eklund et al 2018). Person-centered care can improve people's lives and are integral to building trust and mutual respect (Altman et al 2020). Physicians who recognized their patients’ emotional needs also often provided person-centered care.

As a long-time physician to Alexis, Dr. Evans knew that she had difficulty procuring childcare but that as a single mother, it was important to Alexis that she always be able to care for her infant. As I observed Dr. Evans in the community clinic before Alexis arrived, she showed me a small package of butterfly stickers that she brought from home for Alexis's daughter. Dr. Evans told me that Alexis brought her daughter to every appointment. So when she sees her name on the schedule, she plans to also see the little girl and tries to plan accordingly. As many women that are pregnant also have young children at home, this approach to patient care makes sense. The stickers can occupy a child while the doctor cares for the mother. The stickers also send a message that for patients that need to bring their children, they are welcome to come. For Alexis, the inclusion of her daughter and during the visit added to the personalization of care and her satisfaction with Dr. Evans and the clinic.

Some doctors also consider what it must be like to be the patient and try to make it easier on them. For example, Rochelle told me about how when Dr. Moorehead comes to visit her he rubs her feet. She said, "I don't know if he was checking for swelling or not but he rubbed my feet; made me feel good." If we consider what obstetricians do—treat conditions and monitor pregnancies—it is highly likely that what Dr. Moorehead was doing for this patient with a history of high blood pressure recently controlled was to check for edema or swelling in her legs or feet. Some providers may do this by observation only, or by touching the patient's legs and feet to assess edema. That Dr. Moorehead took this examination a tiny step forward by rubbing or otherwise massaging Rochelle's feet was interpreted by her as an act of care.

Authentic Empathy

Positive patient-provider interactions were also characterized as those that contained a seemingly genuine emotional connection. At the core of racial safety concerns is the worry that providers do not recognize or relate to the person's humanity and that they would not extend to them the same level of care that they would a white person. When providers displayed what seemed to be a genuine emotional connection with the patient, the act went far to support the interaction.

Celeste, a Black 30-year-old sales manager awoke in the wee hours of the morning at 34 weeks and 6 days weeks pregnant feeling like she had wet the bed. Confused, she changed her clothes and went back to sleep. However, when she was again wet when she awoke the next time, she was lucid enough to realize she was leaking amniotic fluid. She was scheduled for a prenatal appointment that same day, and after speaking with the triage line was counseled to avoid strenuous activity at least until her appointment later that day. Celeste described her pregnancy up until that moment as "chill" or otherwise uneventful. She said because her pregnancy had been so "chill" that her doctor, Dr. James Townsend, widened his eyes when she reported the leakage.

Hearing her concerns, he made care plans with Celeste. He would perform a full workup including a litmus test of her fluid. If it were blue, that signaled amniotic fluid and she would immediately go to labor and delivery for evaluation. However, he expressed his optimism that she and the baby would be all right as she was already 34 weeks and 6 days. But to be on the safe side, she would be evaluated and possibly on bed rest to give the baby more time to develop. After she was checked out at the hospital, Celeste was admitted and placed on bed rest until she reached 36 weeks' gestation.

Nearly a week later, Celeste's water fully broke and providers gave her Pitocin to speed the labor along. Dr. Townsend happened to be working in the clinic that day and was called in to assist on her delivery. When he entered the room, Celeste recalls the first thing he did was give her a high five to celebrate their plan coming to fruition. She said, “He comes in, takes off his watch, keys, phone, puts it aside. He comes over, high-fives me, he’s like ‘all right. We started it, let’s finish it. Let’s get this baby out.’…and then after about an hour, we had a baby!” Celeste was able to delay labor by five more days which gave the baby more time to develop. Then at 35 weeks and four days, Dr. Townsend delivered a healthy, tiny baby girl followed by the afterbirth.

The sonographer who documented Celeste’s ultrasound during her inpatient stay had mentioned that her placenta made a heart shape and the physician would need to be sure to remove it all. Celeste recalled the afterbirth saying, “it was terrible…that sucked… it hurt so bad”. Dr. Townsend manually pulled out pieces of a fragmented placenta which was painful to Celeste. However, he returned the next day to check in on her and apologize. She recalled him saying, “I’m so sorry, but like if I didn’t get it you would have hemorrhaged. I didn’t want to have to go to surgery.” Although the extraction of placenta was painful, Dr. Townsend’s apologetic approach to her care smoothed over the unpleasant interaction.

Cases like Celeste suggest that positive patient-provider interactions are not limited to positive outcomes. Yet instead, it is the relationship that covers the experience and its interpretation. Providers tend to emotional wounds and feel with their patients, even if it hurts.

Costs of Talking Over the Curtain

While some Foxhill providers used strategies such as making patients feel like members of the team, continuity of care, person-centered care and authentic empathy, their actions came with a cost. For example, Dr. Evans was always running behind on her schedule. Although she worked hard from patient to patient, if a patient presented with a condition that took longer than the allotted 15 minutes she has, she nonetheless spent the time. It is unclear if her lengthy patient appointments would be tolerated by healthcare administration at one of Foxhill’s clinics where providers report seeing up to 40 patients a day in 10-minute slots. However, at the tiny community health clinic located 45 minutes from Foxhill Medical Center where she is the only obstetric provider, she is afforded more leeway.

Recall Stephanie, the nurse from chapter two who was reprimanded by an attending physician for telling a patient that Pitocin was optional. In turn, the attending offered to roleplay common consent scenarios. The following month, Stephanie was denied a charge nurse leadership position that instead went to a nurse with far less experience than her. Stephanie felt that her personable care for patients was not appreciated and was even reprimanded by her peers on the unit. In response, Stephanie resigned and took a nursing faculty position at a nearby nursing school.

Recall Dr. Moorehead, the physician whose ability to talk across the curtain opened this chapter. I met with him briefly before Rochelle's scheduled cesarean section. Running into him in the hallway, I suggested that Rochelle was looking forward to him being there. He sighed and said that he actually had not been planning to come. However, another physician mentioned to him Rochelle was looking forward to it. As a resident physician, he was anticipating his personal off day. However, he gave up his off day to be the hero Rochelle thought he was and ultimately reinforced an ideal *connected heroism* where providers accomplished an altruistic self through building relationships with patients. However, it came with a steep cost of personal rest.

As costs accrue to individual providers that provide this type of care, why do they continue to do it? I posit that these providers continue to provide this level of care as it accomplishes connected heroism. The burgeoning demands of hospital corporations as businesses consumed with the bottom line characterized by a shortened amount of time with each patient on their growing caseloads demand efficiency but that also comes at a cost: the provider's satisfaction with themselves, ultimately looking in the mirror and seeing a hero look back. I suggest that connecting with patients on the emotional dimension is one way physicians push back on the hospital dictates.

Conclusion

I find that positive patient-provider interactions have relationships in common. For patients who reported or even lauded their experiences with healthcare providers, this satisfaction hinged on a personal relationship. Above I have argued that providers enact four different levers of care that build relationships and trust with their patients. They make the patient feel as though they are a part of the team, provide continuity of care, patient-centered care, and are empathetic. Through these approaches to care, physicians enact *connected heroism*. These actions which represent a relationship between the patient and provider smooth over what could otherwise be a poor healthcare experience, as in the case of the physician's manual removal of the placenta.

However, these relationships with patients instead forge bridges of trust that quell the racial safety fears that a provider will withhold treatment or otherwise harm them because of race. Relationships tamp down racial safety fears and lead to more positive healthcare experiences.

CONCLUSION

Recently, I presented the findings of this research to the obstetrics department at Foxhill Medical Center during their monthly ‘Grand Rounds’ where they hear cutting-edge research about patient care. The medical director helped me set up my slides and adjust the mic while we waited for attendees to arrive. There seemed to be fewer participants than he expected at 8 am as he waited a few minutes before introducing me. Perhaps they wondered what they could learn from a sociologist to improve their medical practice. Looking out into the sparse crowd of doctors and midwives, I recognized a few familiar faces of people whose stories and experiences working on labor and delivery contoured the content of this dissertation. It even seemed as if one of the residents was recording, perhaps to show to other resident physicians who were unable to attend.

After the talk, I received only a few questions from attendees. However, one question was asked multiple times and in different forms: how can they, as individual practitioners, improve clinical care with patients now? How could they improve their practice without changing hospital policies? How could they transfer rapport to a colleague if they held a strong rapport with a patient? Each of these questions, at the core, presumes the answer to improving Black maternal health outcomes lies in the practices of individuals and the reception of care by patients. Their preoccupation with improving patient care without systemic organization-wide policy change indicates the compounding and sometimes conflicting pressures providers are under: to treat patients like consumers while providing them with efficient, evidence-based, and patient-centered care. These pressures, which I have outlined in the dissertation, affect how physicians approach patient care while retaining physician authority.

The second substantive question physicians asked inquired how this research is about race or how it speaks to Black maternal health disparities. Although an important question, it further suggests a distance from providers' understandings of the social forces shaping Black women's experiences of maternal healthcare. In the contemporary moment, the United States faces an on-going Black maternal health crisis where Black women regardless of income and education fare far worse than white women without a college education (Miller, Kliff and Buchanan 2023). Current explanations of the maternal health disparity blame Black women's pre-existing health conditions, advanced maternal age, and the implicit bias a of few practitioners for the rising trends in maternal healthcare disparities. As discussed in chapter two, physicians are oriented towards a technico-scientific conception of risk which prioritizes an epidemiological approach to the statistical probabilities that Black women will experience certain health conditions. As I center Black women's conception of risk, and racial safety in particular, I offer a different framework for risk, one that is grounded in a sociocultural conception of risk that prioritizes the dangers of racism.

A sociocultural conception of risk may seem unscientific or trivial to medical providers who see themselves through a lens of heroic efficiency and as altruistic providers and heroes who save patients from real medical risks. Yet while I agree that the social determinants of health and weathering approaches capture vital population-level data about etiologies of disease, these determinants hold true for many segments of the U.S. population—across race, and by class, e.g. in the obesity epidemic. However, racial disparities remain across class which suggests that a racial structure contours Black maternal health outcomes. Instead of focusing only on implicit bias and how the actions of a few can affect the health of many, I have instead focused my attention on the interaction for clues to solve this tragic mystery. I found an emotional dissonance between the approaches of patients and providers to the interaction. Exploring this dissonance has revealed important mechanisms of inequality and the experience of it in healthcare.

I have argued that physicians understand their role as health providers through a heroic efficiency frame. As expert physicians, they are the only group that has the knowledge and tools to treat pathological cases of birth. When complications arise, they utilize medical science to save the lives of mothers and their children, which means that their interactions with patients are at times brief—when charged with such an important task, supervising risky births, physicians need to exercise their professional judgment and make the correct calls that save lives. Using a heroic efficiency frame to understand the doctor's orientation toward their work provides us with clarity on how they justify their actions. And, as evidenced by the questions of physicians at the grand rounds, we can understand how physicians may want ‘quick fixes’ or individual practitioner-level suggestions for improving the care they provide as it could both improve patient satisfaction and maintain their authority. I am skeptical of quick fixes providing actual change and improved care for Black women patients, as much research demonstrates that workshops on implicit bias and culturally competent care have little to no effect on healthcare disparities (Vela et al 2022).

Instead, as I have demonstrated here, pressures from hospital organizations to provide care according to efficiency and consumer logics leads physicians to care for patients in ways that perpetuate their authority. In particular, this assertion of authority by medical providers in white institutions places additional stress on Black women patients who balance self-advocacy with affective burdens and attempt to make the best health decisions for themselves—important decisions that likely exacerbate weathering.

Moreover, I have found that quick fixes or other efficient approaches to healthcare and maintaining physician authority exacerbate Black women's racial safety fears. Borrowing from sociologists of family, I extend the usage of a racial safety frame to encompass the actions Black women take to prevent experiencing obstetric racism. Black women face local histories of medical racism, poor prior health experiences, and national media coverage of growing Black maternal health disparities. I chronicle some of their actions that can be regarded as racial safety tactics including choosing an advocate, preparing to advocate for themselves, and choosing a hospital. What I have described as the mismatch between patients and providers has an impact and influence on the emotional dimension and shapes how Black women experience healthcare; furthermore, it shapes their adherence to medical treatments and follow-up care.

This dissertation builds on racialized emotions and patient-provider interactions literature by demonstrating how the emotional posture of patients and their physicians shape the experience and outcomes of healthcare interactions. Furthermore, I bring an ethnographic lens to the study of inequality as I have been able to explore how the different conceptualizations of care held by patients and providers interact under efficiency and consumer logics, shaping the experience of care by class and across race. I argue that in order to address the growing Black maternal health disparities, we must first consider how healthcare inequalities happen and are perpetuated at the emotional level and through interactions. Addressing these emotional inequalities could improve maternal health outcomes through improved patient-provider relationships.

Healthcare implications

The findings of this dissertation point to several implications for the provision of healthcare. Neglecting the emotional terrain of patient-provider interactions, or more specifically ignoring the racial safety needs of Black women patients contributes to preexisting medical mistrust. Without trust in the healthcare system, some women consider not having any children. Other women decide not to return to a hospital where their trust has been broken. However, there is an illusion of choice that constrains where and how people get care. For example, although many women have the opportunity to hire a midwife to attend a birth in their own home or at a local birth center, access remains a challenge. Only 34 states currently certify midwives, insurance companies do not always reimburse for their care and paying for midwifery services out of pocket can price some women out of access to an alternative birth model. This illusion of choice represents a continuing significance of race over class as the consuming choice of middle-class Black women does not guarantee access to racially safe care.

Hospitals are white institutions with white cultural logics and feeling rules that regiment how people within their midst are supposed to act in order to maintain access to resources. Black women patients are penalized in healthcare settings, as demonstrated in chapter three, when their advocacy appears oppositional to the dominant white cultural logics. Being upset or angry about healthcare often leads to healthcare workers policing the behavior of their patients. These affective burdens that shape the emotional comportment of Black people in the hospital setting come with consequences for difficult patients e.g. being threatened with security, having the baby transferred to the NICU or even being told to be quiet as demonstrated in chapter four. This emotional domination is one-way inequalities are reproduced as we see that Black women have to consider the consequences of advocating for themselves.

Furthermore, the medical mistrust that poor patient-provider interactions perpetuate works to further decrease physicians' authority. While physicians work to retain their authority by pressuring women into procedures for example, these actions exacerbate Black women's desires for racial safety. As I detail in chapter one, Black women are increasingly turning to hired doulas for emotional and medical support in the hospital. They believe that a doula will serve a 'checks and balances' function on the actions of providers, thus giving doulas increasing more authority.

Lastly, the findings of the fifth chapter suggest ways that healthcare provision can be improved systematically. The providers in this study whose patients report the best outcomes were partly able to facilitate outcomes through relationships. This underscores the importance of open communication with patients, continuity of care, person-centered approaches to care and genuine empathy for those under your care. It also suggests that providers can be emotionally fulfilled career-wise through this approach, as they accomplish a *connected heroism.*

In response to the first question asked by attendees at the Grand Rounds, how can they improve interactions in the meantime and without policy change? I suggest leaning into the power of interaction and relationships to, like the providers in chapter four, forge bonds of trust and mutual respect. Enduring relationships between patients and providers could be an important step in eradicating maternal health inequalities. As none of the approaches—part of the team, continuity of care, person-centered care or empathy-- to care solves the maternal health crisis in and of itself. More importantly, it would be important to know the patient, their fears and desires in order to implement these changes well and result in better outcomes. For example, recall LaToya in chapter four. She saw the same provider over a long period of time, yet reported that the physician did not heed her concerns, so she began to retreat from information sharing with her provider, choosing instead to maintain her peace. The continuity of care in this instance did not improve interactions because it ultimately did not involve building a positive relationship with trust. This is where all healthcare interventions should start.

METHODS APPENDIX

Strolling the Halls of 8North

Six months into fieldwork, I was hanging around the nurses station as team members chatted about their weekend plans. From my vantage point, I could see the nurse manager rounding the corner and approaching the gathered nurses. So I changed the subject of the conversation to something patient care related. After the nursing manager walked away, Maggie the health unit coordinator turned to me and said, "its like you work here" in reference to me understanding the team dynamics, including the tension between nurses and nurse management.

When I first began observing on the unit, some of the staff were suspicious of me, and asked who I worked for or if I was with quality control. As I hung around their workstations listening some of them thought I was reporting on them to higher-ups in the hospital. One day early into my observations, I was observing in the workroom when a senior resident came in to announce to medical student observers on the floor that day that he had a fern under the microscope, if they wanted to see it. All of the medical students scurried out of the room to see the fern[10]. Thoroughly confused, I turned to a resident I had not met before who remained what a fern was. She said, "I'm sorry who are you?" She came late and missed my introduction, making our first interaction slightly off-putting. After explaining that I was a sociologist researching patient experience on the ward, she laughed awkwardly and went back to work. On another occasion, Dr. Taft introduced me to a new resident who was starting their labor and delivery rotation, and therefore just meeting me saying "it's like she's listening to our every word and evaluating us". I promised them I was not evaluating them and that what I was looking for had

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[10] That day I learned that physicians can tell if a woman's water has broken by examining a sample under the microscope. Amniotic fluid crystalizes and resembles a fern leaf.

more to do with how the unit ebbs and flows, how birth on Labor and Delivery worked. I was not interested in what they themselves discussed per se. I am not sure how much they believed me.

Over time, my presence became less obvious. When I rang the call bell for admittance to the unit, the doors just swung open as someone at the desk recognized me. Conversations in the workroom shifted from solely patient-focused to residents' classed upbringings and familiarity with European vacations to exorbitant prices of rent in NYC and lucrative business ventures like having a spa next to a women’s health clinic. The nurses similarly got used to my presence as I helped on the unit when they were short-staffed. I liked to pitch in here and there to build trust and relationships with the nurses and patient care techs. If I were sitting at the desk when someone rang the doorbell and no one was around to answer, the unit health coordinator taught me how to use the intercom and buzz people onto the unit. Mostly, I let Foxhill support staff—the food service, housekeeping, maintenance, patient billing specialist, and chaplains—onto the unit, and instead called over a nurse or someone else to vet patients’ friends and family.

Recruiting Participants

After a few months of observing on the unit, I began to approach staff about interviewing them. I recruited 22 medical providers including physicians and nurses for this study in various ways. I am not sure that the earliest interviewees knew that I was explicitly studying race—as the nurse who sent me a lengthy text message clarification to her interview may attest. Shortly, however, it was clear to all what I was there to study. Midwives and nurses were more forthcoming and willing to be interviewed. They thought long and considered each word. The physicians I interviewed were more careful in their responses, and all tried to portray Foxhill Medical Center in a positive light.

Recruiting and interviewing Black women was more challenging than I originally expected. As a Black woman and mother with connections to the birth world in Foxhill City, I naively assumed that recruiting participants would be easy. It proved difficult, however, to recruit working-class Black women. Middle-class Black women were eager to help some with a research project and what I was doing seemed legible and important. One interviewee told me she learned about my study from a friend and wanted to help because she thought finding people in Foxhill City would be hard. Her thinly veiled critique of race relations in Foxhill was the main reason she wanted to volunteer. However, my proximity to Foxhill Medical Center seemed to deter potential working-class respondents. I was grouped in with Foxhill, and socially drawn out of the Foxhill City residents—many of whom were born and raised in Foxhill City. They resent the medical center's ever-growing reach into their neighborhoods and driving up the cost of rent. In the end, I interviewed 56 pregnant Black women obstetric patients, 31 of them twice. 30 of them were middle class and 26 working-class.

Theoretical Approach to Studying Interactions

There are three dimensions of interactions to which this study is attuned. First, I attend to the personal histories that each individual participant brings with them (DeLand 2021), as their biographies can shape how they experience and respond within an interaction. My interviews with practitioners and pregnant women enable me to incorporate this information in "character-driven" ethnographic observation (Jerolmack and Khan 2017), allowing for a richer analysis. Second, I attend to interactional expectations. Scholars have identified expectations —or the combination of aspirations and institutional promises (Frye 2012)—as an important factor mediating emotional responses to social interaction. Expectations are one link between the self and cultural norms, and emotions ooze as a culturally mediated response to the overlap (or lack thereof) between expectations and experience (Pugh 2015). Specifically with regard to the case of health disparities, the rise of the ‘engaged patient’ (Timmermans 2020) sets new cultural expectations for both clinicians and patients in the clinical encounter, which shapes the way they anticipate the other’s reactions and responses. Third, I attend to the levels of emotional entrainment within interactions. According to Randall Collins, interactions follow a basic pattern: people are physically nearby, they share a focus or concern, and share a similar emotion, otherwise known as emotional entrainment (Collins 2014). In interactions that generate disparity, however, the levels of emotional entrainment between the two (or more) actors are unequal (Collins 2014); closely observing attention and feelings where they converge and diverge will allow me to evaluate the emotional production of inequality. Focusing on biographical context, expectations, and emotional entrainment within interactions will allow me to examine where and how interactions go awry.

Data Collection

Patient-provider interactions, and the way patients interpret, manage and process them, are my units of analysis. While I am interested in the interactions between patients and providers, each person experiences and interprets inequality in interactions differently. The interpretations of a provider and a patient of the same encounter can vary dramatically. And as the individual framing and interpretation of emotions in the encounter are of theoretical import to this project, I collected data on patient-provider interactions and analyzed them from three different data points: provider interviews, patient interviews, and ethnographic observations. In the first interview, I invited participants to let me know when they go to the hospital for labor. I then had the opportunity to observe some interactions on the labor and delivery ward of those patients; in addition, all physician interviewees were also from this ward.

Patient Interviews

I recruited 56 pregnant Black women obstetric patients – 30 middle-class and 26 working-class – through various strategies. I posted recruitment fliers in obstetric clinics, community organizations that serve birthing populations, and online social media platforms. I also contacted pregnancy and postpartum support groups that attract women from all economic backgrounds. These groups ranged from free pregnancy and childbirth classes hosted by agencies that connect low-income women with social resources to fee-for-service prenatal yoga. Owners and facilitators of these programs were also leaving recruitment fliers for their participants. Another source of participants was snowball sampling, with a limit of two referrals per person.

All of the women recruited for this study were at least 18 years of age, self-identify as Black or African-American, and were pregnant and seeking prenatal care at the time of recruitment. Women were interviewed at a minimum of two time points, one at the time of enrollment in the study, and again six weeks post-partum. If there were situations where the researcher (or participant) thought additional interviews were needed, those were arranged. During the first interview with expecting mothers, I asked questions about desires for the birth, expectations of the doctor and hospital, and any apprehensions or fears she has about childbirth. At the second interview six weeks after childbirth, I inquired about the birth experience, if expectations were met, how things changed and how she managed the experience, what cultural repertories she used, and how the experience compared to what she heard from others, among other questions.

Health Provider Interviews

When I interviewed health providers, I asked them questions about the culture of the institution, the type of patients they serve, and why they chose to work there. I also asked them questions about what it is like to the physician of record for black women, given the maternal health statistics, and what, if anything, they do differently to care for these patients. I also asked them to tell me about births or other interactions that stick out to them as important.

All interviews were in-depth and semi-structured and last between one and two hours, on average. They took place in a location of interviewees' choosing, including coffee shops, offices, and homes and are audio-recorded with permission. I asked specific questions about the dynamics of the patient-physician relationship, and let themes emerge from the data (Timmermans and Tavory 2012). I knew I had enough cases and could end data collection when I predicted the topics and themes that would emerge in the interviews, what some call 'theoretical saturation' (Small 2009). While some scholars say you need at least twelve homogenous cases before reaching saturation (Guest, Bunce and Johnson 2006; Hagaman and Wutich 2017), I interviewed 56 Black women, 31 of whom I interviewed more than once. Of the 56 women I interviewed, I classify 30 of them as middle-class and the remaining 26 as working-class. I have also interviewed 22 medical practitioners including physicians, nurses and doulas.

Ethnographic Observations

I conducted my ethnographic observations on a hospital maternity ward in a small Southeastern city. The hospital maternity ward is highly ranked across several local and national ranking platforms and holds several coveted certifications including being a "baby-friendly hospital". They are one of the few hospitals in the region that are equipped to handle high-risk births and have a neonatal intensive care (NICU) unit. As a public hospital, they supervise a large percentage of the area’s births; and because they accept Medicaid, I was also able to observe provider interactions with working-class women in birth there.

In my previous research on the experiences of black women with maternal healthcare, I met several community partners who work in and around the field of childbirth. One of these connections is a hospital administrator with whom I have coordinated access to the field site. With their help, I was allowed to recruit pregnant participants from affiliated clinics, observe childbirth on the maternity unit, and have access to data on patient satisfaction. In my time there, I found doctors and nurses to be genuinely welcoming and supportive of the research.

I observed the patient-provider interactions on the maternity ward over a period of six months. In that time, I observed the dynamics of the ward during different shifts and with different health providers. Although my main interest was the interaction between health providers who are the physicians of record for the childbirth, it was also fruitful and important to observe the interactions patients have with all of the staff that represent the hospital, including doctors, nurses and patient care techs; the hospital experience for women is not just the 15-minute interaction with her doctor, but a stream of interactions over the course of the entire hospital stay.

In my observations, I looked for the ways that “engaged patient” and other discourses were used, and for these and other patterned ways in which providers discussed their patients. As research on policing indicates, officers, as agents of the state, use their discretion to decide who to police and what laws to enforce (Brayne 2020). Similarly, I looked for how health providers use discretion in the enforcement of hospital policies and in what situations. For example, if hospital policy states that all visitors had to leave by 9 pm, I observed the cases where this was strictly enforced and where it was disregarded, and how providers justify the decision to enforce the policy, or not. I also pay careful attention to the dynamics regarding decision-making: who is present, where do they stand, how is the information conveyed, what is the emotional tenor in the room, what types of questions or reactions does the patient have, who makes themselves available for further questions. I also observe the patients' emotional-processing of decision-making after the doctor has left the room.

DATA ANALYSIS

While I was in the field collecting data, the majority of data analysis was through recording, reading, and reflecting on interview transcripts and fieldnotes. Part of the analytic process at this stage included writing memos. I first wrote participant level memos and after the third one, wrote cross-case memos where I documented themes that I see emerging, similarities, and differences between the cases. I also used the memos as a device to compare what I saw within the data to existing research using an abductive theory approach (Timmermans and Tavory 2012). In opposition to traditional grounded theory methods, which give primacy to the inductive and emerging nature of theory without any preconceived notions, I approach data analysis without bias but with acknowledgement of previous research on the topic. This prior knowledge adds to the insights that emerge from the data and allow me to generate ongoing theories about the case that I can confirm with further data analysis and triangulation (Timmermans and Tavory 2012).

After leaving the field, I began a more focused data analysis using Dedoose, a qualitative data analysis software program, to organize and code fieldnotes and interview transcripts. I first applied index codes to large blocks of texts and earmark specific topics or questions of interest across all cases (Deterding and Waters 2018). Then, I used the index codes and previous memos to generate analytic codes, or codes that apply to particular emergent themes of interest, and apply these codes systematically across all data (Deterding and Waters 2018). As data analysis is an iterative process, I returned to earlier codes and recoded as needed (Emerson, Fretz and Shaw 2011). Lastly, I evaluated the fit between the data I collected, previous research, and my earlier theoretical hunches. I used the ethnographic observation data to corroborate and compare to the experiences interviewees describe. I pinpointed exceptional cases and used those for theory building in addition to the patterns I observed.

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