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African American Women's Maternal Healthcare Experiences: A Critical Race Theory Perspective

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ABSTRACT

Black women are experiencing pregnancy-related complications at a significantly higher rate than women of other races in the U.S., as Black women are three to four times likely to die from pregnancy-related complications compared to non-Hispanic White women. Structural barriers and different forms of marginalization continue to limit Black women's access to quality healthcare services. Through critical race theory, we examine what structural barriers exist in the U.S. healthcare system, one that limits access to quality care during their prenatal and postnatal doctor's visits. Using qualitative in-depth interviews, 31 African American women, living in Milwaukee, WI, shared their pregnancy stories. The emergent themes include, institutionalized care – racially insensitive biomedical approach, race and class – unfair treatment based on health insurance, and race as a social concept – dismissed pain concerns because you are a strong Black woman. These themes reveal the experience of racial discrimination toward African American women through healthcare [communicative] practices that are often times seen as "standard" practices, albeit marginalizing minority populations. Findings from this study offer insights for healthcare providers on communicative practices that foster a racially-safe healthcare environment for African American women.

Racial disparities in healthcare delivery is well established in the literature [Centers for Disease Control and Prevention (CDC), 2019; Creanga et al. (2015); Mkandawire-Valhmu (2018)]. Numerous studies report that African Americans receive low-quality care and differential treatment when accessing healthcare services, as a result of their racial identity[1] (Cuevas et al., 2016; Dovidio & Fiske, 2012; Keith et al., 2010; Krieger et al., 2011). Disparities exist for African Americans and other minority populations, for example, in limited information disclosure by healthcare providers (Ryn & Burje, 2002), verbal dominance by healthcare providers (Ha & Longnecker, 2010), dismissive attitude of healthcare providers toward patients' concerns (National Public Radio, 2017), and ultimately, provision of low-quality care (Ward et al., 2013). Racism and racial discrimination are factors that have been linked to the delivery and experience of race-based care[2] in the U.S. healthcare system. From the historical events of slavery to the Tuskegee Syphilis study of 1932 (Scharff et al., 2010) and the ongoing socio-political discourses that reinforce racial discrimination in the U.S. (Williams & Wyatt, 2015), African Americans continue to report racial disparities that impact their health.

Maternal health disparities are a major health concern for African American women. According to the Centers for Disease Control and Prevention (CDC) (2019), the maternal healthcare crisis among African American women is evidence of health disparities in U.S. society. African American women, as well as American Indian and Alaska native women, are two to three times more likely to die from pregnancy-related complications when compared to White women. Sadly, for Black women, this disparity exists regardless of socio-economic status or determinants of health as "[t]he PRMR (the pregnancy-related mortality ratio) for Black women with at least a college degree was 5.2 times that of their white counterparts" (Centers for Disease Control and Prevention (CDC), 2019, para. 6). This provides strong evidence that the issue of health inequities for African American women is not solely of a function of social factors such as socioeconomic status, but rather, it is a complex problem reflective of structural factors that negatively and disproportionately impact African American women (Gee & Ford, 2011; Homan, 2019).

Given the complex nature of maternal health inequities in African American women, critical theoretical perspectives, such as the critical race theory, offer an appropriate analytical lens to deconstruct the unique experiences of African American women within the U.S. context. Employing a critical race theory perspective (Delgado et al., 2017) to the study of African American women's health is valuable in exploring and critiquing hegemonic ideologies and structures that impact the realities and health outcomes of African Americans. In this study, we sought to unravel how African-American women make sense of the influence of their racial identity during maternal healthcare encounters. Specifically, through their stories, we explored and critiqued manifestations of racial discrimination in communicative acts of healthcare providers when providing medical services, with the goal of

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understanding their participation in the maternal healthcare crisis in the United States. Further, a secondary objective was to illuminate how healthcare providers perpetuate institutionalized and structural practices that advance racial discrimination in the U.S. healthcare system. In the following sections, we conduct a review of previous studies that have revealed the myriad problems African American women experience in accessing the U.S. healthcare system, followed by a description of our study and findings.

Literature review

The problem–health disparities, race, and gender

Health disparities have garnered increased attention in the United States over the past twenty years. However, despite a significant comprehensive report on health inequities by the Institute of Medicine and the scholarly discussion that ensued, ethnic minority communities continue to experience a high burden of poor health outcomes across a number of health indicators (Baciu et al., 2017; Institute of Medicine, 2003; Noonan et al., 2016). For instance, African Americans continue to be disproportionately impacted by adverse maternal child health outcomes (Howland et al., 2019; Singh & Stella, 2019). Compared to White women, African American women are twice as likely to have a child with low birth weight and one-and-a-half times more likely to have a preterm birth (Martin et al., 2017). Similar patterns of disparities in African American women are seen across other reproductive health indicators including perinatal loss mortality (Koch & Geller, 2019), and maternal (Petersen et al., 2019) and infant mortality (Kitsantas & Gaffney, 2010).

While ongoing efforts are made to comprehensively delineate the causes of persistent health disparities, growing evidence points to the effects of a myriad of complex, multilevel factors rooted in institutionalized discrimination based on race and gender (Gee & Ford, 2011; Gollust et al., 2018; Shavers & Shavers, 2006). Their systematic marginalization, operationalized through policies, societal practices, and differential access to resources and power, has been cited as the distal cause of adverse health outcomes for African American women (Gee & Ford, 2011; Homan, 2019). Notably, for African American women, the marginalization they experience as a result of their racial and gender identities cannot be analyzed independently of each other. Strong evidence indicate that the combination of both racial and gender discrimination that African American women experience adversely impacts health through physiological and psychological stress pathways (Perry et al., 2013). Beyond the differential access to resources that results from institutionalized discrimination, understanding the experiences of marginalized communities during healthcare encounters are a critical component of unearthing how disparities in health outcomes are produced within the healthcare infrastructure (Penner et al., 2014), particularly for African American women who bear a disproportionate burden of adverse birth outcomes.

Provider-patient communication and the experience of racial discrimination

Communication occupies a central role in healthcare encounters (Adebayo et al., 2020). The sensemaking process of healthcare services is mostly interpreted from the perspective of communication. In reporting their experiences of racial discrimination when accessing healthcare services or low-quality care, patients (regardless of racial identity) have identified communication factors as key variables when examining experiences of racial discrimination during healthcare encounters (Cuevas et al., 2016; Ha & Longnecker, 2010; Raine et al., 2010). For instance, African Americans have reported poor communication and lack of expressed respect by healthcare workers (Cuevas et al., 2016). These findings are similar to many others that have examined the healthcare barriers of African Americans (Ha & Longnecker, 2010; Mazul et al., 2017).

As evidenced in previous studies (e.g., Cuevas et al., 2016; Raine et al., 2010), patients also often assess the quality of care received through the lens of communication; how the provider related to them, the clarity of the message, the depth of the message, the content of the message, and the display of interpersonal connection with the patient. Specifically, the quality of interpersonal communication between physicians and patients impacts health outcomes by influencing patient satisfaction, physician-patient trust, and rapport, willingness to disclose important health information (Arnold & Boggs, 2019). Communication functions as a significant tool in shaping the quality of healthcare services in any context (Abioye Kuteyi et al., 2010; Ha & Longnecker, 2010). Quality communication, or its lack thereof, influences patients' perceptions of the healthcare system and the services delivered during patient visits. More specifically, implicit and explicit racial biases thrive through verbal and non-verbal communication. Studies show that "Black patients feel less respected by the physician, like the physician less, and have less confidence in the physician regarding their medical encounters when the physician exhibits greater implicit racial bias" (Dovidio & Fiske, 2012, p. 948). Moreover, in the context of maternal healthcare visits, African American women have reported poor communication along the lines of rushed interactions, ambiguous word choices, and lack of affection or empathy (Raine et al., 2010). Evidently, healthcare experiences are communicatively interpreted; hence, analyzing women's maternal healthcare experiences as a communication phenomenon provides an important perspective.

Maternal mortality among African American women

Despite efforts made to unravel and ameliorate racial disparities in maternal mortality in the U.S., the persistent inequities in outcomes for African American women remains alarming. Specifically, non-Hispanic African American women have higher rates of maternal mortality compared to other ethnic and racial groups with a two to three-fold increased odds of dying from pregnancy-related complications when compared to non-Hispanic White women (Centers for Disease Control and Prevention (CDC), 2019). One study found that being

a Black woman with a chronic illness was associated with a two to three-fold increased odd of maternal mortality in comparison to White women with the same chronic condition (Tucker et al., 2007).

Arguably, while some evidence exists for the clinical and pathological causes of maternal mortality in the U.S. (Centers for Disease Control and Prevention (CDC), 2019; Creanga et al., 2014), the prevalence of this health problem among African American women remains a puzzle. Previous studies have documented the existence of racial and health disparities in the quality of care received by African Americans when accessing healthcare services (Krieger et al., 2011). Consequently, to analyze the U.S. maternal health crisis from a biomedical perspective with inattention to race and racial discrimination, as often times reported by the CDC, presents an incomplete argument. The role of race as an integral factor in maternal health inequities is evident in extant literature (Mazul et al., 2017). Race, as a factor in healthcare experiences, is further illustrated by the reported experiences of prominent African American women like Shalon Irvings, an Epidemiologist at the Centers for Disease Control and Prevention, who passed away weeks after delivery in 2017 (National Public Radio, 2017). Irving's case was not one linked to poverty or low education, she had two doctoral degrees; rather it was linked to racial disparities in quality of healthcare she received as reports indicate that her health symptoms were repeatedly dismissed days before her demise (National Public Radio, 2017).

Similar to Dr. Irvings experience, the African American maternal health literature is replete with reports of health symptoms being trivialized or dismissed. Stemming from historical events of slavery, African American women are often perceived to be "strong" and able to go through hardships and withstand pain beyond what is considered "normal" (Davis, 2015; Watson-Singleton, 2017). This racial discourse of (perceived) strength negatively impacts African American women within the healthcare context. The perception of being strong has been reported to "force" African American women to internalize their pains and hardships, and healthcare providers often reinforce this discourse (Collins, 2000; Watson-Singleton, 2017). The foregoing review provides an overview of the African American women's interactions with the healthcare systems. However, beyond the problematic communication encounters there are structural barriers, otherwise labeled "standard practices," that propagate health inequities for African American women, which is the focus of our study.

Structural barriers in African American women's maternal healthcare experiences

In this study, we focus on two main structural barriers confronting African American women during prenatal and postnatal care: the institutionalized biomedical approach to maternal care and the structural barrier of public health insurance. The biomedical approach to maternal healthcare is notorious for its overt focus on Western medicine and procedures in attending to women's reproductive healthcare needs. Traditionally, the biomedical approach has been criticized for disempowering women, since women are the primary consumers of healthcare services in the United States and even other parts of the world (Willard, 2005). Particularly concerning women's reproductive health, the medical profession has been critiqued for the medicalization of women's experiences, including pregnancy. In this way, the woman's body is treated as a machine programmed to perform certain operations that can be managed when "faulty" to ensure its appropriate functioning (Andipatin et al., 2019). The dominance of the biomedical approach in healthcare has been found to result in "the medicalization of normal life events (e.g., giving birth, menopause) and an over-reliance on technological solutions" (Willard, 2005, p. 135). Consequently, within the U.S. healthcare system, pregnancy is primarily considered a medical condition, which needs medical intervention for its management and treatment.

Given the lived realities of African American women in U.S. society, the biomedical approach to maternal care further situates African American women as objects in a system that denigrates their racial identity and realities. It is important for healthcare providers to become aware of the reality that "pregnancy and its associated biological processes are complex and expressed in an assortment of ways, they are lived out in equally complicated sets of social and power relations" (Andipatin et al., 2019, p. e553). African American women have unique social and cultural milieu that position them on the margins of the society. Thus, it is important to understand how the biomedical approach works to usurp power and agency from these women based on institutional healthcare practices that likely do not put racial realities into perspective.

Another notable structural barrier in African American women's healthcare access is the type of insurance they carry. In the United States, an individual's socio-economic status can be accurately assessed based on the type of health insurance (that is, public versus private/employer-sponsored). Public (also known as state insurance or Medicaid) health insurance is provided to low-income individuals. For African American women, using the public insurance is often stigmatized (Allen et al., 2014; Taylor, 2019); it does not only label them as low-income, it goes further to limit the access they can have to healthcare. Studies have shown that one of the challenges that confront African Americans on public insurance is finding doctors who accept such insurance plans (Mazul et al., 2017). For those who are lucky enough to find doctors, they are treated with suboptimal care while also discriminated against based on their health insurance (Weech-Maldonado et al., 2012), including limited breastfeeding support (Thorburn & De Marco, 2010). These barriers, as they intersect with race and class, continue to limit African American women's access to quality care during this vulnerable time of their lives. Critically exploring these barriers and their manifestations from a critical race theoretical perspective provides a holistic understanding of health inequities common to these women, if we are to effectively address the U.S. maternal health crisis.

Theoretical framework: Critical race theory

Critical race theory (CRT) is an interdisciplinary theory that provides a framework for studying the experiences of racially marginalized populations in the U.S. society. It was developed

by the collective work of scholars like Derrick Bell, Alan Freeman, and Richard Delgado (Delgado & Stefancic, 2012). Though developed by U.S. scholars, the application of the theory has extended to other parts of the world (Warmington, 2012). Three basic tenets guide the understanding and application of CRT as discussed by Delgado et al. (2017). First, CRT functions to critique the idea that racism is ordinary, that is, normal. This notion of the ordinariness and normality of racism in the society advances the "color-blind, or 'formal', conceptions of equality, expressed in rules that insist only on treatment that is the same across the board, can thus remedy the most extreme forms of discrimination" (Delgado et al., 2017, p. 8). This way, people of color are indiscriminately ignored or unaccounted for in social policies, "because an individual (white) person 'does not see race' and therefore 'is not racist" (Wesp et al., 2018, p. 321). Not only are people of color ignored in social policies that underserve them, they are also discriminated against given the hallmark of what is "good" only resides in whiteness. Second, CRT critiques "interest convergence" and material accumulation of wealth as a core manifestation of racism, one that predominantly serves whites in the U.S. society (Delgado et al., 2017, p. 8). In this regard, as whiteness is positioned as a property of interest (Ladson-Billings & Tate, 2006, p. 2006), CRT challenges the hegemonic functioning of social institutions that advance the interests of Whites, materially and otherwise. Third, CRT upholds the fact that race is socially constructed. In other words, ethnic minority populations are only relevant to the extent to which the society "endows them with pseudo-permanent characteristics," subjecting them to social and power hierarchies (Delgado et al., 2017, p. 9) where they are relegated to the lowest rungs.

CRT, in its usage, attends to issues of racism, which are believed to be ingrained in social institutions in the U.S., especially in the education sector (Ladson-Billings & Tate, 2006). In its scope, CRT identifies issues of racial injustices among ethnic minorities as well as unveils the impact of social, political, and philosophical structures in advancing different forms of marginalization and injustices toward members of minority racial groups (Hylton, 2012). Consequently, CRT allows for a holistic view of racial discrimination as it manifests systemically, leading to inequities in various sectors of society, including healthcare.

Within the context of healthcare scholarship, CRT "guides us in acknowledging the reality of inequality among these racialized groups and the racist ideology that informs healthcare interactions in our society" (Mkandawire-Valhmu, 2018, p. 50). It affords healthcare scholars a unique perspective for understanding the causes of racism in the healthcare system (Ford & Airhihenbuwa, 2010), as rooted in "standard practices and structures." CRT highlights systemic structures that underserve racial minorities, which in turn advance racism. Within health communication scholarship, CRT has been used to study the healthcare experiences of racial minorities like Hispanics, and African Americans (Vardeman-Winter, 2017). For instance, in the application of CRT to African American and Black Hispanics' healthcare experiences, Freeman et al. (2017) found that structural racism persists with institutionalized healthcare practices that might not represent the interest of minority groups. This includes lack of personalized care, as they reported being treated based on papers and numbers. One serious implication of these practices that perpetuate racist ideologies is a deeply-rooted, distrust of healthcare providers and healthcare practices. While studies like theirs have employed CRT to unveil how structural racism shape the experiences of ethnic minority groups within the healthcare system, there is a dearth of literature that utilizes a similar approach to analyze structural racism within the maternal healthcare context.

In this study, CRT provides a lens to critically analyze the interconnectedness of racial injustice and the maternal care experiences of African American women. Focusing on the experiences of African American women will center their voices while simultaneously recording how race and systemic racism construct their healthcare realities for Black women. We used the following question to guide our work:

RQ: How does racial discrimination manifest in the maternal healthcare narratives of African American women?

Method

Upon the approval of the study by the University of Wisconsin-Milwaukee IRB (UWM IRB # 19.A.238), the first author recruited women to participate in qualitative interviews through purposive and snowball sampling. Lindlof and Taylor (2019) argue that qualitative interviews are valuable in contexts where participants lived experience and worldview are central to the research questions. Purposive sampling involves the recruitment of research participants by directly asking members of groups or populations who fit the research criteria to participate in the study, while snowball sampling takes place when individuals are recruited through those who have participated in a study (Lindlof & Taylor, 2019; Tracy, 2012). In other words, it involves recruitment through referrals – asking research participants to encourage other individuals (e.g., friends, family members, etc.) who qualify for the study to participate (Lindlorf & Taylor, 2019). Announcements were made on Facebook groups and pages dedicated to moms (e.g., Milwaukee Moms, KidsCycle: NS Milwaukee area, and African American Breastfeeding network Milwaukee), and the one she created (Black Moms Maternal Health) for African American women living in the Milwaukee area.

Study site

Data collection for this study took place in Milwaukee county, Wisconsin, for close to a year, between March 2019 and February 2020. Milwaukee presently ranks as the most racially segregated metropolitan city in the U.S. (Frey, 2018). Milwaukee also has some of the highest rates of Black infant mortality (City of Milwaukee Health Department, 2018; Ward et al., 2013). According to the Wisconsin Department of Health Services (2019), for the most recent statistics on maternal health outcomes, maternal mortality rates were five times higher among African American women compared to non-Hispanic White women in the city of Milwaukee.

Participants

Thirty-one African American women participated in this study, which includes four women who participated in the pilot study[3] for this present research. Participants were African American women who were currently living in Milwaukee County and had maternal care experiences with healthcare providers in the city or surrounding area. Participants ranged from 20–44 years old and were either pregnant (n = 6) or had been pregnant within the previous year (n = 21). Participants also included women who were part of the pilot study and had been pregnant within the last ten years (n = 4). The majority of the women were either pregnant with their first child or had only one child (n = 16). Ten of the women reported having employer-sponsored insurance, eighteen reported having state insurance, one reported not having insurance, while the remaining three participants did not report their health insurance status. In reporting their marital relationship status, eight women reported being married while twenty-three reported being single or engaged. For participants who reported their annual income, ten did not report their income or were currently unemployed, thirteen had a household income of less than 35,000 USD per year, five reported an income between 36,000 USD and 70,000 USD per year, while three reported an annual household income between 71,000 USD and 120,000. USD

Semi-structured in-depth interviews

Participants who met the eligibility criteria were interviewed by the first author, either face-to-face (n= 6) or over the phone (n= 25). Before the commencement of each interview, the interviewer read the consent form to the participants, and consent was established through verbal affirmation for both face-to-face and virtual participants. Each interview was audio-recorded and lasted between 50 to 75 minutes.

Participants were asked to narrate their most recent pregnancy stories starting from the day they learned of their pregnancy until delivery or present (for those who are still currently pregnant; narrative interview format). Follow-up questions to clarify meanings and solicit other relevant information based on their stories and the focus of the study (respondent interview format) were asked. This included descriptive, experience, typology, and example questions (Spradley, 1979; Tracy, 2012). In the latter part of the interview, participants answered questions that solicited information about their perception of the maternal crisis among African American women. These include questions on their racial and pregnancy identities. Upon the completion of the interview, each participant received a 20 USD Walmart or Amazon gift card.

Reflexivity and positionality

As critical scholars, reflexivity and positionality are key to the unbiased interpretation of our data, especially when relating with members of marginalized groups (D'Silva et al.'s, 2016). Reflexivity focuses on how methodological choices impact the interpretation of the data (Corlett & Mavin, 2018). Knowing that truth is socially constructed, it is imperative for researchers to critically examine how our presence in this research process impacts the process and ultimately the outcome (Dutta, 2010). Our culturally diverse team is composed of Black (three) and White (one) women, from interdisciplinary fields of communication and nursing. We deliberately prioritized the contribution of our minority yet diverse voices to the ongoing discourse of maternal health crisis among African Americans. Our cultural and disciplinary diversity allowed for rigorous and critical analysis of our data-giving room for careful interpretation and report of our findings.

Through a pilot study, the first three authors rigorously assessed the research questions and the interpretation of the data refining it to remove possible biases in how participants respond to questions and how we ultimately analyzed the data. Regarding our positionality, we understand that our lived and ongoing experiences (via our social locations of race, class, education, and gender) are capable of influencing our interpretation of the data. As such we deliberately chose to analyze the data from a theoretical perspective without losing the diversity that our interdisciplinary and multicultural backgrounds contribute to the research.

Data analysis

The first three authors conducted the analysis of the data. The first author took the lead in this process. Data analysis commenced during data collection as the first author engaged in an iterative process of interviewing and reflection. Reflecting on interviews and reading notes during the process of data collection are useful practices in making sense of the data at the preliminary level (Saunders et al., 2018). Following the transcription of the interviews by a third-party service (Temi™ software) and a research assistant, the first author assessed the 554 pages of transcripts for accuracy. This process included removing any identifying information from the data while assigning pseudonyms to participants to further protect their confidentiality.

In the first stage of coding, we engaged in value coding, a type of descriptive coding that copiously accounts for participants' "values, attitudes, and beliefs" as it reflects their perspective to social issues (Miles et al., 2013, p. 75). This type of coding is useful for understanding and reporting issues of identity as it relates to social realities and issues. Since the study focuses on how the racial identity of Black women interfere with their healthcare experiences and outcomes, employing this kind of coding was valuable in unveiling the role race plays in this context. After identifying initial codes (e.g., biomedical approach to maternal care, women as machines), we merged similar codes by categorizing them into themes as they reflected the tenets of critical race theory issues of racial discrimination propagated by social structures in the U.S. society. The third author, given expertise in CRT carefully revised the themes to assess their representation and explanation of CRT. These include analyzing systemic issues, present in women's narratives, and their impact on healthcare encounters. At the end of this stage, we merged themes that were similar in the information they provided. In the end, the first author closely read through the findings again to identify and clarify any form of ambiguity.

Findings

In applying critical race theory to African American women's maternal healthcare narratives, we highlight dimensions of racial discrimination present in women's experiences during medical interactions and the healthcare practice for maternal care. One of the central arguments of CRT scholars is that racial issues and racism are so ingrained in our system and structures that we fail to perceive them as such-they have become "normal life" (Delgado & Stefancic, 2012; Ford & Airhihenbuwa, 2010). As a result of this, the current study employs CRT to uncover dimensions of racial discrimination and racism that are present in maternal healthcare "standard practices," while demystifying the ideology of color-blind healthcare system – "the notion of a racially neutral and democratic social order that works for all people" (López, 2003, p. 83). Using the three tenets of CRT as guiding lens, three themes emerged from the analysis: Institutionalized care – Racially insensitive biomedical approach, Race and class – Unfair treatment based on health insurance, and Race as a social concept – Dismissed pain concerns because you are a strong Black woman. A fourth theme emerged from the analysis outside of the of CRT's basic tenets, Distrust – African American women as charity case.

Institutionalized care – racially insensitive biomedical approach

One of the basic tenets of CRT is the notion that racism is so deeply embedded in the fabric of U.S. social and political institutions that its presence has been normalized and accepted as "standard practice". However, women in this study challenged these standard practices revealing their shortcomings in advancing a racially insensitive maternal healthcare. Centrally woven throughout the narratives of women in this study is the experience of a racially insensitive healthcare system – the supposed color-blind healthcare. In this context, the institutionalized biomedical approach was criticized for its dominance in maternal healthcare practice. African American women challenged this approach as racially denigrating as it has been structurally positioned as "the" way to provide maternal care while ignoring other health approaches to providing maternal care, especially the cultural dimension of health. The narratives of the women in this study pointed out the lack of consideration for women's preferences during pregnancy, speaking to how healthcare providers treated them based on what "textbooks" say, while taking away their racial and cultural presence in maternal care. They criticized it for its White-centric method in attending to women's needs; as the healthcare practices are mostly viewed from the hegemonic standpoint of White women, whose experiences mostly form the basis for healthcare practices during maternal care. When we asked Beth, a 21-year old mother, to narrate her maternal care story, she said:

> So, from the first time that I found out I was pregnant, I knew right away that I wanted to have my child at home or at a birthing center. I know that I wanted it to be as natural as possible and I knew that I did not really want to go the regular route of going to like the doctor checkups and stuff . . . ."I want to have this baby at home, I want to do a natural, I don't plan a birth in the hospital" . . . .So, I talked to my doctor about it and he became inconsistent. He said that I'm high risk and blah blah. And I feel like he started to say that because I told him about me wanting to birth at home. I feel like as soon as I told him about that, everything just changed. So, then they started telling me that I would have to come in every two weeks and monitor my baby's growth because I had IUGR, which is injuring growth restriction. So, they claimed, they told me I was really high risk. . . . I had told the doctor like, "Well, I'm still gonna have my baby at home." And the doctor walked out on me He never came back in the room . . . I'm like, "Y'all are treating me wrong. You're not listening to me. You're not respecting me. This is my body, my baby."

Beth's narrative shows a rigid biomedical approach to maternal care, one that subtly rejects other maternal care methods such as midwifery and home birthing – practices that are historically and traditionally upheld in the African American community (Dawley, 2003). Given this dominant biomedical maternal healthcare practice, African American women are indiscriminately treated based on a hegemonic model of care, one that inherently does not account for their unique realities, as with other social institutions.

The biomedical approach was not only criticized for its White-centric approach to maternal care, but also for its structured, one-size fits all approach for Black women. In this manner, Black women are treated as a monolith based on "what is generally known about Black health," rather than being treated as individuals, further reinforcing the ideology that they are mere statistics. Rachel, a 23-year-old first-time mother, shared:

> I was diagnosed with gestational diabetes . . . they also diagnosed me to take baby aspirin. Like no reason. They said that as Black people, it's more common to have that preeclampsia . . . I honestly don't see why I need to take this. Like I don't have a history of it. This is my first pregnancy. So, I'm like, "I'm not taking the baby aspirin," but me being me, when they asked me like, "Oh, are you taking your medicine?" "Yes," because I don't want to say no, and they'd try to diagnose me with something, like, "Well she's not taking her medicine, so she probably has this thing."

Rachel considered this medical push as a hegemonic and homogenous view about Black women's health, such that they are often perceived as having poor health, just as they are perceived in other contexts (Freeman et al., 2017). She explained that healthcare providers usually lump African American women together, without paying attention to each individual. She said, "Like I don't have a history of it. You can't like, um, basically stereotype me because I'm African American." This way, they believe an instance of illness or behavior in one African American is present with others. This institutionalized practice further led to the silencing of these women, which is a long-term effect of racism in our society. Telither, in a similar experience, also encountered the imposition of medicalized birth by her healthcare providers. She recalled the reaction of her nurses in the delivery room when she told them she wanted a natural birth:

> I think the staff pushed more for different directions for my choices. So, like if I said I want to do a natural birth, they were like, "Why? Why would you want to go natural? We got drug for that and you won't do this" . . . I think they have the assumption that we don't know what our bodies are capable of.

Telither considered her experience as one that invalidates her ability to make an informed decision about her maternal care. She attributed this experience to both her racial and gender identities.

Race and class – unfair treatment based on health insurance

The interest convergence tenet of CRT was foregrounded as women reported the influence of their racial identity, as it intersects with their socioeconomic status, in the quality of care they received. Unique, a 24-year old pregnant woman, in her narrative, said African American women begin to experience differential treatment not only in the quality of care given to them but even based on the type of insurance they have:

> Like when you're asked what type of insurance you have and you feel like, "Oh, I have government insurance" and they like look at you differently or they treat you differently, different from if you had like private insurance or insurance through an employer or something like that."

The fact that Medicaid is only accessible to low-income individuals, and in Wisconsin a majority of these recipients are African Americans (Kaiser Family Foundation, 2019), put these women in a situation where they are constantly disenfranchised because of the intersections of race and class. While Medicaid offers benefits for low income individuals, for African American women, it can function as a reminder of their disenfranchisement and institutionalized practices that foster racism. Rachel further evidenced this insurance-based discrimination in her narrative:

> So I feel like, yeah, I feel like this thing [race and class] is definitely real, they definitely judge you on that. They look at you and it's like, "Oh well we're not going to do much with them. We just gonna patch them up, get them okay, and throw them out of the door." … I feel like that's how they treat African-Americans. You don't have the best insurance. A lot of us, don't get me wrong, we're in all different ranks of course, but like I'm in lower class so I can't afford to, insurance puts us in different places.

Rachel's narrative shows both an expression of lament and distrust in the healthcare system that allows a supposed help for minority through the prism of Medicaid. The issue even becomes more complicated because of the racial climate of the city, where there is evident racial segregation. Shirval articulates how Milwaukee as a city naturally positions African American women as low class, public insurance patients, resulting in low quality of care:

> Ultimately [the way you are treated] I would say it depends on the type of insurance you have. And then we are talking about African American women a lot. And especially here is Milwaukee, if you're talking about this region, I feel like there is a lot of African American women or Black women that's in poverty and might need assistance, whether that's needed, state insurance or whatever that looks like. And I feel like they are treated differently than someone with employers insurance … they [healthcare providers] can see or read into my history and find out if you have some form of education, you know, I feel like that, that, that sometimes they could make that separation … Not to say that I couldn't be treated poorly just by looking at me and not knowing anything about me, but ultimately these people (healthcare provider)], I feel like, it definitely has a lot to do with, your insurance and what's the first thing they see from your records-your socioeconomic status, all of that.

Without mincing words, Shirval's narrative unveiled the workings of race and class in the type of treatment African American get when accessing maternal care. While this is not new (Allen et al., 2014; Taylor, 2019), women's narratives, here, show how covert racial discrimination in the healthcare system leads to mistrust, and poor treatment, which are factors consistently cited in women's maternal crisis narratives (National Public Radio, 2017). Kevris furthered this argument in her narrative by saying:

> I feel like it's because of our race and the things that we've gone through. In America, there's always been a difference in, you know, race, in the color of your skin. You know, it's always been that way. Like if you're white, you have more of a privilege and you are given more opportunities, you know, but if you're Black and if your skin color is Black, no matter if you're, you know, Black from Africa, like, have African roots, I feel like you're still seen as lesser.

Clearly, discourse of systemic racism and the historical events of slavery and colonization were evident in Shirval's narrative, as she attributed African American women's experiences to what is considered "normal" in America – the ordinariness of racism (Delgado & Stefancic, 2012). Consequently, African American women's experiences of discrimination in medical encounters are a reflection of the U.S.'s institutional practices that underserve racial minorities.

Race as a social concept – dismissed pain concerns because you are a strong Black woman

Being a Black woman did not only mean differential treatment for African Americans. For the women interviewed, it also meant that they had to endure pain beyond what they considered normal because they were "strong Black women." Delgado and Stefancic (2012) explained this ideology as the social construction of race, where African American women are not only treated based on science but also on how they have been historically constructed as strong. While this discourse of strength is traceable to the history of slavery, it has become a welcomed racial identity marker, even for African American women themselves. Yet, within the context of healthcare, this discourse leads to women's disadvantage (Abrams et al., 2014). In the current study, this stereotype resulted in the undermining or dismissing African American women's concerns, especially in relation to pain. Sadiat, a 23-year-old first-time mother, narrated her experience as follows:

> At about one in the morning … I was just like, I like, this is not feeling right. I am not comfortable. … We went to the ER and I don't know if it was because it was late that they just like were not taking their job seriously, but like the tone of voice, like I said, super nonchalant … disregarding my pain, and I remember one nurse is just like, "Well yeah, you're pregnant." … as a doctor, if I'm explaining my pain to you and the symptoms that I'm having, like I expect you to take me seriously. I don't expect you to tell me, "Well yeah you're pregnant." "I know I'm pregnant. That's why I'm here explaining my pain to you so I can make sure that my child is okay."

Similarly, during labor and delivery, Ebony spoke of experiencing excruciating pain that was repeatedly dismissed by her healthcare providers:

> She was like, "No, you're just being paranoid." And I was like, "I still don't feel well." She was like, "Oh, you're fine, you're fine." And I was like, "Something isn't right." And then I was telling her like, "I'm passing these, these chunks of blood clot." They were like … "You're fine … ." I'm still having problems and, in a strain, even after taking the narcotics, I'm still like damn pain, cramping bad. And she was like, "You're fine. You know, you're older. That's why you know, you're feeling like this." And I was like, "That's not what this is." And all I kept telling her, "Something is wrong with [the baby]. Something is wrong with me." She's like, "You're okay." So, two weeks after he was born, I decided to go to the ER, and they told me that I needed a D & C [Dilation and curettage] because I still had some of my placenta in me.

Tragically, Ebony lost her baby while also having to go through emergency surgery following complications post-delivery. Similarly, Tabithe, a 20-year old mother of one, explained how she felt healthcare providers perceived African American women as deceitful about their pain level. When asked about how healthcare providers perceived pregnant African American women, she said:

> African American woman are seen as lying about what type of pain we're in and how bad it hurts. "Don't tell me how bad I'm hurting. You are not inside of me." And that's how they always come at you … like you're lying or exaggerating … they treat you like you're lying or like it's not that serious.

Tabithe's story highlights how the dismissal of African American women's concerns on the part of healthcare providers', exacerbates women's lack of trust in healthcare providers and the healthcare system, leaving women feeling disempowered and less-valued.

Distrust – African American women as charity case

Under this theme, African American women expressed how they felt that their racial identity positioned them as a "charity case." Even when healthcare providers provided what they considered quality care, because of their overall experiences, they wondered whether healthcare providers genuinely cared about them and their healthcare needs. In this way, the women viewed the quality of care provided to them as a favor to help the "helpless." Consequently, these women reported that even "good" care provided to them was often accompanied with the notion of charity provided by whites to the helpless Blacks. In Unique's narrative she said:

> I think there's racism everywhere, but I think there's racism in the healthcare system … we're just looked at differently … I think African American women are more looked at as a charity case in a way. They looked at us like, "It looks better if I help this lady lift weights because I'm Caucasian and I'm helping somebody different than me, so it'll look better on my end if I help her."

Unique reasoned that the care delivered to African American women during pregnancy is not aimed at their best interest, rather as a way that doctors, whom she framed as Caucasians, foster a positive image for themselves, so as "to look better." Zee's story was similar as she agreed African American women are often treated as low-class patients:

> I just feel like people care about other races than our, than our own race. Uh, you know, they're just like, "Well, we don't care about the Blacks. Let's just make sure that other races are okay." Like, the Caucasian just make sure they're okay before we make sure the African Americans are okay. So, they basically like put us on the backburner.

Specifically, Zee believes that Caucasians get better treatment at the expense of African Americans, as African Americans are treated as inferior, thus, uncared for. In her narrative, Megan reasoned that African American women are treated poorly because whites have positioned them as inferior who should be "helped" When we asked Megan why she had this perception about doctors, she said:

> It's just, I don't know, like I never had that problem with a doctor, but it's just a thought that crosses my mind too as well. Like, you know, "You [whites] sit and help us, but you feel like we just beneath y'all, like we don't deserve it." Like they think, some not all, but some doctors could possibly think, "We shouldn't have to help because this money [for your healthcare] expenses is coming out of our pockets, we got to help y'all. We really don't want to.

Megan, similar to other women in this study, reasoned that the problem of maternal crisis among African American women is rooted in systemic racism, to control the Black population so that whites may continue to dominate them. While this perception may be subjective, it exemplifies a bigger issue of mistrust in the healthcare system.

The Study's findings show how racial identity impacts healthcare access and experiences for African American women during pregnancy, labor and delivery and in the postpartum period. Through implicit and explicit biases, healthcare providers' communicative acts were identified as racially denigrating and discriminatory toward women.

Discussion

Communication stands at the core of women's narratives when reporting their experiences of racism in the way maternal healthcare services were provided to them. Communication strategies, acts, and dynamics culminate to form the platform through which racial discrimination is enacted and perceived (Kreps, 2006). Studying maternal healthcare experiences from a communication perspective helps to center the voices of women, and CRT helps to uncover ways in which structural racism is communicatively enacted.

In revealing structural practices that inherently advance racial discrimination in the healthcare system, the biomedical approach was critiqued in women's narratives. The biomedical structure of the U.S. healthcare system, as an institutionalized form of racism, paves the way for the denigration and the dismissal of African American women's choices in maternal care. Ultimately, the biomedical approach, as a healthcare "standard" practice, creates a space that dehumanizes women, rendering them incapable of making decisions that concern their own health and the health of their babies. Functioning in a hegemonic healthcare system, positions healthcare providers as the only ones who can make decisions on behalf of women, through structured practices that are not tailored to meet women's unique needs, leaving African American women feeling incapacitated and dehumanized (Freeman et al., 2017).

Through the interest convergence tenet of CRT, our data reveals how the supposed help for the minority groups further places them on the margins of society for less than optimal care

during pregnancy. Racial discrimination manifests through healthcare providers' disposition toward public insurance, that is, Medicaid, as women consistently reported discriminatory treatment based on their type of insurance. In some cases, they were denied care, when the care requested was deemed by a provider as being unnecessary. Again, CRT helps to uncover how systemic practices aimed at promoting health equities are disguised forms of racial discrimination because of the way they are enacted.

CRT further enabled us to see how dominant cultural norms, especially socially constructed racial and gender expectations, negatively impact African American women's maternal care (Freeman et al., 2017). The cultural notion of women as "natural endurers" of pain alongside the racial stereotype of Black women as extraordinarily strong impacted how African American women's pain was perceived and managed, especially during labor and delivery. African American women are indeed often perceived as possessing extraordinary ability for putting up with pain (Davis, 2015; Stewart, 2017; Watson-Singleton, 2017). The strong Black woman, a cultural discourse, evolved from the historical experiences of African American women as they assumed different roles (wives, mothers, breadwinners, activists; Parks, 2010; Woods-Giscombé, 2010) during the era of slavery, and was developed as a coping discourse to upend the notion of promiscuity or "baby mamas" ascribed to African American women (Parks, 2010). This discourse has been found to work to the disadvantage of African American women especially in the healthcare setting (Ashley, 2014; Woods-Giscombé, 2010). Perceived for their supernatural strength, African American women have continued to experience a disenfranchised form of healthcare, one that undermines or dismisses their concerns as patients within the healthcare setting. The dismissal of pain under the stereotype of being strong is a major theme of maternal crisis narratives from Black women in the United States (National Public Radio, 2017). Until healthcare providers begin to confront implicit biases toward African American women, women will continue to experience implicit racism in maternal care and poor maternal health outcomes for African American women will persist.

Distrust in the healthcare system has been a long-standing experience of African Americans, traceable to the Tuskegee study of 1932 and many more unethical treatment of Blacks in medical research (Scharff et al., 2010). As a result of this, women in this study also reported the same perception, albeit not because they were discriminated against. They already had an existing perception that the healthcare system, just like any other social institution in the U.S., is set up against them, and to their disadvantage. Consequently, even when healthcare providers are putting up their best practice, there is still some level of distrust in the way those services are perceived (Durant et al., 2011). This may lead to unwillingness to comply with healthcare providers' recommendations (Adebayo et al., 2020) This experience shows how damaging systemic racism can impact patient relationship with their healthcare providers.

Consistent with the argument of Kreps (2006), communication functions as the tool for uncovering racial disparities in the healthcare. Similarly, our study reveals that the enactment of structural racism and different institutional practices that marginalize minority groups are communicatively performed. For instance, the women who reported different forms of racial discrimination made sense of them through the way their healthcare providers communicated to them both verbally and nonverbally. Essentially, communication is not merely a way through which we make sense of healthcare practices, it is the primary platform of operation for provider-patient relationships in every form.

In identifying the role of communication in healthcare context, health communication scholars can be positioned to address these issues through communication concepts (Parker & Kreps, 2005). Our study has led to the development of important knowledge about healthcare practices that underserve African American women, which include ignoring women's concerns under the guise of standard practice and structural racism. As evidenced in our study, the continuation of these practices lead to medical mistrust and in some cases fatal complications, exacerbating poor maternal and infant health outcomes.

Study implications for healthcare providers and health communication scholars

Findings from this study show that healthcare providers may not be aware of some standard practices in the healthcare system that inherently underserve African American women. Thus, we suggest that policies that are developed by healthcare administrators should target the needs of African American women, as well as other minority populations. To create a healthcare system that serves African American women, healthcare providers and administrators should continuously receive training in intercultural awareness, addressing issues such as racism, health inequities among minority population, as may be manifested in healthcare institutional practices.

In communication scholarship, our study's findings contribute the body of knowledge confirming the central influence of communication in healthcare delivery, as women in this study identified their experience of racial discrimination in healthcare structures and practices, they made sense of them through communication. In reporting how healthcare providers perceive them, African American women consistently reported communicative acts, both verbal and nonverbal, as indicators of how they are perceived. Communication functions at the heart of healthcare delivery. Specifically, with the end goal of addressing maternal mortality crisis among African American women, communication scholars are better positioned to identify communication markers, discourses that may significantly affect healthcare processes, including the interpretation of healthcare providers' attitudes toward patients.

Racial discrimination is not only existent in the health system. It is everywhere; in universities, in workplaces, and in health care. As such, issues of racial disparities should be treated from an intersectional perspective, through active collaboration between individuals and groups from different sectors of society. Facilitating such intersectoral collaboration that will effectively address racial health inequities, is an important research focus for future community engagement research.

Notes

1. In this study, we do not use the terms "Black" and "African American" interchangeably. Whenever the term "Black" is used, we are referencing all people of African descent, including African Americans, while the use of African Americans specifically speaks to African Americans in the United States (See American Psychological Association, 2019, p. 143).
2. This is a type of healthcare delivery that displays healthcare disparities based on racial differences, especially between Black and white patients (Goodman et al., 2016).
3. We conducted a pilot study to explore if both Black immigrant women and African American women share similar maternal care experiences. The findings showed that African American women's experiences are different from that of Black immigrant women. We included the data of the African American women who participated in the pilot

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