

BLACK AT THE OBGYN: RHETORICS OF RACE IN WOMEN'S HEALTH CARE

by

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A Dissertation
Submitted to the
Graduate Faculty
of
George Mason University
in Partial Fulfillment of
The Requirements for the Degree
of
Doctor of Philosophy
Writing and Rhetoric

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Date: _____ Spring Semester 2022
George Mason University
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Black at the OBGYN

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Doctor of Philosophy at George Mason University

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Spring Semester 2022
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DEDICATION

This dissertation is dedicated to my daughter, Nozomi Decota Jabulani Joyner. You are the catalyst for every impressive thing I have ever done and will ever do. My love for you is my superpower.

ACKNOWLEDGEMENTS

To my committee, obviously there would be no dissertation without your input, your generosity of time and wisdom, and your encouragement. Thank you, Heidi for being the mentor and Chair that I needed. I cannot begin to describe the difference you have made in my life. It meant so much to me, when my son was sick, that you reached out and showed that you cared. Although I ate most of the fruit in the edible arrangement, my son did not give up that balloon until it went completely flat. To Drs. Isidore Dorpenyo and Leah Adams, you both have been the most patient, kind, and gracious committee members I could ask for. Thank you for helping me shape this project.

To my husband who supports my dreams and aspirations, who reminds me of my purpose when I get distracted with all the rules and expectations this ridiculous world has to offer, thank you. I have always been able to count on you as my partner to make sure our lives keep running, even as I spent hours and hours in the office begging to be left alone. You are my favorite person. I love you.

To my children who have not always understood what I was doing but who always supported it. Thank you to my daughter, Nozomi, for proposing the occasional mental health day. Thank you to my son, Izekiel, for popping into the office for “scheduled hug time.” You two are overdue for some maximum spoilage after this, and I plan to give it to you. Smooches my munchies! And to Beauregard, my pandemic puppy and writing support specialist, who’s the best boy? You are!

To my parents, thank you for always supporting me and my family despite not always understanding what I was talking about. Your love has been foundational for everything I am and everything I do. I am who I am because you taught me critical thinking, work ethic, and self-confidence. Thank you, Dod, for coming to conferences and listening to me talk about rhetoric and sponsoring my solo writing retreat. I could not have finished in the amount of time I did without your help. I love you both so much.

To my friends and colleagues. Beth, my academic bestie, thanks for all the random Hangout session where we tried to work but mostly just vented. I needed those. To Team Heidi, you know who you are, thanks for being the collegiate, supportive, and honest colleagues that you are. Thank you for offering support and advice when I needed it.

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LIST OF ABBREVIATIONS

American College/Congress of Obstetrics and Gynecology	ACOG
Rhetoric of Health and Medicine.....	RHM
Technical and Professional Communication	TPC
Birthing While Black	BWB
Obstetrician / Gynecologist.....	OBGYN
Health Communication	HC

ABSTRACT

BLACK AT THE OBGYN

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George Mason University, 2022

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This dissertation spotlights the lived and inherited experiences of Black women as they navigate engagements with obstetricians, gynecologists, and other women's health care providers in conjunction with a rhetorical analysis of the American College of Obstetrics and Gynecology. Relying on rhetorical analysis and situated within a Black feminist epistemological standpoint, this study examines interviews with Black women who have had negative experiences in women's health care, often specifically with an OBGYN.

The insights gained from those interviews provide an entry toward better understandings of the way rhetorical constructions of race shape interactions between Black women and their health care providers. Comparing those insights with the rhetorical constructions of race used in OBGYN research, this dissertation argues for more research based in a social constructivist perspective and offers the opportunity to learn from Black women's experiential knowledge in dialogic renegotiations of the meaning of race and its role in health and wellness.

CHAPTER ONE

There was a sound trending on TikTok that says, “Doctors are to Black women what police are to Black men” (Monique, 2020). Admittedly, there are multiple problems with this statement. First, police are almost as deadly to Black women as they are to Black men, so the comparison there is false. Second, doctors are almost as deadly to Black men as they are to Black women. The analogy here is more valuable as an attention hook than it is logical, but the statement reveals a damaged and dangerous relationship between Black Americans and the institution of medicine. Black Americans’ relationship with the institution of Medicine (Big M) is founded in white supremacy and the legacy of slavery. Further, the relationship has been repeatedly characterized by dehumanization, abuse, and ignorance on the part of medical researchers and practitioners. I have experienced the consequences of this relationship myself and was moved by the ordeal and subsequent realizations to study the issue of socially situated health disparities from a rhetorical perspective, not only because rhetoric is my area of expertise but also because the problem is inherently rhetorical. Parties on both ends of the discourse on health disparities – patient and practitioner – struggle to persuade one another and come to agreement on what to do about the problem.

In this introductory chapter, I detail the personal and political exigencies of this dissertation research. I briefly describe the connection between the history of American

medicine (Big M) and many Black Americans' troubled relationship with health care. I also explain the research questions that arose from examining scholarship on the issue and the studies I conducted to help answer those questions. A summary of chapters lays out the trajectory for the rest of this dissertation paper.

Immediately after delivering my first child, I suffered prolonged hemorrhaging and had to undergo an emergency life-saving procedure to stop the bleeding. While I have very little memory of what happened after the delivery, recalling it continues to disturb my husband who was present and conscious for the entire ordeal. The morning before, I was prompted to visit the hospital by unexpected hemorrhaging. I had already experienced the issue which landed me in the prenatal wing of Shady Grove Hospital (note: mention the socio-economic difference between shady grove and Washington Adventist) for two weeks the month before as it was a sign of premature labor. My husband and I explained my medical history when we arrived at the hospital. I was admitted to the maternity ward and connected to a contraction-detecting device and a fetal heart rate monitor. After about two hours, the doctor checked the readings from both devices and informed me that I was not having contractions. Having experienced identical symptoms the month before, I explained that I felt contractions more in my back than my abdomen and suggested the contraction detector (my name for it) be placed on my lower back. The attending physician dismissed my suggestion, declared that I was not in labor, and had me discharged. I was back home that afternoon, in intermittent pain and constant anxiety. By the time I returned to the hospital later that evening, I was further

along in the labor process than I intended to be. I received an epidural when almost fully dilated and after my daughter was born, continued to bleed out until surgeons intervened.

Throughout the process, my concerns were dismissed, and my insight was ignored. Despite my medical history and the fact that I was presently bleeding, the attending physician insisted that there was nothing wrong and that I was not in labor. The blood that only four weeks prior had meant a two-week stay in the hospital now were completely normal and nothing to worry about. My experience with contractions taking place in *my* body was overruled by numbers on a machine. The doctors and nurses could not or would not interfere with the sensor or its calculations by moving it to where I felt the most pain. To receive care for my labor and delivery, I had to wait until my cervix provided irrefutable proof that I was indeed in labor. Proof that the previous physician did not even look for. I still do not know why the second doctor took me seriously when the first one did not. I can only wonder what would have happened if the first doctor had admitted me for labor and delivery, or worse, if the second doctor would have dismissed me because of the same calculations as the first.

At the time, I did not realize that what I was going through was reflective of a larger crisis, but I have since learned that disparities in health between Black and White patients have been apparent for decades. It turns out that my experience is not unique. Black women suffer from some of the worst health statistics across multiple categories. The least of these disparities is life expectancy, where White women live an average of 3 years longer than Black women (Arias et al 2021). When it comes to childbirth, Black women are about 3 times as likely to die in childbirth (Hoyert, 2020) And the maternal

mortality rates have been increasing. Maternal mortality rates are defined by the CDC as, “Maternal mortality rates, which are the number of maternal deaths per 100,000 live births” (1). Over the last three years the maternal mortality rate for Black women has increased by 48%, from 37.3 deaths per 100,000 births to 55.3. In addition to being more likely to die in childbirth, Black women are also much more likely to die from pregnancy related complications up to a year after being pregnant, whether or not they delivered a child. And being pregnant is most risky for expectant mothers after the age of 40, where the rate of deaths per 100,000 is 191 to the average 65.7 and white women’s, 53.9. In other words, Black women over 40 who get pregnant are 2.91 times more likely than the average rate and 3.55 times more likely than white women to die from complications related to their pregnancy (Creanga, 2013). The data shows that Black women are dying to be mothers and the problem is getting worse not better.

For me, what makes the significance of these statistics more painful is that Black women experience fairly similar prevalence rates for the complications and health emergencies that kill us, meaning we do not necessarily experience pregnancy related complications at significantly higher rates, we just die much more often. Tucker et al (2007) find that while Black women experience pregnancy related complications at around the same rate as white women, they die from these complications 2-3 times more often; in the case of my complication, post-partum hemorrhage, Black women die at a rate of 3.3 to 1. For example, the prevalence rate for the postpartum hemorrhage that almost killed me is relatively common among Black and white, but white women actually experience it more often. The prevalence ratio Black – white for postpartum hemorrhage

is .8 to 1. The rates of death per case of postpartum hemorrhage are, 3.3 to 1. Black women are less likely to experience this complication but over 3 times more likely to die from it. This is the case across the most deadly complications. As horrible as that realization is, the information was much less shocking to *me* than it might be to others. The information hurt so much because it was not surprising, partially because it felt like a reprisal of the same message about Black women that has been circulating since this country's inception. The message is that our lives and experiences do not hold equal value to those of white women. That message came through in my experience which I can only characterize as dangerously frustrating.

The problem of socially-situated health disparities bears consequences across racial and economic lines, as famously wealthy and well educated Black women like Serena Williams, Beyonce Knowles-Carter and Dr. Tressie McMillan Cottom have recounted. Whether a Black woman has a Ph.D. or a G.E.D. she is more likely to experience substandard health outcomes than her white counterpart. The causes of health disparities among Black Americans, like those of wealth and general safety, are multifaceted but can ultimately be traced back to the transatlantic slave trade and African colonization. However, disparities research rarely acknowledges historical context in a meaningful way. In other words, research fails to fully account for the rhetorical situation of health disparities or the potential role of rhetorical awareness in addressing them. Instead, much of the attempted solutions to disparities have been in the realms of health communication and literacy. This approach to disparities uses a deficit model to

characterize the underserved patients as under educated and at fault for their own health outcomes.

Big M's Role in White Supremacy: Constructing Race and Its Rhetorics

I was inspired to study this issue from a rhetorical perspective by Harriet Washington's (2008) *Medical Apartheid*. One day, while I was talking about the horrors of giving birth with my sister, she recommended Washington's book with a, "Girl, when you read this book, you'll be real mad. I don't trust any of them now." She was right. Reading *Medical Apartheid* made me real mad. In it, Washington exposes the consistent mistreatment of Black people in the United States by medical practitioners and researchers, arguing against the narrative that abuse has been sporadic, or the actions of a few maligned doctors. Instead, Washington highlights the multiple examples of a doctors' willingness to treat Black bodies as subhuman and expendable.

Since the inception of this country, Big M's disposition toward Black people has been uniquely predatory. Doctors have been known to perform experimental surgery on unwilling Black bodies, both enslaved and free. Washington's work provides a broad historical survey of African Americans in experiences with Big M and more narrowly focused accounts of specific, often horrific, examples of medical abuse of African Americans. She does so to highlight the pattern and situation of abuse that started then and persists today. She wants readers to move their attention past singular incidents like the Tuskegee syphilis experiments and into recognizing the larger history of dehumanization. Her work illustrates how medical research of the 18th and 19th centuries was used not only to keep white laborers healthy, but also to support their social and

hereditary superiority to Black people. In other words, the medical institution kept white labor happy and healthy by solidifying white workers' social and biological status as above that of Black people. To achieve this goal, the institution of medicine designed and promoted the very stereotypes that still lead to implicit bias among medical professionals and everyone else for that matter. While individual medical professionals may be products of a larger racist system, Medicine as an institution (Big M) is responsible for helping build and sustain that system.

Before physicians enjoyed the social status and privilege ascribed to their profession today, they had to organize and build structures that would ensure the power to create knowledge rested with them and only them (Foucault, 1980). In the U.S., medicine's push to secure its place as an irreplaceable institution meant that medical organizations and practitioners needed to produce a lot of 'knowledge.' Unfortunately, they did so by sacrificing the lives, wellbeing, and dignity of Black people, enslaved and free, alive and dead. The medical care of the 18th and 19th centuries did not account for the existence of germs or microbes. Doctors practiced heroic medicine, the kind that seemed to either "kill or cure" (Washington 2008, p. 27). Examples of this include cupping, bloodletting, and other procedures that required the unnatural release of bodily fluids (Segal 2005). In times of great physical duress, perhaps a white person could be prevailed upon to offer themselves for the types of dangerous procedures available as therapy at that time. However, more often than not, if a doctor wanted to test out a procedure, he did so with the body of an enslaved Black person (Washington 2008).

“Black People Were Guinea Pigs”¹

The advances in medicine achieved by doctors like Marion Sims, known as the father of gynecology, happened via the torment of unwilling Africans forced to live in the United States. Washington points out the contradiction between an artist’s depiction of Sims and the written accounts of his experiments on unanesthetized Black women whom he had enslaved. While the painting shows an innocent scene of examination that portrayed a sense of dignity among all the subjects in the piece, written accounts detail the horror of screaming women being forcibly held down while Dr. Sims cut into their flesh at will. This opening scene serves as a metaphor for the history of medical experimentation on Black people in America. Medicine’s role was to advance knowledge that would pacify Black bodies for the good of White health, even if it had to hide the details of this task, as Washington writes “in plain sight” (p.11).

In addition to using Black people as experimental guinea pigs, medical rhetoric, both physical and psychological, positioned them in society either as harbingers of disease and immorality, as idiotic children that required constant oversight, or as inherently angry and violent. Before the Civil War, physicians helped secure the hold of slavery for as long as possible by asserting that without the slave master to take care of them, Black people would be overcome by diseases of the mind and body. As northern states began to join the rest of Western civilization in phasing out the practice of chattel slavery, Southern politicians needed help fighting against pressure to end their barbaric

¹ This is a quote from a woman that I interviewed for Black at the OBGYN which I feel aptly describes the theme of Medicine’s disposition toward Black people.

institution. That help came from doctors who argued that slavery was better, not just for the southern economy, but also for the wellbeing of the enslaved, who were too ignorant and degenerate to be left to their own devices. For example, early psychologists would study those free Black people who had been apprehended and deemed “insane” and often attributed those diagnoses to the pressures of freedom (Washington 2008, p. 143). This kind of rhetorical assistance from the scientific community in the United States secured medicine’s political power by aligning the profession with existing power structures.

Early claims that African Americans were biologically inferior, and probably subhuman, helped ease the consciences of White Christians, as well as their fears that they might be overrun or outdone by the Black people upon whose free labor the entire southern economy relied. In one instance, organizers of the 1904 St. Louis World Fair (Louisiana Purchase Expedition) put Africans from the Congo on display while articles in *Scientific American* (1905) compared them with apes and “goblins” (p. 107). Later, one of the Africans, Ota Benga, was placed in a cage at the Bronx Zoo with a gorilla and an orangutan, and when leaders of the local Black religious community protested, they were ignored in favor of scientific evidence of evolution and Ota Benga’s status as a lower species of human (New York Times 1906). While outward suggestions that African Americans are subhuman phased out of popularity, the inscription of race as a biological concept serves as the contemporary iteration of such ideas.

White Supremacist Arguments of Genetic Hierarchy

The Eugenics movement in the United States is one of the most horrific examples of Medicine’s attempt to inscribe race as a tool for biological categorization, and it only

ended 40 years ago. In a move to “strengthen” the genetic makeup of the US citizenry, doctors sterilized many thousands of people of color, as well as many women and disabled Americans. In her chapter of Williams and Pimentel’s edited collection, *Communicating Race Ethnicity and Identity in Technical Communication*, Flourice Richardson (2014) examines the messaging used by the state of North Carolina to justify their policy of sterilizing over 7000 of their most vulnerable citizens from 1924 – 1979. Richardson recognizes those policies as informed by theories of eugenics, a scientific movement that gained prominence around the beginning and sometime after World War II. Proponents of eugenics argued that humanity would benefit from the weeding out of certain undesirable, or weak, genetic types. Because of this desire to eradicate certain populations, eugenics is rightly labeled by Richardson and others, like myself, as a genocidal enterprise. In *American Lobotomy*, Janelle Johnson describes another eugenics informed enterprise, but instead of killing or sterilizing Black people, the goal was to incapacitate them. She notes how in justifying forceable lobotomies, the rhetoric regarding Black men framed them as inherently angry, and thus dangerous, making it necessary to lobotomize them. Overt proponents of tactics like eugenics, lobotomy, and their ideas have been merely pushed into hiding. Present day permutations of the same premises that undergird eugenicists’ claims continue to assert themselves into scholarly conversations about race and medicine, even as the scientific community writ large agrees that race is a social construct, not a biological one.

Although Washington’s work is not explicitly rhetorical in its focus, I could not help but see how the pattern of abuse was perpetuated by rhetorics of race. By rhetorics

of race, I mean any conversations where race is treated as a relevant factor or topic of discussion. Rhetorics of race is more general than the rhetorical construction of race, which I use to refer to the way race is defined through rhetoric in specific contexts. In the first instance, race (as a rhetorical construct) is deployed for in a rhetorical endeavor. In the second instance, race is being constructed or defined by rhetorical means. For example, the arguments used to treat Black patients differently than White ones are enabled by rhetorics of race, or arguments that use race to support a claim. The rhetorics of race are useful for this purpose because of how race as a concept has been constructed. Instead of race being understood as a purely superficial descriptor, it represents an ideology of human hierarchy, with whiteness as the uppermost category. In other words, race is a concept that has been rhetorically constructed to function socially for the benefit of white supremacy. Thus, before we can change how rhetorics of race have operated and continue to operate, we must also examine how race has been constructed rhetorically. One premise of this dissertation is that race has been and continues to be rhetorically constructed by Big M in ways support white supremacy.

That is not to say that the effect of these rhetorics is always intentional, but that they must be examined critically and adjusted. Both Washington and Richardson show that scientists often see their work as objectively scientific and an arm of the public good, even as their arguments for the acceptance of their conclusions are inherently rhetorical. Although Washington reveals the rhetorics of race woven into the very fabric of medicine's position in American society, she also acknowledges that many scientists see themselves as heroes rather than villains. It is obvious in her retelling of things that

medicine saw its abuse of Black people as sporadic, even novel – something that has happened once or twice but has been corrected each time. Many doctors do not see how medical rhetoric has contributed to a rhetorical construction of race that has been used to oppress Black people in the United States for hundreds of years. In turn, Florence Richardson provides an example of how the rhetorics of race have been used to justify horrendous acts of medical violence. Scholarship in the fields of medicine, health communication (HC), rhetoric of health and medicine (RHM), and technical and professional communication (TPC) has potential to shed more light on an inherently rhetorical problem although much of the work done thus far falls short of robust rhetorical analysis.

Contemporary Symptoms of a Historical Disease

It seems like for the first time, the broader public is starting to recognize the immense disparity in health outcomes between white and Black patient populations and some of the history upon which these conditions have been built. Comparatively, within and between scholarly communities of health and medicine, the problem of health disparities has been recognized for some time. Nevertheless, these problems persist and continue to kill Black people more than anyone else. They persist because the history of medicine's attacks on Black bodies is more than just the result of systematic racism; medicine's historical abuse and dehumanization of Black people helped build the unique brand of racism that the US boasts today.

History shows that America's disposition toward Black people has been shaped by rhetorics of race that used a rhetorical construction of race which inscribed it as a

biological concept instead of a social one. This construction of race treats a social condition like a medical one in order to perpetuate the devaluation of Black life. It supports less medically bound rhetorics of race by making them seem inherent rather than learned. Racquel Robvais (2019) describes this in her dissertation on the rhetorics of sickle cell anemia. In it she explains that “in SCA [Sickle Cell Anemia] discourse we find that the ideology of white supremacy facilitates the emergence of technology to name and corroborate disease characteristics and to make claims that interpret particular bodies as essentially inept and disposable” (p. 61). Robvais shows that rhetorics of health and medicine often reify these essentialist ideas about race in ways that either purposefully or unintentionally support white supremacist ideology. Thinking in the same way, the doctor tells themselves that a Black person is not less deserving of pain medicine because they are lying about their level of pain, but because African Americans are inherently less sensitive. These rhetorics of race refuse to acknowledge the inherent value of human life or reciprocate the contribution made by those who have been racialized. The negative health outcomes that Black people experience as an indirect result of institutionalized medical racism cannot be solved simply. They took centuries of meaning making that inscribed race as a biological marker of inferiority, an understanding that ultimately manifested as arguments used to justify inequitable treatment in more arenas than medicine.

Room for Multidisciplinary Disparities Research

The disciplinary scope of this dissertation is shaped by research in the fields of Rhetoric of Health and Medicine (RHM) and Health Communication (HC) fields, which

each deal with rhetorical considerations in their own way. It is also inspired by the cultural and social turns in Technical and Professional Communication (TPC) scholarship which have allowed for more a more humanistic approach to research which was once purely positivist. The literature shows that Big M's disposition toward health disparities continues to place blame with the patient rather than the institution, effectively absolving themselves of the history of racism that shapes their status in the United States. This stubborn positionality on the part of the US medical system is evident in the approach RHM scholars often make toward helping patients advocate for themselves, but not how doctors can treat their patients with more human dignity and respect.

There is very little historically informed rhetorical study into how doctors' communication practices may influence the level of care they provide, or into how doctors can take an understanding of history into their interactions with Black patients. The field of Health Communication (HC) comes from a prolonged intersection between Communication Studies and Medicine as evidenced by the educational and professional backgrounds of those who published in the earliest days of the journal, *Health Communication* which was founded in 1989 and which according to the Aims and Scope section of the website, publishes on topics including "provider-patient (or family) interaction, health campaigns, health information, health promotion, interviewing, health public relations, and gerontological concern" (n.p). Scholars who published in this journal hailed from medical schools and communication departments alike and worked to apply communication theories to the context of health and medicine in ways that could influence patient behavior. Yet despite the understanding that communication could not

“control” patient behavior (Smith 1989, p.22), much of the reported goals in health communication research involve influencing patients to take certain actions, not doctors or researchers (Kim 2010).

As Kim et al (2010) show, a minimal amount of HC scholarship examines the sender of the information. In a survey of all the articles published in *Health Communication* the journal from 1989 – 2010, Kim et al identify the major focus areas of research. In that period, the proportion of articles that addressed senders rather than audience or message was 7%. Research that included critique and “examined the interplay of power and control in the institutional structures of policy making organizations, structures of campaign design and implementations, and structures of health care delivery” made up less than 2% of the literature (p. 491). Work that examines meaning-making in health and medicine contexts made up less than 1% of the canon. Instead, scholars in this field tend to focus on how to adjust messages and communication toward patients in ways that will lead to better health outcomes by encouraging some behaviors and discouraging others.

Using communication theories to better understand the production and reception of messages, HC scholars look for ways to improve communication from doctors and medical institutions to patients and the wider public. Examples of research in this area include studies that measure the effect of communication materials on patient behavior and those which assess patient reactions to communication efforts. Some studies attempt to account for both. For instance, Jones et al (2016) examine the effect of mentioning health disparities on patients’ ability to consistently complete prescribed health tasks. The

authors suspected that communicating about health disparities may invoke stereotype threat among Black patients which seems to negatively affect patient persistence with a prescribed task. Stereotype threat is the tendency for members of a stigmatized group to underperform when a situation suggests they may be stereotyped. The authors hypothesized that when materials mentioned health disparities between Black and White patients, Black patients became more apprehensive about completing tasks like filling out health assessments because they feared confirming the stereotype of “Black health inferiority” (p. 258). They tested this theory by presenting a test group with a PSA that discussed racial health disparities with a neutral health topic and a control group with a PSA that only discussed the neutral health topic.

Jones et al’s study is an example of communication theory applied to a specific medical context for the purpose of measuring communication’s effect on patient behavior. It also shows how health communication tends to skim the surface of rhetorical theory without delving deep into meaning-making. While the researchers might have attempted to better understand or explain “Black health inferiority” as a rhetorical phenomenon, they chose instead to stop at mere acknowledgment of its existence as a stereotype. Limiting the scope of study in this way is reflective of HC scholarship in general because the goal is only to understand a concept, problem, or theory enough to attempt interventions in patient behavior. While Jones et al’s (2016) work is not part of the corpus of articles that Kim et al (2010) analyze, it correlates with the priorities indicated in literature review’s results. The focus of research in this field clusters around the audience that will receive messages (41%), the messages themselves (15%), and to a

somewhat lesser degree the interaction between the audience and sender of information (13%) (p.491). Together that makes 69% of all research in Health Communication over 22 years. Discussions of the historical or systemic mechanisms in communication that may lead to unequal health outcomes for Black patients are few and far between.

Perhaps the scope-limiting aversion to critiquing doctors or the structures that facilitate their work is wrapped up in the scientific paradigms of objectivity and rationality. Science stepped in during the Enlightenment as a kind of replacement for religion which provides an order to life and death. People sought to make sense out of creation in ways that did not rely on myth or doctrine. For many, science reveals an order that is waiting to be discovered, understood, and tamed for the progress of humanity. Questioning or critiquing the structures that place medicine on such a high pedestal may seem antithetical to the goal of creating order out of chaos.

Scientists have long promoted the idea that study should be objective, and medical science in particular, must fight to be objective for the overall good of the public's health. Carolyn Miller (1979) points to an earlier article in IEEE Transactions on Professional Communication as an example of this thinking in "A Humanistic Rationale for Technical Writing," where she quotes: "Since scientists agree that their observations and conclusions should be presented as objectively as possible, rhetoric should be avoided assiduously in scientific writing" (As quoted p.140). Miller rebuts this thinking by reminding the reader that scientific knowledge is not achieved objectively, but through rhetoric. This understanding that knowledge creation is achieved by consent—that truth is not waiting to be discovered but is agreed upon through deliberation and reified

throughout history in waves and cycles— undergirds much of RHM inquiry. In fact, the areas that Kim et al (2010) identify in the lowest numbers – sender, critique of social and institutional systems, and meaning-making – are the main purview of rhetoricians and by extension RHM scholars (p. 490)

In *Risky Rhetoric*, J. Blake Scott (2003) defines the boundaries of the rhetoric of science by dividing its projects into three main categories: (1) rhetorical analysis of scientific text, (2) analysis of knowledge-making processes, and (3) studies of what he calls the “public rhetoric of science” or the way science is discussed by the public (pgs. 17-19). Scholarship in the rhetoric of health and medicine seems to fall along the same lines. Recent examples of rhetorical analyses of medical texts include Molloy’s (2019) *Rhetorical Ethos in Health and Medicine*, Campbell and Angeli’s (2019) “Embodied Healthcare Intuition: A Taxonomy of Sensory Cues Used by Healthcare Providers,” Russell Kirkscey’s (2019) “Shifts and Transpositions: An Analysis of Gateway Documents for Cancer Genetic Testing,” and Patty Kelly’s (2020) “The Development of American Psychiatry’s Professional Style: DSM-III’s ‘Common Language.’” RHM scholars have the analytical tools to deeply examine healthcare and its contexts; they just have not yet been applied to maternal health disparities.

The idea that diagnosis of an illness involves persuasion from patient to doctor and not the other way around is beyond the goals of HC scholarship, but the role of persuasion in every facet of life is the bread and butter of rhetorical inquiry. In *Health and the Rhetoric of Medicine*, Judy Segal (2005) shows that RHM sets itself apart from health communication by its potential to understand not only the messages that circulate

in health and medicine contexts, but also events, understandings, and opportunities that make those messages possible - in other words, kairos. Segal explains that rhetoric is a viable lens through which to better understand problems in the realms of health and medicine. On the very first page of her seminal work, Segal makes a concession that I have yet to find in any health communication literature, namely that “Patients may have to persuade physicians that they are ill and in need of care” (p. 1).

Segal offers rhetorical analysis as the broad goal of RHM scholarship, and its aims can be both “useful” and “applied” (4). Research can be useful by revealing the inner workings of previously opaque situations and applicable to specific course of action. She also offers a game-changing methodology for RHM research in the concept of “kairology,” “a study of historical moments as rhetorical opportunities” (23). While this type of study can be applied in almost any historically grounded situation, Segal’s suggestion that it be applied to medical history contradicts positivist notions of medical discovery. It invites work that examines medical phenomena from the assumption that rhetorical analysis will reveal what positivism tries to hide, the role of persuasion in creating medical knowledge and sustaining medical systems and institutions. In “Realms of Rhetoric in Health and Medicine” Coleen Derkatch and Segal (2005) detail some opportunities to apply rhetorical principles to the practice of medicine. Explaining that the goal of rhetorical criticism is a deeper understanding of human behavior, to “identify the persuasive element in the discourse... and ask ‘who is persuading whom of what?’” and how, Derkatch and Segal identify some areas of potential inquiry (139). Rhetoric’s

explanatory power can be applied to medical texts and other cultural artifacts to understand how their form and structure support persuasive functions.

Addressing the Gap

My dissertation addresses gaps in HC and RHM scholarship in a few ways. It considers the ways in which medicine as an American institution helped inscribe the rhetorical construction of race to help cement its privileged role in American society. I offer this work as a step toward placing responsibility for better care on doctors rather than patients by outlining a rhetoric of respect that shapes medical interactions in ways that avoid putting pressure on patients to persuade their physicians that they need treatment and instead provides a framework for coming to agreement on what needs to happen.

By revealing the potential space for rhetorical theory and analysis to provide greater insight into the problem of health disparities, I hope to inspire other scholars in the rhetoric of health and medicine to take a long hard look at our potential to push praxis toward more equitable outcomes. While I am disappointed in the lack of RHM scholarship in area of health disparities, I also understand that deficit to be reflective of the field's demographic composition at present. A focus on positionality and an aversion to cultural appropriation or misinterpretation may put some White researchers off the subject of race and racism toward Black people as a site of inquiry. However, I also contend that the ultimate consequence of this hands-off scholarly position is a de facto denial of continued injustice. Nevertheless, a rhetorical analysis of knowledge-building

practices, like Scott (2003) discusses in *Risky Rhetoric*, but in obstetrics and gynecology can help explain how African American experiences with American medicine would benefit from being deeply rooted in a Black feminist epistemological framework.

To address the gap in disparity research, this dissertation offers three lines of inquiry: (1) What rhetorical dynamics shape disciplinary discourse on Black women and socially situated health disparities in Obstetrics and Gynecology? (2) What are some rhetorical dynamics governing Black women's negative experiences with OBGYNs? (3) What lessons can be learned from Black women's experiences with OBGYNs, and how might OBGYNs effectively employ rhetorics that treat Black patients in ways that patients perceive positively?

To answer the first question, I conducted a rhetorical analysis of the public facing and disciplinary discourse of the American College of Obstetrics and Gynecology (ACOG). The first part of this analysis focused on public facing rhetoric in the Birthing While Black Congressional Hearing in May 2021. The other part focused on publications for the last 10 years in ACOG's scholarly journal *Obstetrics and Gynecology*, also known as "the Green Journal." As one of the most politically active organizations for obstetricians and gynecologists, ACOG often represents the entire field, especially in terms of public engagement. ACOG was the only professional organization representing the field at the Birthing While Black hearing. My goal in these analyses was to better understand how rhetorics related to race shaped discourse around maternal health disparities and to look for opportunities to intervene rhetorically.

To answer the second question, I interviewed 10 Black women about their negative experiences with OBGYNs and identified rhetorical trends across testimonies. Their narratives are quoted at length in the chapters that discuss them because they offered much in the way of rhetorical understandings of respect in medical contexts between doctors and Black women. My goals in these interviews was to better understand the rhetorical aspects of their experiences and how those experiences reflected larger patterns in the discourse and practice of obstetrics and gynecology.

To answer the last question, I took a step back to see how all the pieces of information from the first two inquiries fit together. For this question, I looked for ways the rhetorical dynamics at play in medical and political discourse helped me better understand and contextualize the narratives of the Black women whose lives were up for discussion in those contexts. I also aimed to provide a heuristic for OBGYNs – and perhaps all doctors – to engage in more rhetorically effective and respectful interactions with their patients. In the next section, I will provide more details about the methods used in the rhetorical analysis and interviews.

Methods

Rhetorical analysis

I conducted two data collection activities to answer each research question individually. For the question of how OBGYNs discuss Black women and race as a concept, I searched for all publications that mentioned race. For the second question of causes and solutions, I collected citations for publications that mentioned disparities, bias, racism, discrimination, or similar terms. Adobe Acrobat has a search feature that pulls up

synonyms when one search term is entered. For example, if I searched an article for the term “bias,” the search may show me that the word “discrimination” occurs 3 times in a text. While the first search was extremely generative, the second search for articles that deal specifically with health disparities was slightly less so. While the original goal was to discover how OBGYNs talk about Black women in their research and disciplinary discourse, the search for a representative corpus turned up its own interesting observations. Together with an analysis of the research articles, conference papers, and administrative publications contained in *Obstetrics and Gynecology*, the following corpus reflects not only the textual rhetoric around race and Black women in the field, but also the level importance the field associates with the problem of maternal health disparities.

The collection process for each analysis was the same, I collected citations for all issues of *Obstetrics and Gynecology* from the past 10 years that mention race or terms related to health disparities. Using Ovid’s database, I performed a keyword search for all journals containing my search terms. Collectively, these keywords included, race, racism, bias, Black, African, disparities, inequities, discrimination, and system. Because Ovid’s database allows keyword searches across the entire journal, or in an individual issue of the journal, but not across a collection of issues, I had to perform the search across the entire collection in Ovid, from 1995. I also had to download all the citations available because Ovid did not have any functions for organizing the results by date or any other value. Using Zotero to save the citations from those searches, I set the database to organize the issues in chronological order. To set up a random sample set, I extracted

those journals to a new folder and reordered them in alphabetical order by title. I then started from the top and extracted every 5th citation to achieve a 20% random sampling.

After collecting the initial sample set, I used the citations to download full PDFs of each publication. To ensure that every text in the corpus was using the words I searched for in context and not as part of a larger word or alternative text description, I performed a CTRL+F search in Adobe Acrobat for the relevant search terms. For example, in two of the publications, race was a part of the larger word ‘contraception,’ and in one of the publications the word ‘black’ was used to describe bars on a graph. These instances of the terms’ use were out of the scope of either analysis, so I removed those publications from the corpus. I replaced them with whatever publication was listed immediately below the excluded text, performed the same CTRL+F search, and continued to code the texts.

For the first round of analysis, I simply searched the documents for instances of each word in context and highlighted the words. During this first term search, I did not read the text surrounding the search term, I only marked it and moved on. This quick search allowed me to label each text for easy recognition during an initial deep reading. The second round of analysis involved reading each publication carefully, taking note of when the search terms appeared and the surrounding context. This second reading provided a list of themes for how terms regarding race, Black women, and/or health disparities were being treated in the literature that aimed to address them.

Black at the OBGYN

Originally the plan was to conduct surveys first, then interview women who were willing to talk. The goal in that plan was to perhaps get enough data to make some quantitative observations about experiences with OBGYNs. However, despite my best efforts to distribute the survey to a wide array of potential respondents, I got very few responses. Definitely not enough to make any statements about themes or numbers. Upon going back to the drawing board, as they say, I considered that the surveys might be too impersonal, that they asked respondents to think of their own experiences in an abstract sense. In essence, I was going about the study from a white masculinist, positivist, standpoint – from my scholarly head – instead of my own standpoint – my Black lady sense. Reconsidering my positionality and the actual request I was making of women who had likely endured situations as traumatic if not more so than my own, I switched tactics and decided to only interview participants. This change of direction was shaped by engagement with Black feminist theory.

While I go into more detail about Black feminist epistemology in chapter 4, I will take some time to describe how this shaped the methods moving forward. I drew from Patricia Hill Collins' (2008) four tenets of Black feminist epistemology: (1) privileging personal experience as a criterion for meaning. (2) the use of dialogue to validate knowledge claims. (3) an ethics of care, (4) an ethics of Accountability (pp. 758–770). Using these tenets as a guide for constructing a more personally authentic approach to this project, I designed an interview protocol that asked open-ended questions meant to give participants the room to decide what information was important and what parts of

their story I needed to listen to. Instead of extracting the information that I thought I wanted, I asked participants clarifying questions and provided opportunities for the women to imagine themselves talking to their actual OBGYN. The conversational interviews that came out of this less structured interview protocol led to rich discussions of experience, where I shared as much as I received. In turn, this epistemological standpoint inspired my theoretical conception of respect as a rhetorical tool.

My engagement with Black feminist theory is shaped by the works of Combahee River Collective, Audre Lorde, Patricia Hill-Collins, and Jennifer Nash. The Combahee River Collective, a group of Black feminist that began as a study group and became a foundation for Black feminist scholarship and activism, inspires my goals and objectives in this work. I share in their valuation of initiatives meant to positively impact the lives of Black women: “If black women were free, it would mean that everyone else would have to be free since our freedom would necessitate the destruction of all the systems of oppression” (276). Audre Lorde influences my understanding of centering/marginalizing or normal/divergent binaries, and therefore my understanding of the rhetorical dynamics at play in maternal health disparities discourse. She explains that the “mythical norm... defined as white, thin, male, young, heterosexual, Christian, and financially secure” against which Black women are continually contrasted allows Black women and our needs to be ignored or erased in favor of progress or profit (133-4). Patricia Hill Collins and Jennifer Nash offer theoretical frameworks for grappling with the myriad injustices that Black women encounter. While I use Collin’s concept of Black feminist epistemology explicitly, I am also guided by Jennifer Nash’s “loving” treatment of

intersectionality and Black feminism that seeks to build rather than break down, even through critique and disagreement (n.p). In these examples, I situate both the impetus for and the shape of my research.

Significance of this Project: Toward A Rhetoric of Respect

The findings from these studies contribute to the fields of Rhetoric of Health and Medicine (RHM) and Health Communication (HC) by moving a difficult conversation – about how the context of health and medicine makes the problem of structural racism a deadly prospect for Black Americans, especially Black women, who more than anyone else must consider the prospect of motherhood as a potentially deadly venture – forward toward rhetorical solutions. While I do not argue that these changes in disposition toward Black patients will be easy or simple, I do offer guidance for shaping a path toward more respectful interactions.

In this research, I have found that respect as a rhetorical practice may be able to override bias because respect does not require a person to think highly or even well of another. Commitment to respect only directs the respecer to follow certain rules. Physicians who practice a rhetoric of respect would not need to run their decision making past value judgements about the patient's ethos to follow a framework that respects patients as inherently valuable. Respect is part of the “primordial” essence of human connection (Hyde, 2005). While rhetorical constructions of race may dehumanize Black people in discourse in ways that white interlocutors do not necessarily notice, a rhetoric of respect forces a person to ask themselves, “Is this person human or not? And if not, how am I human? If so, then must I not treat them in the same way I intend to be

treated?” These are rhetorical questions in the literal and popular sense, and they require an answer of practice not sentiment.

Rhetorics of respect can be tested out in situations, expanded upon and refined through practice, and molded to suit various medical contexts. Its applications go beyond obstetrics and gynecology, but because this field is literally founded on paternalized withholding of agency for the benefit of a particular white supremacist ideology, to start here seems the most practical. In these ways, this project offers a potential node of departure from traditional white masculinist ways of knowing and doing toward ways of connecting and agreeing that are guided by Black feminist theory. Again, moving the fields of RHM and HC toward more equitable outcomes in research practice and impact.

Limitations: This is just the beginning

I tend not to think of this dissertation in terms of limitations, only in terms of possibilities not yet realized. For instance, the rhetorical analysis of ACOG is specific to the last 10 years and focused mostly on materials available to the public. Without insider access to the discourse that happens within the field of obstetrics and gynecology, which I do not have, I can only make observations from the outside. However, I see that only as an opportunity for someone within the field to take up my call and apply the framework themselves, or for RHM scholars to build coalitions with OBGYN scholars and build research and praxis methods on a foundation of respect. With regard to the interviews, I would have liked to interview more participants if I had the material and temporal resources. However, starting with a small number of interviews provided a guide for designing further studies. I can only speak to what these women shared with me, and the

themes may not be generalizable because Black women are not a monolith. But as Collins explains in *Black Feminist Theory*, there are noted patterns common enough among most Black women in terms of positionality and social situation that I can make statements about the relationship between the social positionality of being a Black woman and the history of medicine, even if I cannot say *Black women experience X when visiting a women's health practitioner*. As I will demonstrate in the chapters that follow, limitations are truly merely possibilities not yet realized.

Chapter Outlines

Chapter 2 of this dissertation is entitled, “Black Motherhood and the Rhetorical Politics of ACOGs Public Facing Rhetoric.” In this chapter, I answer half of my first research question: What rhetorical dynamics shape disciplinary discourse on Black women and socially situated health disparities in Obstetrics and Gynecology? The focus in this chapter is on public facing rhetoric from ACOG as represented by their attendance at a US House of Representatives hearing called “Birthing While Black” and in their policy and position statement, as listed on their website. I conduct a rhetorical analysis of an example of the public discourse on maternal health disparities. In this chapter, I will argue that rhetorical understandings of Black motherhood become points of positionality around which interlocutors in the Birthing While Black hearing continually situated and resituated themselves around.

Chapter 3, “Disciplinary Dissonance: Problematic Rhetorical Constructions of Race in OBGYN Disciplinary Discourse,” investigates ACOGs disciplinary discourse around maternal health disparities. In this chapter, I examine publications in ACOGs

scholarly journal, *Obstetrics and Gynecology*, and conduct a thematic analysis of rhetorical constructions of race and their influence on research in the field. Turning to Burke's concept of terministic screens I explain the impact of faulty rhetorical constructions of race as a lens through which researchers continue to interpret their racialized patients. I argue that obstetrics and gynecology as a research practice is not yet actively renouncing the use of race as biological construct as opposed to a social one, and that the terministic screen of race as biological produces a disciplinary dissonance where researchers recognize race is a social construct but have not yet worked out how to use that understanding to shape their research methods.

"Black at the OBGYN" is the title of the fourth chapter, and it details my interviews with Black women who reported dissatisfaction with their OBGYN care. In this chapter, I provide more details regarding Black feminist epistemology and its influence on the research methods. The focus of this chapter is on themes in the answers to the interview questions and what they revealed about Black women's understanding of how race influences their care. I assert that their interpretation of events reveals areas where rhetorical interventions can be most impactful and stands as validated knowledge needed to formulate new ways of constructing respectful relationships between doctors and patients.

As the most significant theoretical contribution of this dissertation, Chapter 5 moves from an identification of areas where respect can be shown, to a "Rhetoric of Respect" that can serve as a framework for changing practical dispositions toward Black women in OBGYN settings. I explain three tenets of a rhetoric of respect:

acknowledgment, deference, and reciprocity, and illustrate what those concepts look like in practice. I also provide a deeper engagement with three of the women I interviewed, highlighting areas that represent disrespect and offering alternative behaviors that would constitute a rhetoric of respect. Here, I argue that a rhetoric of respect can be a powerful tool for acting in a way that corresponds with a change in terministic screens. Instead of seeing patients through an racial essentialist lens that allows doctors to determine for themselves whether a patient is deserving of certain accommodations, practitioners are invited to recognize the social construction of race and its effect on their patients as human beings, and further to operate in ways that respect that reality. I envision rhetorics of respect as theory that applies in situations where one party has more privilege and the other more at stake in the success of the rhetorical interaction because it necessarily overrides other social factors that may allow for disparate treatment between interlocutors. While I see rhetorics of respect at work in many such situations, as I describe in the chapter, here I offer an explicit way of understanding and implementing such a rhetoric, something that was not apparent in the research to date.

The conclusion chapter of this project draws connections between chapters 2 - 5 and considers possibilities for moving forward in research that applies a rhetoric of respect. My ultimate goal in this work is to establish a foundation upon which to build a research paradigm that respects all people, but especially Black women.

CHAPTER TWO: BLACK MOTHERHOOD AND THE RHETORICAL POLITICS OF ACOG'S PUBLIC FACING DISCOURSE

This chapter is about the rhetoric of Black motherhood and its role in the public discourse around maternal health disparities. Disparities between Black and white women along several metrics are well documented. Hoyert (2020) found that “in 2020, the maternal mortality rate for non-Hispanic Black women was 55.3 deaths per 100,000 live births, 2.9 times the rate for non-Hispanic White women,” meaning non-Hispanic Black women are almost 300% more likely to die from giving birth than white women. Further, Hoyert (2020) found that the rise in maternal mortality rate between 2019 and 2020 was the statistically significant for both non-Hispanic Black women and Hispanic women and birthing people, meaning childbirth is getting statistically more risky for everyone but white women, even as technological innovations and scientific breakthroughs ought to make the process safer. In this chapter, I focus on the rhetorical dynamics that shape public discourse on Black motherhood and maternal health disparities. I examine public facing rhetoric from the American College of Obstetrics and Gynecology (ACOG) as represented by their attendance at a US House of Representatives hearing called “Birthing While Black” and in their policy and position statements on the subject of race, as listed on their website. In this chapter, I will argue that rhetorical understandings of Black motherhood provide points of positionality around which interlocutors in public discussions of maternal health disparities situate themselves and their arguments.

Background

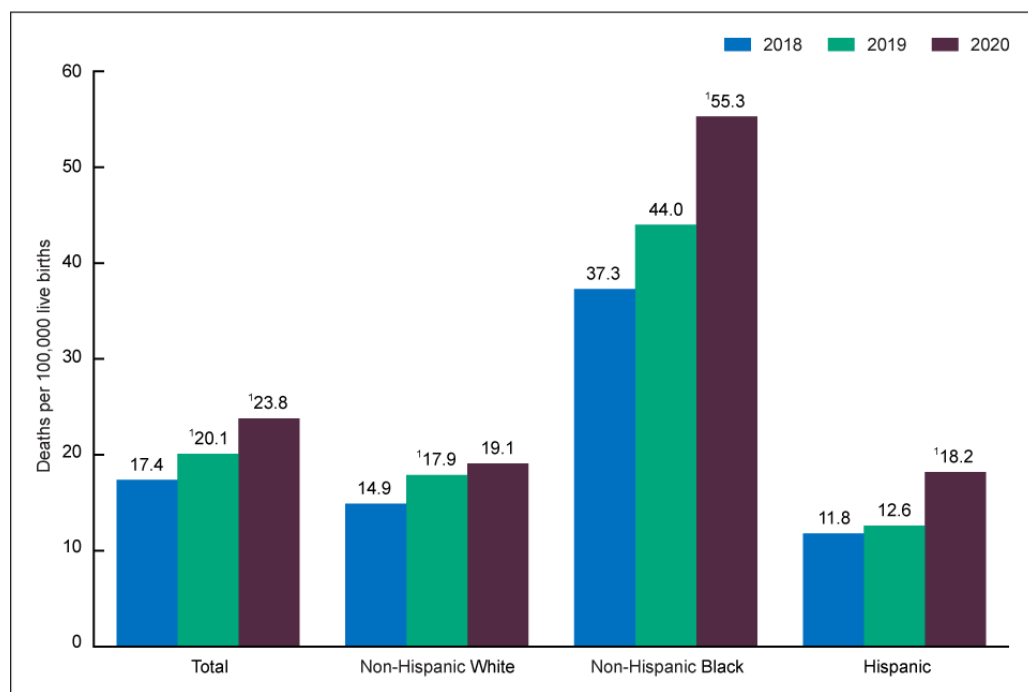
In May 2021, The House of Representatives held a hearing to discuss the issue of disproportionate maternal mortality and morbidity among Black American birthing people. “Birthing While Black: Examining America’s Maternal Health Crisis” brought together experts in maternal medicine like Dr. Tamika Auguste, a member of the board of directors at ACOG and other Fellows of the American Congress of Obstetrics and Gynecology (F.A.C.O.G.), Veronica Gillespie, M.D. and Joia Adele Crear-Perry, M.D. Celebrity advocate, Tatyana Ali, and Charles Johnson, husband of Kira Johnson, who lost her life because of substandard OBGYN care, were also asked to give testimony. The publicized purpose of the hearing was to examine the causes of and possible solutions to maternal health disparities in the United States.

The American College/Congress of Obstetrics and Gynecology represents a broad body of researchers and practitioners in the field of obstetrics and gynecology. As their website states, “Founded in 1951, ACOG is the premier professional membership organization for obstetrician–gynecologists. The College produces practical guidelines for health care professionals and educational materials for patients, provides practice management and career support, facilitates programs and initiatives to improve women’s health, and advocates for members and patients” (ACOG.org/about). In this capacity, ACOG appears to set the standards for high quality women’s health care. Their participation in these hearings is reflective of the role of practitioners in the field of obstetrics and gynecology in legislation concerning maternal health in general, and in Black maternal health specifically.

The hearing's title, "Birthing While Black" (BWB) alludes to the metaphor of Blackness as a risk factor in criminal justice where "driving while Black" is justifiably assumed to be the reason many African American's are pulled over by police. A driver being Black is all the probable cause a police officer needs to pull them over, meaning that just being black makes driving a riskier prospect than it would be for a white person. This title draws on the idea that giving birth while being Black puts African American birthing people at greater risk of dying in the process. This allusion to racism in the criminal justice system draws the connections between systemic racism in one arena to the like in another, namely medical racism in the United States that leads to a disproportionate number of Black women dying either in childbirth or shortly after. It frames the hearing as one that will address the racialization of Black women and its consequences in maternal health outcomes.

The situation into which this hearing arose, however, involves a more complicated history of entanglements between essentialist racism in medicine and the foundation of obstetrics and gynecology, leading to a maternal health crisis that involves all birthing people in the United States. Thus, not only does the United States have a maternal health disparities problem, but also a maternal mortality problem in general. The World Health Organization (2017) reports that the United State's maternal mortality rate of 19 deaths per 100,000 births is more than twice that of the United Kingdom's 8 deaths per 100,000 births almost five times that of Spain's 4, and nearly ten times that of Italy's 2 deaths per 100,000 births. And while Hoyert (2020) found that the rise in deaths among Black and Hispanic women were statistically significant, the mortality rates rose slightly

for white women as well. The following figure (figure 1) from Hoyert (2020) shows the mortality rates for non-Hispanic White, non-Hispanic Black, and Hispanic births, as well as a combined total.



¹Statistically significant increase in rate from previous year ($p < 0.05$).
NOTE: Race groups are single race.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Figure 1

Although the findings and initiatives proposed at the BWB hearing by panelists like Dr. Auguste were promoted as addressing health disparities, the arguments for their

implementation and funding did not address or even find a reason for the difference between Black women's and White women's treatment at health care facilities. In other words, while the panelists recognized systemic racism as a thing that exists, they seemed unable or unwilling to find any mechanisms that support it in the system or to propose ways to disrupt it. Instead, the solutions proposed promoted a kind of color-blind way of addressing maternal mortality as if it affected everyone equally when the statistics show that it does not. In response to these findings several initiatives have begun to address the main causes of maternal mortality but not maternal health disparities. For example, ACOG has drafted guidance and policies regarding what they call "the fourth trimester" to emphasize the need for ongoing maternal healthcare, postpartum. Other programs were also promoted during the BWB hearing, including the AIM program (Alliance for Innovation on Maternal Health), the Perinatal Quality Collaborative, and Maternal Mortality Review Committees. As Dr. Auguste explains during her testimony at the hearing: "Maternal Mortality Review Committees make recommendations for preventing maternal deaths. The AIM program provides tools and resources and the Perinatal Quality Collaboratives provide the networks to facilitate system wide implementation of these best practices" (p. 21). Dr. Auguste foregrounds those solutions with the reminder that maternal health disparities are a multifactorial issue and will need solutions from all angles, not just from a health care standpoint but also the levels of community and system as detailed by Peterson et al (2019).

Peterson et al (2019) broke down the contributing factors of maternal mortality in the US along institutional levels and proposed strategies for addressing these factors.

Levels include a patient and their family, their community, their health care provider, the health facility, and the system. A patient or their family can contribute by not recognizing risks or signs of a health emergency. A community can put a patient at a disadvantage by not providing access to affordable housing, nutritious food, or transportation. A health care provider may fail to diagnose a problem or provide inadequate care for the issue at a facility that fails to train staff properly or consistently in the protocols that prevent infection or address obstetric emergencies. And finally, the health care system may fail to properly coordinate systems for patient care and improving operational protocols. Any one of these factors can contribute to maternal mortality. These findings may well be valid, but they fail to address why mortality rates disproportionately affect Black women. The solutions representatives at ACOG offered took similar color-blind approaches to improving women's health care. Seeing Turnbull's new theory of the rhetorical situation as a way of explaining the rhetorical dynamics at play, and drawing on Kimberly Harper's and Jennifer Nash's historical accounts of the rhetorical constructions of Black motherhood that shape discourse around maternal health disparities, I assert that these approaches are shaped by a rhetorical situation wherein certain parties are invested in one way of seeing Black motherhood and others are invested in a different understanding of the construct.

My goal in this chapter is to describe the rhetorical dynamics that shape ACOG's public facing discourse on maternal health disparities and the limited actions being proposed and taken to reverse those disparities. I argue that rhetorical dynamics of that hearing were characterized by the assertion and reassertion of particular positionalities on

the part of certain conservative representatives in The House and the rhetorical constructions of Black motherhood in which those positionalities are invested. I examine these dynamics through the lens of the rhetorical situation. I also contend that the ability to shift a conversation from specific solutions for an especially vulnerable population to solutions that benefit a much broader range of people is rooted in power dynamics that continue to enact majority centric ideals. I turn to Walton et al's 3Ps (positionality, privilege, and power) to help explain how the positionality of interlocutors at the BWB hearing and unequal distribution of privilege and power in those rhetorical proceedings not only influenced the shape of the proceedings but also the types of arguments ACOG brought to the table to begin with. To illustrate the difference between ACOG's public position and the solutions they present in the BWB hearing, I conduct a rhetorical analysis of ACOG's position and policy statements and compare them with public statements made by Dr. Tamika Auguste as a representative of ACOG and Drs. Gillespie and Crear-Perry during the BWB hearing.

The Black Mother: Always a Symbol, Never a Subject

In this section I assert that ongoing rhetoric regarding Black motherhood frames the discourse around maternal health disparities in contradictory ways. Lindal Buchanan (2013), Kimberly Harper (2021), and Jennifer Nash (2021) all illustrate that the symbolic power of the code mother has a way of erasing individuality and autonomy. More importantly for this study, these scholars also show that the mother's significance changes if she is Black and can be both helpful and harmful. Jennifer Nash highlights a recent phenomena that was not necessarily apparent when I started this project. More

attention is indeed being paid to Black mothers and their pain, and using crisis as a frame of understanding to engender that attention is also problematic. Much of contemporary attention to a Black maternal health crisis is on trend with more attention on the political Left to social justice in general, and Black women specifically. What happens when the trend changes? Like Kimberly Harper, Nash is focused on Black women and what they represent in the public imagination. Whether seen as the perpetual sufferer, or a villain, the Black mother is never treated as just a person.

Lindal Buchanan's *Rhetoric of Motherhood* (2013) proposes motherhood as a powerful symbol used in women's rhetoric. She argues that it not only empowered women in public discourse by providing a kind of culturally situated credibility, but also constrained their ability to participate in certain arenas or be recognized for contributions outside their roles as wives and mothers. In *The Ethos of Black Motherhood: Only White Women Get Pregnant*, Kimberly Harper (2021) examines popular rhetoric around pregnancy and motherhood, finding Black women conspicuously absent from positive framings of motherhood and if included, often only as an afterthought or cautionary tale. Harper's investigative angle complicates Buchanan's characterization of the code of motherhood as a signifier for gender and all its constraints. And Jennifer Nash's *Birthing Black Mothers* (2021) further complicates understandings of Black motherhood in the United States by calling attention to the ways Black mothers are used as symbols of pain and suffering in political and social discussion that are framed as liberatory, but also help perpetuate the social and political realities that ensnare us. These perspectives on Black

motherhood reflect political positionalities that shape discourse around maternal health disparities that occurs in the BWB hearing.

In her monograph on the rhetoric of motherhood, Buchanan (2013) invokes Barthes levels of signification to describe motherhood as a cultural code that both empowers and constrains women's rhetoric in the public sphere. Referring to the denotation of mother as something altogether different than the connotation or social construction of mother. While the term or marker of mother may be denotatively defined by the act of being pregnant and/or giving birth to a child, symbolically Buchanan argues that motherhood stands in for gender and all the cultural rules and norms contained within its institution. Depending on the context, womanhood can be described in either "god terms" or "devil terms" (loc 197). Buchanan argues that *the mother* is a god term that operates as the representation of everything positive about being female, whereas the term *woman* operates in the opposite way as a devil term. All the socially advantageous traits available to a female body are associated with motherhood. As a result, traits like "altruism, strength, nourishment, love, protection, and morality" help create the stereotypically selfless mother figure, and her foil is the self-centered, immoral, irrational, hysterical, and materialist woman. Whatever may fall in the middle is lost to the public imagination. This erasure of the embodied mother as an individual can provide some cover or rhetorical power, but it also restricts the rhetorical potential of deliberations concerning women who are marked as mothers.

To illustrate her argument, Buchanan discusses the case of Diane Nash, a civil rights leader whose contribution to the movement reached far beyond her maternal status

but whose achievements as a political activist have been overshadowed by attention to her actions as a soon-to-be mother. Instead of being recognized for her co-founding and leadership of the Student Nonviolent Coordinating Committee (SNCC), most historians focus on her choice to go to jail rather than pay court fees or bail when arrested doing civil rights activism. These accounts fail to mention, as Buchanan details, Nash's fervent promotion of the jail-no-bail initiative that argued against paying bail for several reasons. Nash is quoted as explaining her rationale thusly, "Since my child will be a black child, born in Mississippi, whether I am in jail or not he will be born in prison." (Nash as quoted by Howard Zinn, Kindle Location 865). She made her choice to go to jail and used the rhetoric of motherhood to justify it. Buchanan wants to emphasize that Nash's contribution to the civil rights movement was rooted in her organizing and activism, but her status as a mother erases her personal contribution in historical accounts because the code of motherhood is such a powerful symbol.

Buchanan's *Rhetorics of Motherhood*, while inclusive in its scope, still fails to account for the different ways in which motherhood is conceptualized along racial and class lines. She mentions that lower-income mothers are not given the same latitudes as their upper and middle-class counterparts but does not delve further into how race reshapes the rhetorical construction of the mother. In other words, Buchanan does not fully grapple with the difference between rhetorics of White motherhood and those of Black motherhood. Kimberly Harper's (2021) *Ethos of Black Motherhood* provides the specific reconceptualization of motherhood that effect the treatment of Black mothers in the US. In particular, we see in Harper's analysis that the cultural credibility of

motherhood afforded to white mothers is not necessarily available to Black mothers whose maternity is often maligned or regarded as problem.

Harper (2021) draws on Buchanan's (2013) use of god terms and devil terms, but is firm in her assertion that the ideals associated with mother as a god term are not available when the modifier, Black, is added. Instead, perhaps even more so than the term woman, Black mother is associated with images that evoke contempt and dehumanization. At least the default woman is human enough to be hysterical. The Black mother has been historically associated with negative tropes used to justify her enslavement. For example, while the poor white mother can be seen as resourceful and protective when she bends the rules to give her children some advantage as Buchanan shows, the Black mother's attempts to provide advantages for her children are marked as criminal and a desire to get something for nothing. Harper speaks of rhetorical conventions "where white women and children benefit from the protections of white privilege" while these conventions also "criminalize the poor" (97). We see the Black mother as a devil term at work with the 'welfare queen' stereotype perpetuated during the Reagan administration and reasserted during the Clinton administration (Rich, 2016). In 1976, Ronald Reagan gave a campaign speech where he described a woman in Chicago "who holds the record. She used 80 names, 30 addresses, 15 telephone numbers to collect food stamps, Social Security, veterans' benefits for four nonexistent deceased veteran husbands, as well as welfare." (Brockell, Washington Post, 2019). After that first mention of her, the "welfare queen" stereotype became a common rhetorical trope in his presidential campaign. Stephanie Sears (2010) explains:

The welfare queen became synonymous with the poor Black mother living in our nation's ghettos—unwed, unemployed, undesired, and undeserving. Charged with creating and literally reproducing a culture of poverty, she and her children robbed the country of its moral and economic resources. (39)

What is evident in Harper's presentation of significations inherent in the idea of Black motherhood is the many, often contradicting, ideals are at play. The Black woman is simultaneously inhumanly strong and overdramatic about pain. She is sexually aggressive and promiscuous – which is why she has multiple children without an active father figure in the home – but also a pious mammy figure whose devotion to her children and the children of her community is unmatched. Harper declines the opportunity to further explore the overall effect of those contradictions on the treatment of Black mothers in healthcare settings in favor of a deeper exploration of the public imagination as it concerns the credibility and social capital afforded to Black women as mothers. Nevertheless, these conflicting conceptualizations of Black motherhood deserve further attention.

Nash's *Birthing Black Mothers* discusses the ways the idea of the Black mother, with all her contradictions, has come to stand in for a different set of ideas. Now, Nash contends, instead of acting as the stand in for a system of gender, or even as a devil term meant to embody all that can be bad about a mother, the Black mother becomes the face of pain and suffering. In this role, the Black mother is used as a political tool of 'the Left' to give cultural credibility to those who want the liberal or progressive vote (loc 238). Nash points to the Black woman's suffering and death at the hands of medical violence and neglect the Black mother's proximity to state-sanctioned murders of Black men as the social markers that make her the symbol for pain and suffering. Nash also interrogates

the concept of crisis as a rhetorical tool for calling to action in response to something that was a normal part of life but now must receive more attention. She examines what she calls “a moment where the long-standing conditions of the ordinary have been newly framed as a crisis,” a strategy that has “transformed Black mothers into a distinct form of Left political currency” (loc 242).

Nash’s explication of crisis as the impetus for new attention to the plight of Black mothers is relevant to this chapter’s discussion of the Birthing While Black hearing foremost because the deliberations are in response to a “maternal health crisis”. Her critical analysis of crisis as a frame through which society can be persuaded to consider Black women brings to light the issue of what happens when Black women’s deaths are no longer considered especially urgent. As Nash points out, Black women have been dying more often than White women since the early 1990s. However, the earliest government funded studies into maternal health disparities start in 2018 (2021). I would also argue that Harper’s explanation of Black motherhood as a devil term is appropriate for this context. I suggest that not all involved in the discourse around maternal health disparities is willing to accept “the crisis frame.”

The 3Ps

Reminded by Walton et al, (2019) that positionality, power, and privilege are inherently connected, I find it inappropriate to discuss positionality or personally negotiated situatedness without recognizing the influence of power on an actor’s ability to negotiate at all and how that shapes the form and function of their actions. The ability to account for power is especially appropriate for a better understanding of ACOG’s

rhetoric at the BWB hearing, and Walton, Jones, and Moore provide an analytical framework for discussing power as an element of the rhetorical situation.

In *Technical Communication After the Social Justice Turn* (2019), Rebecca Walton, Kristen Moore, and Natasha Jones offer a theoretical framework for discussing the role technical communicators can play in either supporting or disrupting injustice in their work. Their framework, which they call “the 3 P’s” for positionality, privilege, and power, can also help conceptualize how technical communicators and health communications scholars and their texts can either reject or reify problematic and oppressive paradigms that shape a patient’s experience with health care and ultimately contribute to the health disparities discussed in this dissertation’s introduction. Further, these analytical lenses help the technical communicator and scholar assess their own agency in the situations that produce unjust technical communication. Walton et al argue for coalitional activism because analysis through the 3 Ps shows that strategy to be the only effective way to make change. Walton et al’s 3 Ps is an especially fruitful framework for producing the kind of research and scholarship that participates in social justice aims, like reducing or eliminating health disparities. It provides a starting point for active coalition building, a way of understanding the tools available to any given writer at a given time. It is helpful for critiquing technical communication texts that already exist and for thinking through a rhetorical situation before starting a writing project. Broadly defined, the texts I examine in this chapter constitute technical communication, and I see the 3Ps analytical power as a tool for inserting an understanding of power in negotiations of the rhetorical situation.

The analytical potential of the 3Ps goes beyond applications in technical communication, however, and across all rhetorical situations. In the following analyses, I intend to use the 3Ps as articulated by Garrison-Joyner and Caravella (2020) to conceptualize the role of power in the rhetorical attempts to build coalition in the “Birthing While Black” hearing within the metaphor of a spider’s web, or “the web of power” (x). Figure 2 is an infographic that uses the visual metaphor of the web to explain the 3 Ps. For this visual metaphor, power, positionality, and privilege shape and are shaped by one’s proximity to a mythical norm or center. In the web of power, you are either a spider or a bug. And which one you are depends on the situation, your positionality on the web, and the degree of privilege it provides in context. The spider (read: white heteronormative, neurotypical, cis man) sits at the center; therefore, the closer you are to the center the more likely you are to be a spider in relation to others on the web. In the same way the spider can feel any part of the web because all threads run through the center, those people who are positioned closest to the mythical norm have access to more threads of privilege. People positioned farthest from the center have access to the least amount of privilege. Again, all these details are situationally dependent, so the same person can be a spider in relation to one person and a bug to someone else. When applied to the BWB hearing, the web of power is a visual metaphor for understanding the influence power has on the establishment of positionality during the hearings. In addition to their positions on the issue of maternal health disparities, each participant at the hearing established a position on the web of power that shaped the rhetorical moves available for coalition building, or coalition busting.

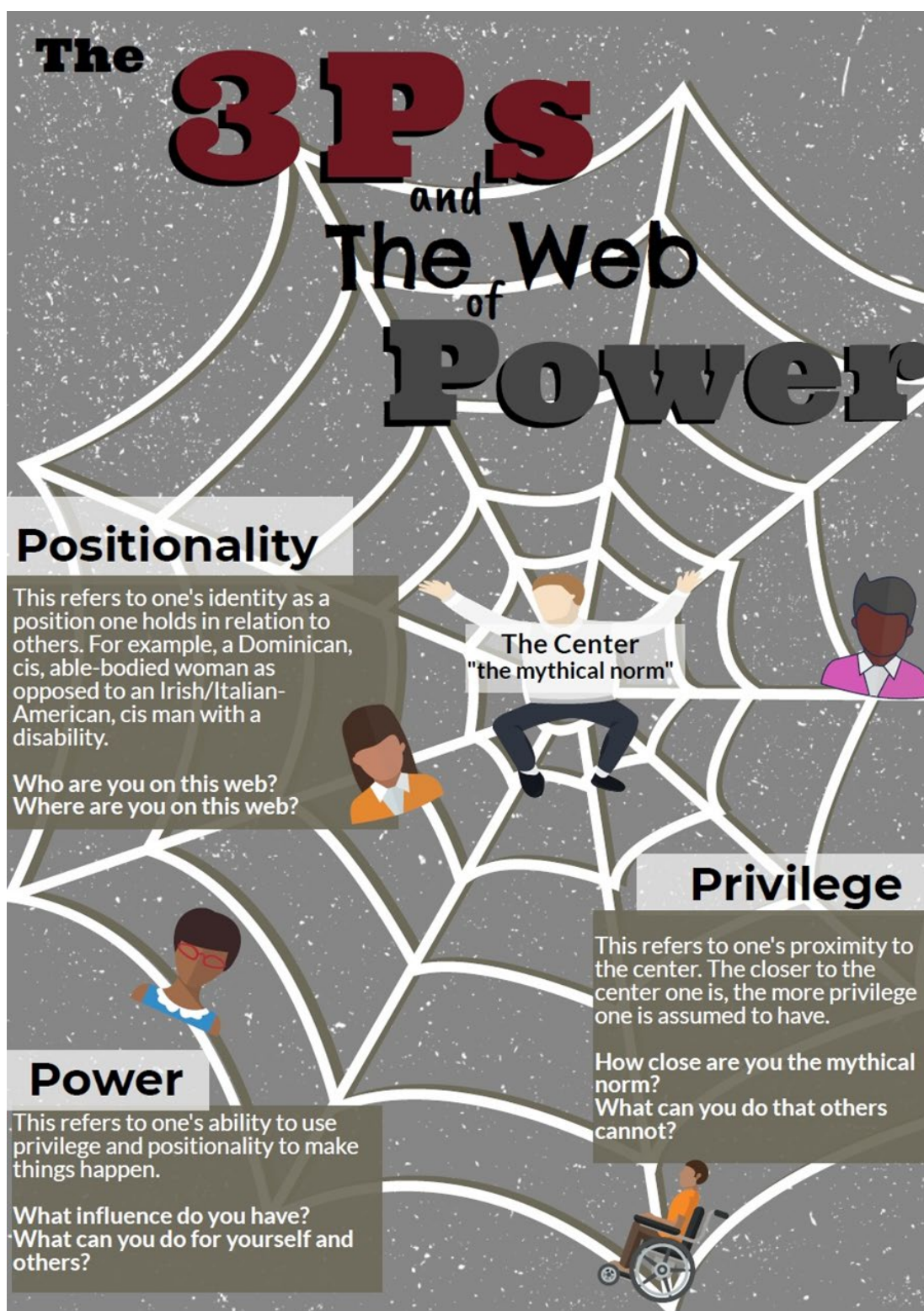


Figure 2

Another aspect of Walton et al's concept of coalition building is that it de-centers whiteness. The web of power in Figure 2 only works the way it does because the other agents on the web are forced to position themselves in relation to the mythical norm. Everyone winds up focusing on whiteness except the white person, who sits at the center of the web. However, coalitions shift focus away from the center and create new, multi-dimensional centers around which rhetoric takes place. In this way, coalition building not only multiplies the individual privilege of those who maintain the coalition, but also takes power away from the former center and moves it into the new coalition where it is distributed through various rhetorical means. In other words, coalition building re-shapes the web of power; it re-designs the rhetorical situation and in so doing, creates new exigencies and ways of approaching them.

Coalition busting is the opposite of coalition building, and it happens when interlocutors on the web of power cut off avenues for agreement. I think of coalition busting in a similar way to how the term union busting is used to describe tactics by corporations to disempower and undermine labor unions. Coalition busting refers to tactics by certain participants in a discussion to regress, inhibit, or delay agreement and coalition building during deliberations on a topic of concern. The tactics require a leveraging of unequal power dynamics to derail the progress of discourse toward agreement and to keep interested parties discordant. A rhetor who encounters this rhetorical strategy must be prepared to pivot and reassert their own positionality or risk being subsumed or overruled by the coalition buster's attempts to control the conversation. The expert panelists at the BWB hearing provide several impressive

examples of ways to respond to attempted coalition busting, which appears in the hearing as a way for those voices that are accustomed to being centered to maintain their centrality.

In the remainder of this chapter, I describe a few of the rhetorical dynamics at play in policy and position statements by ACOG and the deliberations of the US House of Representatives Birthing While Black: Black Maternal Health Crisis” hearing. Beginning with the ACOG’s policy and position statement, I demonstrate that their public facing rhetoric regarding maternal health disparities reflects a disposition toward the problem that allows their representatives to be more adaptable in situations where their positionality must negotiate the rhetorical situation with other interlocutors who may have more situational power. I posit that on both sides of the political debate around maternal health disparities, parties position and reposition themselves around the rhetorical constructions of Black motherhood that Buchanan, Harper and Nash describe. Further, I argue that their debates around the subject help co-constitute a larger understanding of Black motherhood as constantly in contention with white masculinist systems of knowing and doing, a positionality that alienates Black women in theory and dehumanizes us in practice, and that dynamic plays out in the Birthing While Black hearing. The result of studying policy statements alongside public statements by representatives of the organization, like Dr. Auguste at the BWB hearing, is a better understanding of how rhetoric shapes the landscape of actions and language taken to consider and address maternal health disparities.

ACOGs Policy and Positions: Public Facing Rhetoric without Public Engagement

For the first rhetorical analysis, I examined ACOG's policy and position statements. As documents that are drafted and approved by ACOG's board of directors and published on their website before any kind of membership/password wall, policy statements represent the public facing discourse on various issues of public concern. Policy and position statements also represent an articulation of position after internal deliberations. In other words, these position and policy statements are published without the expectation of needing to defend them. The board approves messages, presumably after their own debates. Once they are published on the website, they represent the organization's position as a whole.

My process for collecting statements was perhaps more systematic than necessary, but it gives me the confidence to say that this analysis considered all of ACOG's statements about race and maternal health disparities. I collected all the Policy Statements and Position Statements and saved them as PDFs (<https://www.acog.org/clinical-information/policy-and-position-statements>). ACOG's Statements of Policy represents the organization's support for political issues and legislative initiatives while their Position Statements communicated ACOG's disposition on matters of concern specifically to OBGYN practice ([ACOG.org/clinical-information/policy-and-position-statements](https://www.acog.org/clinical-information/policy-and-position-statements)). My analysis of these statements takes those rhetorical distinctions into consideration.

I executed a CTRL+F search for words related to racism, disparities, or Black women. Keywords included minority, race/racism, color, Black, African American,

systemic, and bias. Adobe's Find feature will also show words that are related to the search term entered, so if another word was offered – for example if searching for *racism* brought up the word *discrimination* – I would investigate the context of the suggested word's use to see if the document belongs in the corpus. Figure 3 shows an example of how the CTRL+F search function provides suggestions.

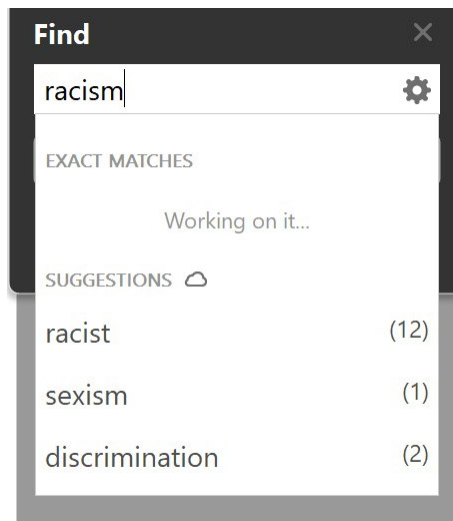


Figure 3

All position and policy statements containing any of these words were also scanned to make sure the word was being used in the correct context. If so, the statement was included in the first round of analysis. A total of 7 documents met the original corpus criteria: four policy statements and three position statements. Once the initial corpus of

analysis was established, I read the documents, looking for elements of the rhetorical situation. For instance, if a passage seemed to communicate the document's exigence, thesis/message, or purpose, I would mark those utterances. After the first round of rhetorical analysis, I excluded those statements for which a discussion of racism or bias was more of an afterthought than the main focus, whittling the number down to three including two statements of policy and one position statement. The three statements that are included in this analysis are entitled, "Racial Bias," (2017) "Violence and Racism in the Criminal Legal System: A Women's Health Crisis," (2020) and "Addressing Health Equity During the COVID-19 Pandemic" (2020). These statements represent ACOG's public facing position on issues of racism and health equity.

ACOG's policy and position statements are characterized by equal parts recognition and deflection. These statements reflect ACOG's engagement with the Black mother in crisis trope that Nash describes. By framing Black motherhood as in crisis, the writers were able to promote OBGYNs as potential heroes rather than possible villains. The type of deflection of responsibility that occurs in ACOG's statements manifests as a rhetorical use of history to distance today's OBGYNs from the origins of obstetrics and gynecology and in the personification of racism as something that acts on its own without human involvement.

Each of the statements in this corpus presented multiple articulations of recognition, followed by plans for action. These admissions set help forestall accusations that the field of obstetrics and gynecology has not yet grappled with its troubled past. For

instance, the first sentence of their statement on “Violence and Racism in Law Enforcement” begins with a recognition and moves into suggestions for behavior:

The American College of Obstetricians and Gynecologists opposes racism in all of its overt and covert forms and recognizes that institutionalized racism, including in policies and practices by law enforcement, is a public health and women’s health crisis. ACOG is committed to taking action to eliminate racism, bias, and systemic inequity, including with respect to law enforcement. Below are examples of how women’s health care physicians and clinicians can work to confront these issues (para. 1)

The proposed actions that follow those admissions represent ACOG’s priorities with regard to addressing racism in criminal justice. In particular the advice on advocacy seems the most poignant to the Birthing While Black hearing:

Advocate for federal, state, and local policies that support investments in community safety that center the experiences and needs of communities of color and other marginalized populations, provide implicit bias and anti-racism training to support law enforcement, institute robust law enforcement accountability measures, facilitate the decarceration of prisons, jails, and other detention facilities, support community-based alternatives to incarceration, and that support research regarding the impact of racism in law enforcement on health outcomes. (para. 4)

This action step provided by ACOG emphasizes the need for investing in community safety rather than incarceration as a way to combat the effect of implicit bias on the health and safety of Black women. However, representatives of AGOC do not promote those priorities at the Birthing While Black hearing, as I will explain in more detail in the next section of this chapter. In their statement on Violence and Racism in Criminal Justice, ACOG is able to frame the field of obstetrics and gynecology as being on the right side of history by opposing racism.

In the policy statement, “Racial Bias,” ACOG recognizes their own racial biases as opposed to law enforcement’s. Acknowledging that racial bias affects the quality of

healthcare that marginalized patients receive, this statement makes the case for the field's progress toward more equitable treatment. The most powerful sentence in this piece is, "we recognize that structural and institutional racism contribute to and exacerbate these biases, which further marginalize women of color in the health care system." Here, ACOG is avoiding the accusation of ignoring history by admitting that "Medicine, including the field of obstetrics and gynecology, has engaged in practices that were very harmful to women of color" (n.p.) These acknowledgements help set a foundation for a new relationship between Black women and the field of obstetrics and gynecology. The actions they propose after that recognition include being aware of one's own biases", prioritizing the improved health outcomes of women of color in research objectives, and encouraging racial and ethnic diversity in the profession. Whether these action steps are carried out remains to be seen. There is as much evidence that nothing will change as there is of potential progress. For instance, ACOG's policy and position statements also demonstrate some deflection of responsibility on the part of the organization, as I explain next.

In their statements on racism and racial bias, the use of past tense and passive voice helps distance today's OBGYNs from the actions of their predecessors, even as the discussion focuses on the ongoing effects of racism. For example, the statement in "Racial Bias" that I describe in the previous paragraph keeps abuse in the past tense, as opposed to describing a present where OBGYNs continue to harm women of color. This statement goes on to describe the sterilization of women in the passive voice instead of placing responsibility on practicing OBGYNs: "numerous incarcerated women in

California, who are disproportionately women of color, were sterilized without lawful consent” (1). The statement’s use of passive voice shows a desire to separate the action from the doer, or to separate the problem of racial bias from the individual practitioner. These statements beg the question: well, who sterilized them? This kind of separation of action from doer is also convenient when prescribing actions that OBGYNs should take. Instead of taking responsibility for the actions that should be taken to address racial health disparities, “Addressing Health Equity During the COVID-19 Pandemic” reads “efforts to eliminate preventable morbidity and mortality, with a focus on eliminating racial inequities in maternal health access, quality of care, and health outcomes, need to be expanded during the pandemic” (n.p.), not ‘we need to expand them’ but they “need to be expanded”. Again, the question becomes, “who will expand them, then?”

The other rhetorical tactic that reflects ACOG’s positionality in the discourse of maternal health disparities is the personification of racism. Converse to the pacification of actors in the history of racism in Medicine, the personification of racism treats the behavior of individual people and the structure of systems as an actor in itself. In this way, no one is guilty of racist behavior. Instead, as ACOG writes in “Racial Bias” “Many professions, including medicine, are beset by implicit and explicit racial bias,” as if racism snuck up on these professions and tricked them into abusing Black women. This is not only another instance of passive voice, as professions “are beset by” racial bias, but also a characterization of racial bias as something that acts independently and upon institutions. In fact, nonhuman ideas repeatedly function as the active subject of sentences in ACOG’s policy and position statements. For instance, in “Addressing Health Equity,”

ACOG writes that “Social determinants of health, current and historic inequities in access to health care and other resources, and structural racism contribute to these disparate outcomes.” The active subject in this sentence is the noun phrase “social determinants of health” that “contribute” to unequal health outcomes. Again, no human individual or institution assumes the role of subjective actor. Instead, these statements are framed around a nonhuman idea, namely racism, as the main contributor to problems. By personifying these ideas, ACOG is able to situate its representatives and members as either innocent or heroic, but not abusive or harmful on their own.

ACOG’s policy and position statements represent a carefully crafted and negotiated articulation of the organizations willingness to accept responsibility for improving outcomes, but not for the present state of health and medicine for Black women. Their framing of the maternal health disparities as a detached phenomenon illustrates Nash’s point about Black motherhood as crisis. Within a frame of crisis, racial bias and maternal health disparities become entities that must be battled and conquered by altruistic health care practitioners. They become detached from the people who enact them in practice. This rhetorical tactic allows ACOG to position itself as a defender of Black women’s health, even as the field’s history paints an entirely different picture. The framing of Black motherhood as a crisis shifts focus away from individual OBGYNs and the systems that support them to the collective struggle to save Black mothers. But from who? I ask. Who and what are we saving Black mothers from?

ACOGs Testimony at Birthing While Black: Public Facing Rhetoric and Political

Engagement²

The rhetoric of the ACOG's policy and position statements reflect engagement with the larger political contexts that shape legislative hearings like Birthing While Black (BWB). Although the statements are debated on within the discipline and submitted for public viewing after agreement, their wording provides a rhetorical platform upon which representatives can build their strategies in other public arenas, like a congressional hearing. I see ACOG's part of the discourse at the BWB hearing as an extension of the rhetorical dynamics at work in their policy and position statements. In this context, ACOGs positionality comes to bear on deliberations around funding initiatives aimed at improving health outcomes for Black women, providing a different perspective on how ACOGs rhetoric functions in the public sphere. For the following analysis, I conducted a systematic coding of the hearing transcript looking for specific themes that were shaped a focus on the rhetorical situation. In what follows, I will explain how the positioning and repositioning that occurred during these hearings can be understood in terms of how rhetorical constructions of Black motherhood served as static points around which interlocuters could situate their more dynamic arguments and how varying degrees of

² The Birthing While Black hearing occurred after I began research for this dissertation project. It was not a part of the original research proposal. However, given my ongoing interest in the subject, I made time to watch the nearly 4-hour hearing as it streamed on YouTube in May 2021. As I watched, I noticed who was speaking on behalf of Black mothers and realized that the hearing itself was a significant representation of public facing discourse on the part of ACOG but also on the part of legislators, who arguably have equal or more power to effect change. The decision to include a rhetorical analysis of the BWB hearing led to additional findings that would have otherwise gone unseen.

privilege empower some parties more than other in ways that constrain the rhetorical situation and the possible symbolic actions that can take place within it.

That last sentence was a big and complicated statement so let me break that down into pieces. Remember that Jennifer Nash posits Black motherhood as standing in to symbolize crisis, and that part of the price of that symbolic positionality is public suffering. Nash's notion is built upon the foundation that Lindal Buchanan provides in terms of god terms and devil terms, where in an identity can either represent all that is good about it or all that is bad. Harper demonstrates that Black motherhood has been used as a devil term to symbolize all the ways a woman can be a bad mother. Motherhood as a god term is not available to Black mothers. The available constructions of Black motherhood become symbols in which opposing sides of the political divide invest to anchor their understanding of the BWB hearing's exigence. Situating themselves within discourses that rely on one construction or the other, interlocutors at the hearing, including democratic legislators, republican legislators, and invited witness like those that represent ACOG, shape their rhetorical utterances accordingly. For members of ACOG, shaping their discourse accordingly sometimes meant yielding to the power dynamics at play and moving their own positionality on the subject, even if momentarily, away from their original position toward more color-blind perspectives in order to gain support for their cause.

On the one side, relying on the construct of the Black mother in crisis, ACOG representatives and democratic leaders, urged the House of Representatives to pass legislation funding the programs they assert will improve maternal mortality rates. On the

other side, republicans showed hints that they were holding to the Black mother as a devil term, and repeatedly looked for ways to shift the hearings focus from health disparities along racial lines to disparities between urban and rural localities. While the goal of democratic lawmakers and representatives of ACOG in this hearing was to gain support for the Momnibus bill, the goal of republican legislators seemed to be coalition busting. Thus, legislators with the privilege to derail the discussion took every opportunity to do so, using their power to try and re-shape the rhetorical situation.

The rhetorics of crisis that legislators and witnesses weaved throughout the proceedings at Birthing While Black were meant to emphasize the exigence of the event and its vital importance. While the opening remarks of the hearing are full of representatives mentioning the “maternal mortality crisis”, the next most glaring example of the theme of crisis working at the BWB hearing is reflected in Charles Johnson’s telling of his wife’s story. Kira Johnson died after suffering internal hemorrhaging that went untreated for over 8 ½ hours, despite his repeated pleas for help. Kira’s death exemplifies Nash’s (2021) assertion that Black women framed within a context of crisis symbolize suffering. The numbers are not enough to engender action, there must be a symbol of suffering and Kira is the unwilling player of that role. It is a shameful oversimplification of a woman who lived a whole and individual life however shortly cut. A complicated subject of her own story is reduced to a mother and wife whose suffering and untimely death may hopefully inspire actions that will help other Black women.

There is a tension at play in the “Birthing While Black” between Black mothers as suffering and in crisis and in the enduring construct of the bad Black mother. But the

tension is articulated in the hearing as occurring between scientific values and social/political ones. Part of the positionality of political interaction with science is an understanding and negotiation of differing value sets. Politicians are accustomed to dealing with scientist as those scientists explain esoteric concepts and the policies that should change in response to new understandings. In this hearing, although the expert panelists are not there to explain a scientific concept, part of their role in the hearing is still to bring the ethos of scientific positivism to bear on the situation. This is in contradiction to their role but the problem they are providing insight for is social. In times of disagreement, there is always a desire to cling to the idea of objectivity in science and medicine. Consequently, a dissonance is apparent between the type of relationality normally at play during these hearings and the one at play in “Birthing While Black.” And the burden of balancing that tension, or sustaining a dialogue in spite of it, falls on the shoulders of those representatives and panelists who have orchestrated this event.

To provide a kind of positional buffer, Dr. Auguste and the other panelists must explain and reinforce that the problem of racial health disparities is social and not biological, but also use language that harkens back to positivism and the words politicians are accustomed to hearing from the scientific community. In Dr. Auguste’s testimony there’s an establishment of her own positionality and ethos, the day’s exigence, and a recognition of historical and systemic racism as the cause of disparities. In addition to these points, she and the other expert panelists make the point the disparities have multiple causes, and these require multiple solutions. This move may be an attempt to

establish their positionality as more neutral and therefore closer to those representatives that may not yet support the Momnibus bill.

While democratic representatives, like Representative Ayanna Pressley, could continually push the conversation toward the Black motherhood in crisis construct by claiming “the Black maternal mortality crisis is still killing our loved ones and destabilizing our families,” representatives from ACOG were much more constrained in their potential utterances (pg 10). During a Question-and-Answer portion of the hearing, Dr. Auguste was made to respond to an attempt at coalition busting by republican representative from Pennsylvania (first name) Keller. When discussions around initiatives to increase diversity in the health care workforce, including midwives and doulas, Mr. Keller broached a questions about regulations and deregulating midwifery. By calling back to a conservative ideal of deregulation as a way to liberate the free market (Horwitz, 1986). He asks, “Dr. Auguste, to what extent are Federal restrictions surrounding midwives contributing to these work force challenges?” Dr. Auguste’s response is a repositioning of her own expertise as unrelated to the answer. She replies, “

I am a clinical expert and am not exactly familiar with all the legislative and Federal restrictions. However, I think the key takeaway point here is that there is a known shortage of healthcare providers in these rural areas.

So, we are talking about midwives and physicians. There is also a maldistribution of where those health providers are. So, we can look at those sort of--look at those sort of issues and really help to bring them into the communities where they are needed.

Some programs, like the National Health Service Corps, will help to bring those needed maternal health providers to some of those rural areas and urban areas where they are needed. (34)

On top of her self-positioning, she brings the conversation back to a constituency of concern to Rep. Keller even as she declines to answer his question. By reiterating that

there's a problem of distribution in addition to a problem of numbers, she avoids directly contradicting the congressman but also redirects attention back to her own points of argument. I would argue that her rhetorical flexibility is a feature of ACOG's discursive strategy of creating distance between the present audience and the institutions that have failed Black women.

My findings confirm Nash's assertions and answers my questions about why relatively little in the way of improving health outcomes for Black women has been promoted or supported. Nash notes that marking Black maternal mortality as in crisis, rhetors are attempting to create a sense of urgency that may speed up the process of taking appropriate action. However, as Nash also notes, the false urgency created in a rhetoric of crisis is hollow. People rush to have conversations about what to do or what the problem is, but very little if anything actually gets done. It seems this is the case for the "Black Maternal Health Crisis" (BWB, 1) which took place in May of 2021 and has still not passed in April of 2022.

Conclusion

As I have argued, rhetorical understandings of Black motherhood provide static points of positionality around which interlocutors in public discussions of maternal health disparities situate themselves and their arguments. Thinking about Walton et al's 3Ps (positionality, privilege, and power) as a way to help explain how the positionality of interlocutors at the BWB hearing and unequal distribution of privilege and power in those rhetorical proceedings, I found that privilege and power not only influenced the shape of the proceedings but also the types of arguments ACOG brought to the table to begin with.

My aim with this chapter was to describe the rhetorical dynamics that shape ACOG's public facing discourse on maternal health disparities and the actions being proposed and taken to reverse those disparities. I found that the assertion and reassertion of particular positionalities on the part of certain conservative representatives in The House and the rhetorical constructions of Black motherhood in which those positionalities are invested made all the difference between understandings of the truly complex sets of factors that contribute to disparities and the actions being taken to address them. My examination of these dynamics through the theoretical lenses of the rhetorical situation and the 3Ps showed that the ability to shift a conversation from specific solutions for an especially vulnerable population to solutions that benefit a much broader range of people is rooted in power dynamics that continue to enact white masculinist paradigms. In the next chapter, I continue to examine ACOG's discourse regarding maternal health disparities and racial bias in obstetrics and gynecology, this time with a focus on their publications as representative of their disciplinary discourse.

CHAPTER THREE: DISCIPLINARY DISSONANCE AND RHETORICAL CONSTRUCTIONS OF RACE IN OBGYN RESEARCH

With some recent exceptions, the research agendas of academic disciplines related to medicine have not included teaching doctors new ways of seeing themselves. Much of the focus has been on communicating knowledge produced by doctors, and there is little impetus in these fields to interrogate how that knowledge is produced. Advantageously, as Foucault shows in *Knowledge / Power*, one of the analytical strengths of rhetorical theory is its ability to reveal the historical events and unquestioned assumptions that make knowledge creation available to some groups and not others. We do have the tools for changing perspectives, or at least examining the current ones more critically. Particularly for obstetrics and gynecology, the origins of the field are inseparable from the contemporary version we have today. Further, the culture of OBGYN care that was birthed from those violent beginnings (pardon the pun) continues to shape US healthcare at large. However, to date, not much of a historically critical analysis of the culture of obstetrics and gynecology has been conducted, either in the field of health communication or in rhetoric of health and medicine.

In the previous chapter, I examined the rhetorical positioning and power dynamics that shape public conversations and discourse regarding maternal health disparities. The key takeaway from that study was that whatever voices within ACOG that are pushing moves toward more equitable and culturally responsive care must carefully maneuver through the perspectives and positionality of other stakeholders who may have more or less power to redirect the conversation. Because of these constantly shifting relations of

positionality and power between interlocutors, the language that represents maternal health disparity discourse tends to be euphemized or generalized in myriad ways. The difference between what ACOG leadership knows to be the problem and what they need to promote in order to gain buy-in from otherwise uninterested parties reflects a dissonance between public facing discourse and the material reality of Black women. This dissonance is also apparent in the disciplinary discourse of obstetrics and gynecology as I intend to show in this chapter.

As I demonstrated in the introduction to this dissertation, although the exigence for rhetorical analysis of the research and practice of OBGYNs exists, most of the literature that exists either in Health Communication or Rhetoric of Health and Medicine focuses either on the goal of persuading patients to behave in prescribed ways or in studying patient behavior. The question that no one has asked is how do doctors and researchers communicate with themselves in ways that either disrupt or reify problematic paradigms, like race? While Janelle Johnson's examination of lobotomy as a medical object and Fountain's discussion of gross anatomy illustrations and medical discourse are examples of RHM's potential for examining how doctors and researchers create meaning among themselves, there is little in the fields of RHM, Health Communication, or Obstetrics and Gynecology that does so in the context of health disparities. To address this void in the research, I have conducted a rhetorical analysis of the publications that represent OBGYN discourse surrounding race and the care of Black women.

My overarching inquiry was “what rhetorical dynamics shape disciplinary discourse on Black women and socially situated health disparities in Obstetrics and Gynecology? In this chapter, I perform a systematic rhetorical analysis of the representative artifacts of ACOG and examine the rhetoric regarding Black women in OBGYN scholarly discourse. For this study, I broke that inquiry down into two more specific research questions: In what ways does OBGYN discourse construct and discuss Black women, their bodies, and their care - particularly regarding health disparities. Additionally, what do they have to say about the reasons and possible solutions for disparities? My constructs of interest included race, health disparities, Black womanhood, health, and care. In other words, I paid very close attention to how those concepts functioned in the literature that constitutes a representation of OBGYN discourse. I found that not only was the rhetorical use and construction of race in publications often antithetical to what we understand race to be, but also that the publication patterns of papers and research concerning racism and maternal health disparities showed de-prioritization of the issue in practice. The following analysis will reveal the rhetorical constructions of race that I argue serve as a terministic screen through which doctors view their racialized patients.

For this study, I conducted a rhetorical analysis of the research and other disciplinary artifacts that characterize disciplinary discourse in obstetrics and gynecology. Rhetorical analysis provides a methodological framework for studying the ways in which discourses help construct objects and subjects. In the context of studying health and medicine, rhetorical analysis has been used to investigate how certain people and

concepts become defined by their relation to other medical objects and phenomena. For example, Foucault's (1988) analysis of madness as a construct studied the use of the concept at different points in history, discovering that historical context had great bearing on whether madness was the result of "spiritual possession," manifested as "social deviancy," or indicated the presence of "mental illness" (Hodges et al 2008, pg 571). Foucault uncovers how different institutions, like the church, or psychiatry/psychology, ultimately define the ways society thinks, speaks, and acts by controlling how society constructs certain concepts.

Another benefit of rhetorical analysis is its ability to show how notions of power are integral to rhetorical constructions as evident in Ewen Speed's (2006) "Patients Consumers and Survivors" which identifies three ways in which users of psychiatric services are constructed through discourse, and how those constructions enable or constrain further discourse by and about those users. Whether a patient was defined as a consumer, a survivor, or a victim reflected the power differential between the patient and their care provider. A consumer has power and agency and must be persuaded to *buy* what their provider is *selling*, while a victim needs help or to be rescued, perhaps even from themselves. Similarly, I use rhetorical analysis to interrogate the construction and use of race, in OBGYN discourse, focusing in particular on the how it reflects and influences larger ideas – long debunked – about race as a social and biological marker.

To better understand the way certain rhetorical constructs help determine the shape and scope of discourse, I employ Burke's (1968) theory of terministic screens which examines how the words we use come to represent a particular worldview and go

on to reify that view through their continued use. Burke's use of rhetoric is ontological. Rhetoric is used to define what is and what is not, and the quality of existence. For Burke, rhetoric is meaning making, and the way we use language is an implicit argument for a particular interpretation of reality. Burke's concept of terministic screens helps illuminate the establishment of positionality through language. The following analysis will contribute to a better understand of how the field of obstetrics and gynecology constructs those whom it racializes through the rhetoric in its publications and its publication patterns and how those constructs color a doctor's reality as it relates to their Black and Brown patients.

The Green Journal as a Site of Discourse

When I originally began this research, my plan of investigation was quite ambitious. I attempted to wrangle together all the major OBGYN organizations. The list started at 20, but further investigation into the organizations and their activities narrowed the list down to 5. Those 5 organizations seemed to represent all facets of the OBGYN clinical and academic communities; however, only one of this organizations has the legislative influence to make an investigation into their public facing rhetoric valuable. That organization was the American College/Congress of Obstetrics and Gynecology (ACOG). Thus, ultimately, I decided to narrow the scope just to the artifacts produced by ACOG; these included the public and private facing discourse. As a reminder, my research questions in this study ask in what ways OBGYN discourse constructs and discusses Black women, their bodies, and their care - particularly regarding health disparities. Further, what do they have to say about the reasons and possible solutions for

disparities? To answer these questions, I examined a representative sample of publications in Obstetrics and Gynecology for the last 10 years.

In the following discussion of themes and observations, I begin by explaining what I noticed during the search and then transition into the textual analysis of publications. From the textual analysis, I found that the treatment of race as a terministic screen through which doctors and researchers applied essentialist ideas about health and corporeal constitution is evident in the way research methods used race as a form of taxonomy that framed Black bodies as inherently unruly and thus risky.

Articles to Abstracts: A Disturbing Ratio

The search for a representative corpus performed the double duty of providing a corpus for analysis and revealing a pattern of publication that was also telling. As discussed in the previous chapter, members of ACOG, also given the designation F.A.C.O.G for Fellow of the American Congress of Obstetricians and Gynecologists, weighed in on the issue of maternal health disparities at the “Birthing While Black” hearing and their themes and talking points were founded in current socially situated understandings of race as a construct and racism as a structurally systemic problem. The degree to which they were able to get other stakeholders in that hearing to agree to those positions was under review in that chapter. In this chapter, I am more focused on whether ACOG’s actions match the rhetoric of that day. However, what I found during my search for a representative corpus of publications was a pattern of publication that suggested certain conversations were published and promoted in full, while others were only

accepted for ACOG's "Annual Clinical and Scientific Meeting" and published only in their abstract form.

The observation revealed itself in stages. As I collected citations that mentioned health disparities and its relative keywords (racism, bias, and discrimination), it became apparent that most of the citations were dated in May. Across a span of 10 years, out of 137 publications that mention or discuss health disparities, 60 or approximately 44% of citations were published in May. Upon further inspection, unlike the citations from other months, these citations only provided abstracts, no full form articles. ACOG publishes 12 issues per year, one per month split into two volumes. Their publication schedule is evenly distributed across the 12 months of the year; however, when it comes to publishing on health disparities, 44% of the conversations that occur are in May. The ratio of full research articles to abstracts was not the same when I did a more general search for race. Thus, I interpreted this uneven distribution to reflect a larger pattern of subject matter prioritization.

Remembering that one of the key attributes of a discourse community is its role in supporting the dialogic exchange of information (Swales), the unique distribution of articles to abstracts regarding racial disparities is concerning. While there is plenty of dialogic information sharing going on at the Annual Meeting, the dialogues that continue to have influence in scholarly communities are research publications and the future studies that cite them. As scholars of scientific rhetoric have noted, citation practices are a way of supporting the ethos of a researcher (Latour and Woolgar 1979, Kuhn 1970, and Gilbert 1977). I argue that by confining most of the research on health disparities to

conference papers, ACOG forecloses further opportunities for dialogic information sharing by restricting the persuasive power of new realizations. This practice has a compounding effect if, as Gilbert (1977) asserts, references are one way in which scientific research is made persuasive then how can researchers build on the work of previous studies if those studies are only available as abstracts.

What comes across when I see this pattern of publication is a mis-prioritization of disparities research. I am not suggesting that someone or a group of people have decided purposefully to only discuss health disparities at the annual meeting. Instead, I turn to Patricia Hill Collins' 2016 *Black Feminist Thought* to describe what I believe to be the underlying foundation of these practices. As Collins explains, Black women's knowledges and perspectives are often delegitimized in White male centered discourses, even when Black women's issues and exigencies are under discussion. Thus, the problem is not that members of the editorial board of *Obstetrics and Gynecology* do not want to discuss maternal health disparities, but that those studies which center Black women's perspectives and expertise are often met with critique that questions their ethos or credibility. Perhaps, this implicit doubt when discussing disparities in care and outcomes leads to lower acceptance rates for published research articles. However, at an annual meeting, where part of the rhetorical function is to reinforce the values and ideals that give shape to the organization, discussions around addressing disparities are more welcome even if they are determined not to meet the standards of rigor set for full form publishing. Understanding the persuasive power of referencing, as an ethos building device for both the original researcher and those who carry their studies forward into new

work, it becomes apparent that the disproportionate number of studies regarding health disparities and racial discrimination in obstetrics and gynecology whose findings are only available as abstracts reflects a systemic issue in the editorial and publishing practices of ACOG.

There are some limits to my interpretation of the information above.

Firstly, I cannot know how many research articles have been submitted for full publication. Without that information, I also cannot make any definitive statements about acceptance rates of some subject matters over others. Further, one could also rebut my interpretation on the basis that I did not design a study for interpreting the publishing patterns of the journal. My analysis in this instance has not been systematic. I simply noticed a pattern and made inferences. However, I would counter that a systematic analysis of publication patterns that includes a review, not only of subject matter, but also of the demographic backgrounds of researchers is a logical next step made visible by my initial observations. In other words, one could think of my reactions to this publishing pattern as more of a hypothesis or pilot study than a full out analysis. Still, I found the discovery too important not to discuss. Further, because most of the abstracts that mentioned causes of health disparities were only abstracts, I was unable to conduct a thorough rhetorical analysis that could attempt to answer my second research question about the causes and solutions to disparities. However, I was able to conduct a study to answer my first question, as I will detail next.

Rhetorical Constructions of Race and their Use as a Terministic Screen

The second half of this study focuses on rhetorical constructions of race. To briefly review the methods of the second study, I collected a representative sample of publications that discussed or mentioned race in any significant capacity. For this study, a significant capacity meant that race had some effect either on the collection of data or its analysis, or it was the main subject of discussion. My analysis turned up four themes in the rhetorical construction of race. Those themes included race as a risk factor, stratifying data by race, matching subjects for race, and adjusting or correcting for race. In each of these constructions the connecting through line is a treatment of race as a biologically significant marker instead of an arbitrary social one.

Data Collection

The collection process for each analysis was the same. I collected citations for all issues of *Obstetrics and Gynecology* from the past 10 years that mention race or terms related to health disparities. Using Ovid's database, I performed a keyword search for all journals containing my search terms. Collectively, these keywords included, race, racism, bias, Black, African, disparities, inequities, discrimination, and system. Because Ovid's database allows keyword searches across the entire journal, or in an individual issue of the journal, but not across a collection of issues, I had to perform the search across the entire collection in Ovid, from 1995. I also had to download all the citations available because Ovid did not have any functions for organizing the results by date or any other value. Using Zotero to save the citations from those searches, I set the database to organize the issues in chronological order. To set up a random sample set, I extracted

those journals to a new folder and reordered them in alphabetical order by title. I then started from the top and extracted every 5th citation to achieve a 20% random sampling.

After collecting the initial sample set, I used the citations to download full PDFs of each publication. To ensure that every text in the corpus was using the words I searched for in context and not as part of a larger word or alternative text description, I performed a CTRL+F search in Adobe Acrobat for the relevant search terms. For example, in two of the publications, race was a part of the larger word ‘contraception,’ and in one of the publications the word ‘black’ was used to describe bars on a graph. These instances of the terms’ use were out of the scope of either analysis, so I removed those publications from the corpus. I replaced them with whatever publication was listed immediately below the excluded text, performed the same CTRL+F search, and continued to code the texts.

For the first round of analysis, I simply searched the documents for instances of each word in context and highlighted the words. During this first term search, I did not read the text surrounding the search term, I only marked it and moved on. This quick search allowed me to label each text for easy recognition during an initial deep reading. The second round of analysis involved reading each publication carefully, taking note of when the search terms appeared and the surrounding context. This second reading provided a list of themes for how terms regarding race, Black women, and/or health disparities were being treated in the literature that aimed to address them.

Terministic Screens of Race

Terministic screens, such as race as a biological concept, shape information in the image of a particular perspective of the world. Naomi Rockler (2002) notes why terministic screens are an appropriate framework for discussions of race, “some terministic screens serve as vocabularies that select or highlight racial politics and oppression, while others serve as vocabularies that deflect attention away from social issues” (p.400). The use of certain constructions is not only achieved through rhetoric but also works to achieve a particular rhetorical purpose. Further, we also must understand that constructions of race as a biologically significant marker, reify an essentialist view of Blackness, one that often places blame for health disparities on the Black person instead of the society that made them Black to begin with. This implicit blame skews research possibilities because researchers continue to look for concrete explanations in a fluid concept, and through those misplace priorities contribute to the continue misinterpretation of race influence on health. This slippage, conflation, or simple misunderstanding has material consequences, however, and must be addressed in the material.

Other scholars have used of terministic screens to explain contexts where race and racialization become key rhetorical features of the discourse. In those contexts, a particular configuration of race becomes a terministic lens through which interlocutors interpret reality, often to the detriment of those who have been racialized. Ruth Frankenburg (1993) organizes terministic screens of race into three categories or “moments:” “essentialist racism, color- and power- evasiveness, and race-cognizance” (140). Each of these moments served an interpretive lens for the white women she

interviewed to understand their relationship with Black people in particular and race in general. Essentialist racism posits that some races are essentially better or worse than others; it promotes a hierarchy of races. Color- and power-evasiveness upholds the systems that essentialist racism built, but does so without ever explicitly recognizing race or power as variables in those structures. The third category, race cognizance, refers to an understanding of race as a social construct and its use as a tool of oppression. Frankenburg notes that because society no longer deems overt essentialist racism acceptable, race- evasiveness is the most common screen through which the white women she interviewed operated.

Rockler (2002) applies Frankenburg's interpretive categories to the way Black comic book consumers interpret the social significance of Black authored comic books. She found that White comic book consumers' interpretations reflected the terministic screen of color/power- evasiveness while Black readers tended to understand the same books through the lens of race-cognizance. Rockler interpreted that pattern to mean that "minority group members tend to filter identity issues through terministic screens within which oppression is relevant while majority group members tend to filter identity issues through terministic screens within which oppression is not relevant" (p.400). I suggest that a similar dynamic is at play in discussions of maternal health disparities. The terministic screen of race as a significant factor in health and/or disease allows doctors and researchers to ignore the social effects of race in their models and methods. While racialized patients are likely to see the social aspect of race as highly relevant, which I will discuss more in the next chapter, a terministic screen of race as the risk factor or

mitigating factor in disease allows doctors and researchers not to notice race's social relevance. At the very least, as I will show in the following analysis, this terministic screen reduces myriad complex social factors into one easily conflate-able concept: race.

Stratifying by Race

Stratifying by race occurred when data was distributed or organized along racial categories for the purpose of understanding how a phenomenon acts in relation to an individual's self-reported or observed race. This proposition does not necessarily presume that race is biological; however, race is used as an ineffective proxy for a range of unknowns that cannot be accounted for by education, income, or other social factors. In other words, race becomes the only recognizable correlating factor for whatever is being examined. The problem with this use of race is that it leaves the mechanism by which race may affect an issue open to interpretation. Knowing that Black women die more often does not tell you why Black women die more often or how being Black affects that situation. There are more inconsistencies with this use of race. At times, studies seem to define races in whatever terms are convenient for their data collection. For instance, race might be organized as "white" and "nonwhite," a binary distinction that lumps everyone into those two categories and works from that position. Other times, the categories were "Non-Hispanic white," "Non-Hispanic Black," and "Hispanic," suggesting that the Hispanic category contains both Black and white people and that that difference is inconsequential, while the difference between non-Hispanic white and Black subjects does have consequence. The arbitrary distinctions do not provide additional insight in the material, but they do allow for the next construction of race as a risk factor.

Adjusting/Correcting/Controlling for Race

The construct of race that occurred most frequently in the sample set was adjusting calculations and analyses for race, a use for race that gets black boxed into accepted mainstream medical practice, because it is hidden in the codes and algorithms used to test for certain variables. To adjust for race means that race is an important factor in whatever model the researcher is trying to build or produce. So the model is built to consider race in its outputs. For an algorithm that is meant to decide if a person should receive a particular medicine based on a variety of metrics, race will be one metric that may skew the rest of the calculations. Publications phrased this construct in myriad ways. Some referred to the readjustment as a correction, meaning that whatever number they had in mind for one race, needed to be corrected when applied to a different race. Sometimes, they simply refer to themselves as “accounting for race” or “considering race” . Other times, the researchers must “control for race,” so the effect of someone’s race does not cause chaos to erupt in their data. Seriously though, controlling for race has the same logic issue as stratifying by race because it does not explicitly point to the social predicament of being racialized. Instead, race becomes a stand-in for the factors that seem to correlate with race and cannot be explained by other things.

As this was the construct of race that occurred in most of the publications I analyzed, even when race was also used in one or both of the other two constructs I will discuss, it could be argued that when researchers see race, they see it initially as a problem. Another issue with adjusting for race was in the idea that race was not significant. Often, after a researcher would “correct” for race, numbers that were higher

for African American patients became insignificant. Race in either case was used to decide whether data was significant, and if it was, that significance was necessarily negative.

The problem of race in these research methods is one of too many vagaries. Doctors do not explicitly identify the social features of race's influence on health. This fuzziness in the use of race allows some to assume the race that is self-reported or observed by the researcher corresponds to some particular genetic makeup. The fact is that someone could come in, say they are white, come from an entirely African American family, and contribute to the data that researcher has on white people. At the same time, a person could come in who 'looks' African American and identifies as such, but whose heredity includes as many white people as it does Black. And that person may contribute to the data the researcher has for Black people. Include the fact that many Spanish-speaking people have African ancestry but do not identify as Black, and you can begin to understand why the assumption of race as metric for correction is illogical.

Race as a Risk Factor

The final construct I will discuss is race as a risk factor. At their core, I think all of these iterations of race in the research frame race as a risk factor. However, a good portion of the articles I surveyed named race as a risk factor explicitly. As a construct, race as a risk factor feels true. Being Black in America does come with its risks. However, disease is not one of them, not directly anyway. However, one of the trending phrases was "Black race was a risk factor". In every case, the context was a disease or condition that according to their data more Black people had than others, and so being

Black became a contributing risk factor for having that condition. This treatment of Blackness as a causal and not correlative factor raises several questions. First, why? What can anyone learn from the idea that their race is a risk factor? When we understand race as a social construct, the need to calculate how many people of a particular group have a disease is negated. But for the sake of an argument, let us just say race was the biological marker that it is not, what can a patient do about their race? How can knowledge that certain people contract something more often help in research around treating or curing that condition? Unless there is something about having brown skin that contributes to the contraction, development, or whatever of a condition, there's really nothing to be gained.

As a risk factor, race serves as a distraction from other factors that may contribute to the development of disease. This construction of race also contributes to the continued essentialization of race as a biological concept which puts Black patients at a disadvantage because other potential causes are overlooked. The use of race as a terministic screen that embodies a "principle of discontinuity," that continues to separate some people from others, and sets Black people up as a different *kind* of people. This use of race as a taxonomic device highlights the differences between health outcomes and ties those outcomes to a category of people, Black people. In this way, Blackness becomes associated with a risky lifestyle regardless of the lived daily reality of an individual Black person. If by simply being ascribed Black as a race, a person is automatically understood as "risky," what effect might that have on the treatment a Black person receives for the diseases for which their race is a risk factor?

This use of race represents what Dorothy Roberts (2008) calls race-based medicine. In her article, “Is Race Based Medicine Good for Us? African American Approaches to Race, Biomedicine, and Equality” studies this issue more broadly by investigating different approaches and dispositions toward “accounting for race” in medicine. Troy Duster and Kelly Happe are two more scholars addressing this issue. Both argue in different ways that attempts to operationalize race as a genetic category, despite their seemingly good intentions, only serve to reinforce and bring back into practice essentialist assumptions about race. Troy Duster (2015) takes a critical race theory approach to examining the impetus for contemporary race-based scientific research. Explaining that much of the research that attempts to use race as a categorization device does so with seemingly altruistic goals, Duster nevertheless asserts these projects reinforce the implicit, but incorrect, belief that race is a biologically explainable concept. Its ultimate futility is why the terministic screen of race as a risk factor is so problematic, in all its iterations it hides the social aspects of race that contribute to health inequality by not naming them explicitly. Because of its historically constructed rhetorical function as a biologically essentializing concept, race’s social dynamics are often overlooked even by those who know better. These constructions of race are evidence of that oversight.

Discussion

To be clear, these constructions of race are not just popular, they are ubiquitous in the research. Almost every publication in my sample contained one or more of these

constructions of race. The only exceptions included articles that explicitly discussed racial disparities and made a point to define race as a social construct. From my examination of the discourse then, I was left to conclude that research in obstetrics and gynecology does not yet have a working model for applying a social constructivist perspective to their research methodologies. I am not claiming that members of ACOG do not understand race as a social construct, only that the research methodologies published in their journal do not yet reflect that understanding. In short, although prevailing understandings of race are as a social construct, research methods in obstetrics and gynecology continue to use race as a biological construct, I assert that this disciplinary dissonance occurs out of a gap in the scholarship where no social constructivist methodology has managed to find footing. Even a keyword search in Obstetrics and Gynecology for the words ‘constructivist’ or ‘construction’ turned up only 2 abstracts between them, not a single full-length article.

My conclusions are also supported by other scholars who have examined the use of social constructivism in knowledge translation and psychiatry. However, a telling trend in the literature regarding social constructivist paradigms is the need to explain terms in detail. For example, Hamish Wilson (2000) sees a social constructivist epistemology as the solution to doctor-patient relationship disfunction, as purely objectivist and positivist perspectives fail to accommodate for the individual in favor of science’s need to generalize. The biomedical model, as he understands it, is only meant to serve the needs of academic medicine, not practice in care. The social constructivist model is then broken down into smaller important terms and compared by aspect to the

biomedical model. Similarly, twenty years later, Rees et al (2020) also make the case for a social constructivism by providing a thorough explanation of the concept. As a departure, however, these authors describe social constructionism's potential applications in academic medicine. Thomas et al (2014) survey the use of social constructivism in knowledge translation research specifically and find that it is an appropriate framework for helping clinicians understand themselves better as they relate to society and their patients or research subjects. Other examples of social constructivist perspectives are available in disability studies and psychiatry, where the very definitions of these terms are examined as social constructs that change and can be changed at will. These studies ask researchers to question how their understandings of disability or mental illness change research around health care in some contexts.

Where I diverge from these scholars is in my application of constructivism, not regarding the way patients or doctors understand themselves, but in how the science of medicine understands a concept that has been mistakenly used in the forming of its very foundation in the US. While much of what has been published regarding a social constructivist perspective in medical research focuses on how doctors and patients construct intangible ideas such as health, wellness, culture, identity, and so on, I am focused, like Duster Troy and Dorothy Roberts, on the forced and false materiality of a concept that is as intangible as any of the other ideas that I listed. A social constructivist perspective sees race, as an arbitrary social marker that invites or makes excuses for bias - as a social construct. And research in obstetrics and gynecology should operate in the same way.

While rhetoricians may not be in a position to redesign clinical research methodologies, we can offer new standards for editorial practices and demand that only research which treats race as the social construct that it is should be granted validity. Further, when we put this new paradigm in conversation with Black women's experiences in healthcare, we open up avenues for dialogic reconstructions of race and care. Moves to accomplish such a paradigm shift are underway, as I have seen in the most recent notes to authors about using race in research; however, I would add to those efforts the opportunity to learn rhetorical lessons from Black women who apply their intellectual and social expertise to the tasks of supplementing their own healthcare and advocating for themselves and other vulnerable members of their communities, as I will discuss in the next chapter.

Conclusion

To reiterate and close, at their core, medical constructions of race undergird essentialist constructions of Blackness in general and Black motherhood, in particular. This perspective ultimately places the responsibility for disparities on Black people, either by their genetics or their behavior. In contrast, a social constructivist perspective prevents us from seeing Blackness as an inherent quality in a person and instead as a social condition with material consequences and therefore changes our approach to addressing problems that stem from that social positionality. Thus, a study would not adjust for race but perhaps for the distance from the nearest affordable grocery store because the former is an intangible concept while the other exists in material reality.

CHAPTER FOUR: BLACK AT THE OBGYN

Black women's historical relationship with Medicine in the United States is marked by abuse and dehumanization. The stereotype that African Americans are inherently distrustful of doctors frames distrust as a reaction to the USPHS Syphilis study that was conducted from 1932 to 1972 by doctors who lied to their Black patients about their participation in the study. Black men with syphilis, who thought they were receiving treatment, were actually taking a placebo, and being studied for a better understanding of the disease in its late stages. In other words, researchers withheld medicine specifically for the purpose of watching the men die of syphilis. As horrible as those events were, they are not the sole reason many African Americans do not trust doctors. African American perspectives on Western healthcare are not a monolith, but they are often situated within a combination of personal experiences with doctors and varying degrees of historical awareness.

In my own experience as a child and young teen, doctors were always expert professionals, whose advice was based on years of education and an aptitude for deductive reasoning. It never occurred to me not to trust them. My own distrust of doctors did not begin to develop until my late teens when they began asking me questions that reflected certain assumptions about my character and behavior. As I began seeing doctors as an adult, I felt less listened to and more judged. During appointments that I made to address specific physical ailments, like a sprained ankle or dislocated knee, the attending physician often turned the conversation to diet and exercise, even when the

injury had been sustained during exercise. Over years of feeling like I could count on one hand the number of responses I would receive from a doctor, regardless of my reason for being there, I started avoiding the doctor's office. The only exceptions to this developing aversion to doctors were my two pregnancies for which I maintained regular prenatal visits to an OBGYN. As I recounted in the introduction, my first childbirth experience was difficult and marked by a refusal to listen to me or validate my perspective and experience. None of this had anything to do with my understanding of history. It was only after a pattern of dissatisfaction that I began to situate my own experience against a larger socio-historical backdrop.

In this chapter, I detail the study I conducted involving interviews with Black women who had negative experiences with OBGYNs. This chapter calls attention to white masculinist systems of creating knowledge their historical roots and their contemporary failure to address health disparities, like those discussed in previous chapters. In turn, it offers a Black feminist epistemological standpoint as an alternative mode of investigation and knowledge creation. My goal in this part of the dissertation is to introduce the content of these interviews with the reverence and respect they deserve and put forth the argument that these perspectives offer a way of understanding the influence the social positionality of being Black has on Black women's experiences at OBGYNs.

Obstetrics and Gynecology's Use of Black Women as a Means to their Ends

To be sure, the socio-historical backdrop of health care for Black women is ugly. The history of Black women's relationship with medicine in the US has gone through

several stages and iterations, all of which are characterized by the indiscriminate use of Black women for any ends but their own. Enslaved Black women were used not only for their labor, but also for their ability to produce more human beings to enslave. In this capacity, they were subjected to any medical treatments that might help them perform the job of procreation. In *Medical Bondage*, Dierdre Cooper Owens (2017) describes the treatment of enslaved women, both those of childbearing age and older enslaved women who often served as midwives. Her review of medical journals and private physician's journals shows that Black women's value as slaves was rooted as much in their ability to bear children as in their ability to perform labor, perhaps more so. She recounts how white physicians expressed more concern over their inability to retain viable samples of their patients' organs and tissues than with their patients' survival/death.

The disregard for the humanity of enslaved Black women practiced by early antebellum physicians fueled the creation of gynecology as a medical specialty and therefore also serves as a partial model upon which doctor-patient interactions are founded. As Cooper Owens (2017) writes, "The contested relationships around sex and Black women, gynecology's birth, and slavery's growth are inextricably entwined around the emergence of women's professional medicine in the antebellum era" (72). This statement reminds us that while much of the rhetoric around helping Black women relies on the assumption that because of Black women's perceived position at the bottom of the social hierarchy such work will positively benefit all women – as I demonstrated in Chapter 2, the converse is also true. Thus, when conversations around how to address maternal health disparities morph into debates around whether those initiatives can help

the larger population, it is worth noting that the wrong things done to Black women in the name of progress also negatively affect all women. Cooper Owen's statement further explains why maternal mortality rates in the United States are some of the worst in the Western capitalist world. If the default position of a gynecologist has foundations in patriarchal slavery, then of course the entire specialty would revolve more around supporting and regulating reproduction than supporting the health and wellbeing of a woman.

Abuse and experimentation on Black women did not end with the emancipation proclamation. Instead, doctors and researchers participated in more covert ways of abusing Black women. One example that I chose to save for this chapter is that of Fannie Lou Hamer, a key figure in the 1960's civil rights movement. Quite appropriately, Ms. Hamer is most famous for her exclamation, "I am sick and tired of being sick and tired!" (1964). While she was referring to the treatment of all Black Americans in the context of civil rights, her statement is a fitting way to characterize the treatment of Black women at the hands of doctors. As a dark illustration of this perspective, Hamer was victim to what was euphemistically referred to at the time as a "Mississippi appendectomy." Essentially, in 1961 she was sterilized without her knowledge or consent while hospitalized for an unrelated minor surgery. She only found out about her sterilization from the maid of one of the doctors that performed the procedure. Ms. Hamer is quoted as saying "I would say that about 6 in 10 women who are hospitalized are sterilized with their tubes tied." (1964). While her own anecdotal statistics may not be recognized as valid through

mainstream academic systems, her estimation comes from her deeply connected situation within the Black communities that she worked to liberate.

Although Fannie Lou Hamer's experience and her contextualization of that experience happened at different times, once enmeshed, the two could not be separated. Her positionality as a Black woman organizing for the liberation of Black people situated her trauma as a representation of the larger struggle for human, civil rights. In the same way, while many Black American women are aware of the Tuskegee experiments, and some are aware of the eugenic movements in North Carolina where thousands of Black women were sterilized without informed consent, and some are even aware of the ongoing nonconsensual sterilization of undocumented immigrants being held in detention centers by the US government, the connection between distrust of medical professionals and those examples operates through the lens of personal negative experiences.

The difference between Medicine's investigations into distrust and Black women's understandings of their own misgivings is evident in the literature around the issue in the field of Health Communication, where strategies to address the problem tend to center Eurocentric masculinist epistemologies. Recent publications on the subject reaffirm ways of knowing that come out of scientific positivism. In other words, the same means of knowledge creation that was built on the torture of Black women is being used to better understand how to stop killing them. Well-meaning scholars ask: *what can we do to address health disparities?* And their answers often come as a push for cultural competence.

In Health Communication scholarship, a push for cultural competence training dominates communication-related interventions in disparities. Cultural competence refers to a health professional's ability to communicate and work with patients from discordant cultures and backgrounds. Borrowing from Sharf and Kahler's 5 levels of meaning (Ideological, Sociopolitical, Institutional/Professional, Ethnocultural/Familial, and Interpersonal), Perloff and colleagues focus on the 5th and final level. They use the interpersonal level as a way of teasing out the beliefs, expectations, and perspectives that shape patient physician communication. From this angle, the authors interrogate the concept of cultural competence. They ask: can cultural competence be achieved; if so, how; and finally, what would the effect be on doctor-patient relations? Perloff et al find that while programs designed to provide cultural competence boast success, their increases in cultural competence are reported primarily by physicians and health care workers who took the training. These programs were also designed with little to no input from patients and community members. The studies that report success do not provide enough details about the training to systematize successful practices. Ultimately, they conclude that cultural competency training while still unproven as a remedy to intercultural communication challenges can positively affect interactions if studied more systematically.

Cultural competence research and theory has taken several shapes in the literature. Cultural Humility, Cultural Responsiveness, and Cultural Safety all refer to the same basic goal: better understanding between doctors and patients of disparate cultures. However, each iteration of cultural competence reflects the goals and priorities of the

scholar who promotes it. For example, Tervalon and Murray Garcia (1997) offer cultural humility as an alternative to cultural competence that emphasizes a constant openness to learning new things. Critiquing cultural competence training as a practice that suggests medical professionals can learn all they need to know in a single training session, the authors propose humility as an understanding that one can never know all there is to know about another culture, much less multiple cultures. Cultural humility represents a self-reflexive practice in which practitioners remain open to learning new things about the effect of culture on their patients' perspective of health and wellness. Practicing humility in contexts where there is an imbalance of power is meant to help equalize things. As they provide more details on the concept of cultural humility in education settings, Murray-Garcia and Tervalon (2017) point to the need for practitioners to exercise “an active and repeated laying aside of our assumed expertise and in humility becoming the students of our patients” (p. 24). In this way, cultural humility acknowledges the validity of the patient's perspective and asks the practitioner to disrupt power dynamics that try to invalidate or ignore it.

Cultural responsiveness is similar to humility in that it recognizes a constant need for reflection and reassessment of one's competence but with more emphasis on how that competence contributes to the needs of specific patients and populations. For example, differentiating competence from responsiveness, Minnican and O'Toole (2020) define culturally responsive communication as “communicating with awareness and knowledge of cultural differences and attempting to accommodate those differences” as opposed to operating with perfect understanding of all cultures which the term competence implies

(p. 2). Their definition, while acknowledging the ongoing process involved with giving better care, still places the power of awareness and knowledge in the hands of the health care professional. Although the goal of better understanding a patient's culture to better communicate with them is certainly positive, every move toward improvement is focused on the growing expertise of the healthcare professional and disregards whatever knowledge the patient may bring to a given interaction.

Theoretical Framework

This continued dismissal of Black feminine ways of knowing is arguably rooted in the same ideas white antebellum doctors used to insult and disregard the expertise of Black midwives (Harper, 2021). White masculinist epistemologies are rarely referred to so explicitly. They tend to be treated as *the* way of knowing and acquiring knowledge, not just *a* way. Patricia Hill Collins, however, names white masculinist epistemology as a way of highlighting how appropriate the term “Black feminist epistemology” is for describing a way of knowing practiced out of necessity by Black women. Similarly, white masculinist epistemology is a way of knowing practiced by white men out of necessity. Both standpoints reflect distinct systems for knowledge creation and validation, however, rhetorical analysis applied from a Black feminist epistemological standpoint opens possibilities for finally privileging the expertise of Black women who have inherited knowledge production processes that lead to practical strategies for self-preservation. Black feminist epistemology is a way of approaching this research and a way of understanding the knowledge produced by Black women in everyday situations, like visiting the OBGYN.

In *Black Feminist Thought*, Collins refers to a matrix of domination where various hierarchical social systems run into and through one another in the identity of an individual. This is also referred to as intersectionality, a term coined by Kimberle Crenshaw (2015), the idea that the hardships that come from being Black and those that come from being a woman are not experienced separately but often simultaneously and with compounding effect, like any other combination of oppressive conditions. This framework not only provides a structure for recognizing the contributions Black women can make to knowledge production regarding their own healthcare, but also a way of teasing out the overlapping oppressive forces that contribute to problems with their care.

The Study

In order to answer the research questions of this dissertation, I conducted a rhetorically analytical study of Black women's narrative constructions of race and its role in their health care. After sharing an emotional post about my own birthing experience, I also shared an invitation to participate in this study. Over 40 women initially filled out the form to participate, and by the end of all the emails and follow-ups, I wound up interviewing 12 women and using 10 of the interviews. One of the women's story took place in another country, and because I am focused on the obstetrics and gynecology in the US, I excluded her interview. The other interview that I chose not to include was one where the participant seemed reluctant to participate once we had started. I interpreted her reluctance to answer questions as a silent revoke of her consent to participate and excluded her remarks from the study. In total, this study examines interviews from 10 Black women, over the age of 18, from various socio-economic backgrounds and

geographic areas around the United States. Nine out of ten of the women I interviewed had graduate degrees; the other had an undergraduate degree. I expected this to be the case because the participants came out of my extended social network and were likely to have similar attributes to me.

As a reminder, the research question I endeavored to answer with this study was, “What are some rhetorical dynamics governing Black women’s negative experiences with OBGYNs?” My study relied on 10 interviews with Black women about their negative experiences with OBGYNs or other women’s health practitioners. I applied a Black feminist epistemological perspective in the design of my study as well as my analysis of the data. For the purposes of this study, I looked to Collins’ four tenets of a Black feminist epistemology:

1. Personal experience as a criterion for meaning
2. Dialogue to validate knowledge claims
3. Ethics of care
4. Ethics of Accountability

In the next section of this chapter, I will explain how my methods were guided by this epistemological standpoint.

Personal experience as a Criterion for Meaning

Understanding the importance of wisdom in Black feminist epistemology boils down to personal experience. As Collins notes, the difference between education or intelligence and wisdom comes by way of experience. From this perspective, a newly

graduated man whose education may have trained him to provide healthcare for women is not as credible as a midwife with less formal education who has helped deliver over 50 healthy babies. For many Black women, wisdom beats knowledge every day of the week because you can know something in theory, but until you have experienced it, all you have is a theory, a guess at what really is going on. For this study, the personal experiences of these women paired with their general knowledge of history make for the kind of wisdom needed to effectively improve health care and outcomes for Black women.

The most important way this research diverges from the norm is in its privileging of personal experience as a criterion of knowledge production, not as data waiting to be interpreted. I did not interview Black women so that I could generalize their experience or turn it *into* knowledge. The insight Black women bring to debates around their care *is* knowledge, full stop. The goals of this study were not to boast a particular method for understanding Black women's experiences and provide concrete instructions for their care. Instead, my place in this context is to call attention to, not to evaluate or interpret. In these interviews, I asked the women to interpret their own situations and experiences. They provided their own reassessment of their situations within the larger historical contexts of Black women's health care in the United States. I interviewed them so they could turn the knowledge produced by scholars and doctors into wisdom that can change behaviors. By asking them to analyze their own experience and perspective, I am foregrounding their expertise as Black women over my own as a researcher or technical communicator. However, as part of the back and forth process of these conversational

interviews, I did disclose my own experience and positionality as a way of situating my ethos in the interaction.

- The questions that asked participants to analyze their own experience were:
- What do you think was going on with your care?
- Why do you think you were being treated that way?
- Tell me about your familiarity with the history of Black women's relationship with medicine in the US?
- How do you see your experience fitting into the larger history as you understand it?
- What advice would you give your doctor or other doctors that intend to treat Black women?

Providing the opportunity for participants to take a critical look at their own narrative not only privileged their perspective as knowledge and experience that combined to make wisdom, but also provided an opportunity to validate those knowledge claims through additional dialogue. The women I interviewed were not only able to contextualize and re-interpret their experience, but also leverage their insights into actionable takeaways for practicing OBGYNs.

Dialogue to validate knowledge claims

When Collins describes the use of dialogue to validate knowledge claims she explains that “for Black women, knowledge claims are rarely worked out in isolation

from other individuals and are usually developed through dialogues with other members of the community” (260). For this study, the dialogue Collins speaks of was achieved through follow-up questions, clarifying questions, and additional disclosures on my part. For follow-up questions, the goals were to encourage more elaboration on certain interesting parts of their narrative and to provide space for more details in parts of their narrative where the participants seemed to think they were talking too much. For example, if a participant mentioned that some part of their narrative was a long story all by itself, I would encourage them to tell the tale. Sometimes, I waited until after they finished the story they were telling and then asked them to return to the subject they skipped over before. For clarifying questions, I would usually repeat what the participant said and ask if I had understood them correctly. Some clarifications helped to solidify the timeline of the narrative so that I understood how one event led to another. Whether following-up or clarifying, I tried to ensure that the story they told was the story they meant to tell. In many ways, I drew on my writing center training in this endeavor. My job was never to help interpret or analyze, only to make sure the participant’s analysis was understood in a manner they approved of.

As part of the knowledge validation process, I also included some self-disclosure where appropriate. For example, during parts of the interview where the participant could ask me questions, I was often asked what brought me to this research topic. At that point, I would tell an abridged version of my own childbirth and women’s health care experience. If possible, I would start with a detail from my own story that was similar to theirs. I also told women if their experience had been echoed in previous interviews or in

the literature I had read on the subject. As it is my position that my role is to draw attention, I felt comfortable sharing that my research had shown similar experiences or understandings. The response to these disclosures varied from knowing disappointment to tempered relief. Again, the underlying epistemology behind this interview strategy was to validate knowledge claims and insights through dialogue, to validate that I understood them correctly and to validate them as perspectives.

Ethics of Care

An ethics of care requires a level of connectedness, emotional attachment, and empathy in the production of knowledge. In the context of this study, that meant that I would not separate the positionality and feelings that brought me to the work from the work itself. Collins notes that while Eurocentric masculinist ways of knowing promote intellectual distance that is meant to prevent bias, a Black feminist way of knowing is connected in nature, meaning it is achieved through relationships and conversations with others. Caring about the people involved in your production of knowledge is an important part of validating that knowledge into wisdom.

To practice an ethic of care in this study I focused on care in the design of my methods and in my use of the information provided. In the design of my methods, I focused on respecting the privacy of my interviewees and on asking questions that gave them an opportunity to express themselves fully without feeling censored. I am careful to use this data for the purpose of addressing disparities in health and care for Black women. This is not a study solely for the purpose of knowing something new. I care about the impact of this research in a personal way, and I do not try to hide that I care.

Ethics of Accountability

Ethics of accountability refers to the idea that a researcher is responsible for the claims they make and for their personal position on an issue. In this sense, the knowledge a person attempts to introduce as wisdom is only as credible as the person introducing it. If that person is known for their involvement and connection to the actions ideas inspire, then their ideas are given more credence. If not, those ideas are met with more apprehension and or distrust. In essence, it is not enough to talk the talk, what a person says only holds sway if they are also known for walking the walk. Accountability and caring are connected in this way because accountability serves as proof of care.

Accordingly, I am responsible for the knowledge claims that I share through this research as well as my ongoing involvement and contribution in initiatives that aim to eliminate health disparities. If I simply finish this dissertation and then ride off into the sunset never to look back at maternal health disparities or medical racism again, I am not being accountable. I will have simply used these women's wisdom for my own educational gain. And the women I interviewed will know. We follow each other on Twitter. Further, if I go out and misrepresent their stories, they are going to know. I established connections outside of the study with those who wanted such connections specifically to be held accountable. I am accountable to the women who made the study possible. They will all receive a copy of my dissertation before I submit the final version for approval, and I am prepared to remove portions of the dissertation or amend them in

response to feedback from my interview participants. This commitment reflects my accountability, care, and the ongoing dialogues that validate my conclusions as wisdom.

The Interviews

Over the course of 2-3 weeks, I conducted interviews with 10 Black women on Zoom. These interviews were scheduled to last 45 minutes, but one was only 20 minutes and another was about 90 minutes long. The women I interviewed were from various cities around the United States, including Chicago, Atlanta, Detroit, Cleveland, Washington DC, St. Lois, Springfield, and San Diego. Some of them had completed a survey before the interviews, most had not. They agreed to be interviewed and to be anonymously quoted in the dissertation. I agreed to give them alternative names in the dissertation, and two women offered suggestions for their aliases. For each Zoom interview, I was located in my home office with the door closed. However, like many of the women I interviewed, my children did not always remember that the door being closed meant that I should not be interrupted. Rather than holding the conversations up, those brief interruptions seemed to improve our report and make for a more comfortable conversation. While I did make room for a free-flowing conversation, there are a few questions in these semi-structured interviews that I asked every participant. In what follows, I will review the trends in responses.

Would you say you've had one to a few negative experiences or that you are regularly dissatisfied with the care you receive from OBGYNs?

I asked this question mostly to set up an organization for their narratives. I wanted to know upfront if they would be recounting one story or a series of stories so that I could write more effective notes. And although I am aware of the history between Black women and medicine, and the research on the subject, I was still surprised at the responses. Most of the women I spoke to reported having been regularly dissatisfied with the treatment they received from the OBGYNs they wanted to talk about. Three of the women said that they were currently with an OBGYN that they were satisfied with. The rest expressed difficulty finding an OBGYN they felt comfortable with. I understood these responses to mean that more OBGYNs continue to treat Black women poorly than anyone at ACOG would like to believe.

Can you tell me more about that? Do you have a recurring problem with the OBGYN, or is it something new every time? Is there a particular experience that stands out in your memory?

For several participants, the line between *recurring* and *something new every time* was not as clear as expected. Some participants struggled to answer this question quickly and clearly, sometimes stumbling over the words because a clear delineation was not available to articulate. In some instances, it seemed as if the feeling of dissatisfaction carried over from visit to visit, even when the actual circumstances of dissatisfaction changed, which may have made the problems feel recurring when they were actually separate instances with common details. For instance, Natalie answered with “I think I’ve been regularly dissatisfied. But what has I think, perhaps, come to a head – so it’s really been like the whole time, but this last one was really like the cherry on top” (00:42).

Natalie's pause and backtrack to clarify showed that individual instances of dissatisfaction are connected and not processed as separate events. The connection between individual interactions with OBGYNs and a broader relationship with health care comes across especially as patients switch doctors only to receive similar treatment. When asked this same question, Aisha, needed me to clarify whether I meant a recurring problem with the same doctor or a recurring problem across doctors. When she responded with a request for more details she explained that she had multiple stories to tell across almost every OBGYN she had ever seen. Although, the sheer ubiquity of negative experiences across multiple practitioners did not come across to me as I conducted the interviews, the pattern certainly became visible as I reviewed the transcripts. No one's negative experience could be explained in the singular; every interview covered multiple instances of dissatisfaction with multiple practitioners.

For some other participants, this question seemed to inspire a seeking of permission to tell the whole story. In response to "is it something different every time?" Delores asked me if I wanted more details or less. When I answered with, "more, please, as many details as you are comfortable giving," Delores took a deep breath and started telling me her story. Her narrative included details about her move from Indiana to Illinois, the struggle to find a Black OBGYN, and her subsequent inability to do so. A clarifying question I asked about the chronology of her experience inspired her to think back to her childhood and her first time visiting an OBGYN, but that was not the "main story" she had come to tell me. It was only after I gave her permission to give me all the details that she seemed empowered to explain things from her perspective.

Amanda seemed to be looking for the same permission as Delores because her response to the questions was “Well did you say? Is it okay? If it’s kind of... lengthy?” (00:56). I responded, “Yes, absolutely, take as much time, give as many details as you want” (00:59). And like Delores, Amanda continued to provide a complicated story of various systems and experiences that came together for her as one large tapestry of memory. She told a story that began with inadequate treatment at a student health center, made its way through a barely avoided forced hysterectomy, into a birth experience marked by racial and class prejudice, back around to memories about her first experience with a women’s health practitioner. Amanda did not contextualize her experience in a silo. Instead, she understood one instance to be connected to the other by more than just herself as a common factor. She and Delores understood race to be the connecting thread among all their negative experiences, and so they were recurring because they responded to an ongoing catalyst. That understanding was not as surprising as the idea that they wanted permission to do so, or at least some sign that the interview was a safe space to do so.

Do you have any thoughts on what was going on with your treatment or why you were treated that way?

The most surprising answer to this question occurred more than once, but after thinking through the nature of medicine’s treatment of Black people, it made more sense. A few of the women, at one point or another, mentioned that the procedure(s) done to them would earn the doctor, practice, or hospital more money (Natalie 33:17, Bernice 28:23) . For those women whose stories involved hysterectomies or cesarean section

births, the idea that the doctors pushed for those procedures out of greed was not out of the question. In *Medical Apartheid*, Harriet Washington discusses the practice of performing unnecessary surgeries on enslaved Black people to get more money from their enslavers, and of Black people being exploited for profit by researchers and entertainment promoters. Needless to say, the United States boasts enough examples of Black people being used for profit that these women's suspicions were not unfounded. While doctors stand to make more money doing these procedures on patients of all races, the likely hood that they can do so without consequence is higher when the victims are more marginalized patients.

Although none of the participants tried to deny the influence of race on their experiences, some of the women in this study were hesitant to explicitly name race as the mitigating factor in their treatment. All of them mentioned race at some point during the interview. About half of them began their answers to this question with some hedging in the form of "I don't know" (Samantha, 11:25; Renee, 13:05), or "I can only speculate" (Amanda, 6:23), or "not sure..." (Delores, 7:42). Aisha mentioned that at first she thought the issue was age and rigidity in her doctor before admitting that she believed race was a factor. The other five participants, however, quickly made mention of their race as part of the reason for their poor treatment. Bernice's immediate response was, "Oh 'cause I'm Black" (23:03). Natalie, who responded, "I'm a Black woman with a PhD, right? And I know I know something," felt as if her Blackness and education combined made people more defensive and aggressive with her as if they begrudged her her intelligence and success (29:19). The distribution of answers reflects the predicament

of Black women when we encounter microaggressions and other similar experiences of bias or mistreatment.

One of the most insidious aspects of contemporary manifestations of racism is that they often occur in ways that are hard to prove are racially motivated. Subtle hints that suggest an assumption of inferiority or of unearned intimacy are easily dismissed by the perpetrator as a misunderstanding or misspeaking, but from the perspective of the assaulted, within the context of history and present injustice, these actions often feel malicious. Even when we cannot be sure that what is happening is a microaggression, the effect is similar because we have to devote cognitive and emotional attention to wondering about it. Because the human brain is wired to pick up patterns to use as cognitive shortcuts, and those patterns become more influential if they occur in highly emotional situations like threats or insults (Mattson, 2014), I suspect that the experience of being Black in the United States includes certain patterns of treatment that can likely be associated with certain patterns of speech and tone that we then recognize as threatening or insulting. And the emotional nature of these situations makes these patterns or microaggressions much more recognizable to those who experience them than to those who perpetrate them (Mattson, 2014). The women in this study who hesitated to immediately name racism as a factor in their treatment were likely contending with this issue. At this point in the interview, most of the women did not know that I had experienced my own birth trauma; so, they may have still been apprehensive about trusting me as an interviewer with very personal information and opinions. Thus, their willingness to name race outright may have been mitigated by the risk of being

disregarded or judged. Although all the women eventually mentioned race as it regarded their healthcare, some of those insights came in response to the next question.

What instructions or advice would you give your physician on providing better treatment?

Although all the women I interviewed understood race as a factor in the quality of their healthcare, some did so as an answer to my question about advice for other healthcare professionals. In those cases, their advice included the need for more cultural sensitivity and implicit bias training, or they appealed for more sensitivity to the needs of Black women in general. For example, Delores and Amanda both suggested that because Black women deal with certain mitigating factors regarding their health, doctors should take the time to consider those factors and even ask about them when treating Black women. Amanda also suggested that “greater attention needs to be paid to the kinds of implicit bias that health centers have against Black and Brown women” (12:31). And Delores emphasized that doctors need to be more flexible because they deal with a vast variety of people.

Kennedy’s appeal for more sensitivity focused on the situation of being younger, perhaps late teens and early twenties, and feeling less empowered and informed. She insisted that younger people need even more sensitivity. And her advice was also similar to that of other women who would ask doctors to “exercise a little empathy” (Samantha, 14:15). This includes taking the time to learn more about a patient, particularly their goals and desires to have a family or not to. Learning more about a patient might help doctors see them more as individuals instead of numbers on a chart or money to be made. Natalie

specifically advised that doctors not focus on the amount of money to be made from a procedure and instead consider the health and wellness of the patient.

Some of the women's advice focused on using the information effectively.

Bernice asserted that many doctors "don't actually stay abreast of medical research." A conclusion she came to after several different OBGYNs insisted she have a hysterectomy to remove fibroids, none of whom seemed aware of fibroid embolization as an option. Only after she met her present OBGYN did she encounter a practicing physician that also conducted research. She expressed feeling lucky to have found a doctor that was also a scientist. Both Amanda and Samantha suggested that doctors were showing a kind of intellectual laziness by insisting on promoting the same procedures regardless of a person's individual situation. Samantha advised "use your brain... it's not just black and white... look at the scale of gray and adjust accordingly" (14:04). Amanda also implied that perhaps they should look for more ways to help Black women have families instead of helping them not have babies. This implication is likely rooted in Amanda's experience of having her doctor push for her to have a hysterectomy so strongly that she felt she needed a medical proxy to ensure he did not perform the procedure without her consent.

Almost inextricable from advice about being open to new research and information is the appeal for doctors to listen and respect a patient's perspective and decisions. In one way or another, every woman I interviewed asked that doctors be better listeners and suggested that respecting their patients' decisions was part of listening. For some women, the advice to listen was about the credibility of their personal experience

over the education of the doctor. This advice is reflective of a Black feminist epistemological standpoint which values personal experience as contributing to wisdom more than any theoretical knowledge. As Renee explains, “we know what is going on with our bodies” (18:12). Samantha made a similar point when she asserted, “just because your textbook says 8 [is normal] for this particular blah, blah, blah... if I’m at an 8 and I’m telling you I don’t feel good, then you need to readjust your belief system.” Delores took the advice a step further and told doctors to ask more and better questions and listen to the answers.

On the other side of using information and new research effectively and listening to the patient is the advice to provide all the relevant information a patient needs to make an informed decision. Renee remarked that “communication makes all the difference” (15:41). “If you tell me what’s going on and what you have to do, I can’t fault you if a mistake is made, or at least not as much, because mistakes happen. Just don’t leave me and my family in the dark.” Maria echoes Renee’s advice and says “show me the data” (27:30). Maria’s most positive experience with a doctor involved him showing her patterns in the data from a hormone test and explaining why they helped him rule out polycystic ovarian syndrome (PCOS). During her previous experiences she felt that her doctor tried to pressure her to do things without explaining why.

The last detail from these answers that seems rhetorically significant is the same appeal that showed up in the Birthing While Black hearing I discuss in chapter 2. Two of the women I interviewed made the point that providing Black women with better health care would result in better care for all women, and “benefit everyone because everyone’s

getting better care.” (Amanda, 13:45). As Katrina worded it, “My health is always a matter of the public good” (24:01). Like the representatives from ACOG who testified at the hearing, who were also Black women, Katrina and Amanda understand the fleeting nature of a moment where attention is being paid to the needs of Black women and so they tie the goals of better care to the benefit of ‘all.’ The underlying appeal, however, is to whiteness. The message is really that doing these things will help white people also. And they know they need to make that point because history shows that empathy for Black women is unreliable in the United States. Black women’s understanding of history does not always come from books, however, sometimes it comes from stories passed down and around.

Are you aware of any stories or experiences in your own family around medical abuse or mistreatment by doctors?

Many of the stories the women in this study could share from family members came from their mothers. Several of the participants’ mothers had undergone a hysterectomies, including Katrina, Maria, and Bernice. Katrina remembers her mother’s post-hysterectomy condition and recalls that her mother was in a great deal of pain afterward. She also knew that both her grandmother and great-grandmother had both had hysterectomies and that her grandmother reported never receiving any pain medication after the procedure and needing to report back to work almost immediately. Bernice’s mother regretted having the procedure and expressed that she no longer believes she actually needed it. Aside from a family history of hysterectomies, the other participants’ mothers had other traumatic experiences.

Some participants' mothers experienced serious life-threatening illnesses only to be told that they were imagining them. For instance, Samantha's mother collapsed and was paralyzed from the neck down, and after looking her over, the hospital sent her home with a referral for a psychiatrist. The hospital did not perform any scans of her body, they just told her it was in her head. Later, a different doctor discovered that a part of her mother's brain was putting pressure on her spinal cord, causing the mysterious paralysis. Renee's grandmother was also told to see a psychiatrist after she reported blood in her stool and other digestive issues. She was later diagnosed with Stage 4 colon cancer.

In other instances, participants disclosed the need to provide oversight for their mothers' care because of a history of low-quality care. Amanda's mother "cycled through different doctors because of misdiagnosis. Maria's mother's fibroids went untreated until they were the size of basketballs and when they were finally removed, she was left with a lot of loose skin. When she went for a consultation to have the skin removed, the doctor treated her so rudely that she was afraid to have her abdomen be seen by any other doctors for a few years. Since then, Maria has accompanied her mother to all her appointments.

Perhaps the most difficult response to this question came from Delores who shared that she had lost five family members in one year. Although three of the deaths were due to COVID, Delores identifies inconsistencies and injustice in every case. Her adoptive mother, who died of COVID, was in the hospital for an extended amount of time before being diagnosed. Her treatment was so poor that members of the family had to visit and take care of her. Otherwise, no one at the hospital would bathe or feed her.

Delores witness the same issue when her father was hospitalized for an extended period of time. She recounted sitting with her father for around 12 hours and never seeing a single person come in to check on his condition. When Delores's biological mother died, she had been left unprotected in a space with COVID patients and then contracted the illness herself. But, according to Delores, when she first arrived at the hospital for a different reason, she did not have any COVID symptoms.

My mother is white, but she had a hysterectomy in her early 40s like Katrina's mother. But I do not remember her in pain, and she had medical leave to use so she could recover at home. My mother's hysterectomy is less influential for my perception of my place in society than my paternal grandmother's late diagnosis of pancreatic cancer. My grandmother complained of stomach pains over the course of years, and she was repeatedly dismissed. She was finally diagnosed with pancreatic cancer after she got her lungs scanned in response to an asthmatic emergency. She had an asthmatic emergency because her doctor convinced her that her asthma medication could be causing her stomach pain, so she stopped using it. When I experienced my own birthing trauma, I connected my experience of not being listened to with my grandmother's late diagnosis and eventual death. In the same way, the connection between the participants' Black mothers and their own negative experiences is reflective of the kind of connected knowing Black women practice.

Can you tell me a little bit about what you know about medicine and Black people in the United States?

It was no surprise that every woman mentioned the Tuskegee experiments when asked about their understanding of medicine and Black people in the US. And most of the women also brought up Henrietta Lacks and the theft of her genetic material as the foundation for untold numbers of medical innovations and discoveries. However, the close personal connections some of the participants had with these historical events were not expected. Delores met several family members of men who were involved in the Tuskegee experiment and saw firsthand how that event affected them generations later. Even Aisha, who said she really did not know much about the history other than Tuskegee said she had heard stories from people about why they did not trust doctors. In this admission, she made the connection between hesitancy and history.

One of the strongest themes among answers to the question of historical knowledge was the understanding that Black women had been used as “guinea pigs” or science experiments (Renee, 30:29; Amanda 19:49). Amanda, Renee, Kennedy, Natalie, Katrina, and Bernice all mentioned experimentations on Black and Brown people for surgical procedures and to test new medications, like birth control. Katrina reflected on her positionality in relation to history and considered herself as “joining so many black women throughout history” (11:20). Renee describes the bleak message so much history of abuse sends:

Black people have been guinea pigs and practice tools for the advancement of medicine. Black women serve to be experimented upon. That’s what we’re out here for. We are out here so that some white woman doesn’t have to endure as much pain during her c section because they know how to do it and learned on the black one who didn’t get any anesthesia... I’m not exempt. I’m Black too. So I get experimented upon, and I get brushed off, and I get not listened to. (32:25)

Another interesting phenomenon that occurred was the fact that in some interviews the subject came up without prompting, suggesting that the Black women I spoke to already understood their healthcare as shaped by a historical relationship between Black women and medicine. I did not get to ask Katrina the question about history because she went into that topic on her own and discussed her reading of *Medical Apartheid*. Like Katrina, Maria made her own references to history without prompting. When she recounted her story and the pressure she was under to have a hysterectomy she mentioned the Eugenics movement and sterilizations in North Carolina (mention Flourice Richardson). When I asked her the question directly, she mentioned the Tuskegee experiments and Henrietta Lacks and connected that history to her work as a diabetes advocate. She recounts a story in which she visited a research facility and while the person giving her the tour was very proud of their genetic breakthroughs, all she could think about was whose cells gave them a foundation to work upon.

Lastly, one disheartening pattern that emerged from the interview transcripts was the knowledge that many healthcare providers operate under the false belief that Black people do not experience pain to the same degree or in the same way as other human beings. Samantha and Kennedy discussed how that stereotype affects the prescription of pain medicine for Black people. Explaining that the belief that Black people don't feel pain leads to distrust and the assumption that they are seeking drugs when they express that they are in pain. Delores recounted hearing about an unofficial rule for that says, "a white woman's 7 is a Black woman's 4" (29:52), meaning that the same illness or injury

is automatically 3 points more painful for a white woman than it is for a Black woman.

Kennedy goes on to connect that stereotype to the early experiments on Black women by J Marion Simms.

Other references to history were disturbing and enlightening in turns. They included a story from Delores's grandmother, a former maternity nurse. She told Delores that when she was still working at the local hospital, sometimes when a young and/or single Black girl would deliver a baby, they would tell her the baby died and give the baby to another family. Natalie discussed Vanderbilt University's history of robbing Black cemeteries of bodies for their students to study with. She also mentioned the closing of the Black medical schools of the past that left only three standing, and the fact that those three HBCU medical schools still produce the largest percentage of Black doctors in the United States. Kennedy was more familiar with the history presently being written and mentioned listening to programs about maternal mortality rates and how Black women end up dying because something is wrong and doctors disregard the issue. All of these women understood their own experience as one piece of a larger history of wrongdoing.

Conclusion

My goal with this chapter was to introduce the content of the Black at the OBGYN interviews as established knowledge in their own right and to put forth the argument that their perspectives are crucial for understanding social positionality of being Black and its influence on Black women's experiences with OBGYNs and other women's health care practitioners. I wanted to call attention to the way white masculinist

systems of creating knowledge have shaped the parameters of scholarly discourse and knowledge production, even in my own research methods. Further I aimed to highlight the historical roots of these paradigms and their contemporary failure to address health disparities. Alternatively, I resituated myself within a Black feminist epistemological standpoint as a more appropriate mode of investigation and knowledge creation.

Most of the women I spoke to reported having been regularly dissatisfied with the treatment they received from the OBGYNs they wanted to talk about. Although all the women I interviewed understood race as a factor in the quality of their healthcare, they expressed this understanding at within different contexts. For some, the topic of race came up in their advice to doctors, for others it came up in their answer to what they thought the underlying causes of their poor treatment was. The idea that the social positionality of being Black has bearing on individual interactions with OBGYNs was expressed in the myriad ways it came to bear in their experiences. Black women's experiential knowledge provides a well of information for providing better care. In the next chapter, I discuss how a rhetoric of respect is a appropriate intervention in the types of experiences described by three of the Black women I interviewed.

Moving forward after this dissertation, more interviews with multiple generations of women might reveal how strategies and understandings of race's influence on health and healthcare are passed down and communicated within communities. Such research would provide an avenue for approaching community engagement in more informed and impactful ways because it makes the invisible visible. As the interviews showed, one of the ways these paradigms work to suppress and oppress Black women is by hiding in

plain sight. Examining how these experiences are interpreted in memory and shared as part of the knowledge production process would be the next step in producing more focused rhetorical interventions.

CHAPTER FIVE: A RHETORIC OF RESPECT AS A THEORY FOR AGREEMENT

As a study, Black at the OBGYN revealed a lot in relation to my second research question: How do Black women understand the social construct of race and its influence on the care they receive at the OBGYN? Further, it contained rhetorical themes and understandings that also helped answer my third research question. What rhetorical interventions might be developed to address the pain points in Black women's health care? While I did make the argument that their testimonies already provided such knowledge in the previous chapter, I intend to further that argument with a theoretical addition and heuristic for rhetorical action in doctor-patient interactions involving women's health practitioners and Black women.

In this chapter, I establish and detail the concept of a rhetoric of respect. A rhetoric of respect provides a framework and paradigm for deliberate behaviors that ensure respectful, and therefore rhetorical, interactions between parties of differing levels of privilege, like the relationship between doctors and their more marginalized patients (ie Black and Brown women). The ways Black women discussed their experiences highlighted major areas for rhetorical intervention and a rhetoric of respect approach to interactions — which I will detail in what follows. I will show that a rhetoric of respect necessitates actions that can help counteract the influence of problematic paradigms or terministic screens. Further, I will demonstrate what disrespect and respect look like in

practice, drawing from the narrative experiences of the Black women I interviewed for Black at the OBGYN.

The problems identified and explicated in chapters 2, 3, and 4 of this dissertation constitute a lack of respect for Black women. The rhetorical dynamics at play in public discourse on the topic of maternal health disparities show how Black women are often purposefully ignored and how a problem that is disproportionately affecting them must be repositioned to seem universal in order for some legislators to see value in addressing it. Rhetorical constructions of race used in OBGYN research continue to essentialize race in ways that allow Black women to go over regulated and undertreated. Because rhetorics of Black motherhood construct an irresponsible, overly sexual but also utterly accountable Black mother, our actions in public are hyper-surveilled not only by the state, but also by random members of the general public. Kimberly Harper describes the over regulation of Black women's reproduction from those who were enslaved to those single mothers who were subject to the "man in the house rule" which Harper explains denied Aid to Families of Dependent Children (AFDC) to any mother who was said to have a man staying the night at her house (32). The idea was that whatever man she decided to see romantically was then responsible for the welfare of her children. Harper also explains how some of the language used by Margret Sanger as part of her participation in the eugenics movements of the 1940s, continued to be used to justify the forced sterilization of so many Black women well into the 1960s and 1970s. Sanger's depiction of Black mothers as having children "carelessly and disastrously," was echoed by lawmakers in Illinois, Iowa, Ohio, Virginia, and most notably in North Carolina, who

pursued legislation that would tie government aid to sterilization as Flourice Richardson (2016) discusses in “The eugenics agenda: deliberative rhetoric and therapeutic discourse of hate.” These eugenics programs operated under the idea that essentialist racist idea that Black people were an inherently less intelligent and biologically inferior to white people and that proof of this inherent inequality could be found in the genetic makeup of humans. Thus, because of their inferiority, Black people’s reproductive activities should be limited either voluntarily or through involuntary sterilization.

These constructions are not only wrong, but they are rooted in a history of hatred and abuse of Black people generally. Continuing to use these constructions, despite having the intellectual understanding that they are problematic, fails to acknowledge the harm done to Black people who are viewed through these faulty screens. Black people who are viewed as genetically less sensitive to pain receive less effective pain management and suffer needlessly (Hoffman et al, 2016). Black women consider the possibility of early death when conducting family planning (Birthing While Black) because Black women are still almost 300% more likely to die during or shortly after childbirth than white women (CDC). Legislators and researchers continue to disrespect Black women through active reification of problematic power dynamics and paradigms that support individual instances of injustice in OBGYN settings. These instances of injustice can range in consequence from feelings of inefficacy to debilitating injury or death, and they begin with the incorrect rhetorical construction of race as a biological concept.

My conclusion here is backed up by the testimonies of Amanda and Katrina who, without prompting, repeatedly mentioned feeling disrespected by their doctors and other women's health practitioners. For Amanda, the issue was one of deference: "They didn't respect my decision," she remarked, and she understood the problem to be "definitely an issue of respect" (6:23). For Katrina, her advice to doctors could be summed up in an appeal to "treat Black women with respect and dignity" (22:07). While not every woman I interviewed was so explicit in her appeals for respect, as I will show, their testimonies often described instances where: 1.) doctors failed to practice a rhetoric of respect, either by refusing to acknowledge the perspective of their patient as valid and act accordingly; 2.) lacking deference to a patient whose stake in the success of treatments is much bigger than that of their doctors'; 3.) or an inability to reciprocate the good faith efforts of a patient to agree on a treatment plan or course of action.

In this chapter, I will show how a rhetoric of respect includes rhetorical actions that demonstrate respect for a patient. I will begin by describing the tenets, which I assert constitute the framework, and then demonstrate how each tenet operates in practice. I explicate these rhetorical moves, or lack thereof, through a close reading of the excerpts from interview transcripts. Through a comparative analysis of the rhetorical constructions of race in OBGYN research and the experiences of Black women at the OBGYN's office or delivery room, I illustrate how each construction leads to disrespectful encounters and go further to describe how actions guided by a rhetoric of respect would counteract or prevent such instances of disrespect. My goal in this chapter is to offer a theoretical heuristic for actively shifting paradigmatic rhetorics regarding Black maternal health

from those that fail to acknowledge race's social influence on medicine or its most marginalized patients to those that exercise respectful ways of working with patients toward better health outcomes.

A Rhetorical Definition of Respect

The concept of respect has been defined and redefined by philosophers and practitioners alike with most conceptions of respect being shaped either by the object or subject of respect. In other words, respect is defined either by the person deemed worthy of respect or by the duty of the person paying respect to do so. When respect is defined by the person receiving it, questions of individual intrinsic worth and intellectual autonomy shape the conversation. When defined as the duty of the person paying respect, the concept is reduced to a moral principle. In both instances, respect is understood both as a feeling and as an action.

When philosophers discuss the concept of respect, they almost invariably begin with Immanuel Kant (1971) whose uses of the term respect-for-persons to describe an acknowledgement of the innate value of each individual and how they should be treated as an ends and not a means. Kant asserts that in human interactions, each individual must be treated as valuable without the need to contribute to some other agenda or cause, as an end in itself. The idea that individuals contain inherent value and must be treated accordingly is continued by Kenneth Henley in *The value of individuals* (1977), who argues that individuals are valuable in ways that cannot be reasoned, but also do not need to be. Starting from the same origin – the idea that respect for an individual as an individual means that a person is deserving of respect by nature of their subjectivity –

Henley posits that our regard for the wellbeing of others operates in the same way as our regard for our own wellbeing, without the need for reason. To illustrate, in the same way I, as a subjective individual, care for myself because I am myself, I care for another simply because they are also a self, even if they are not myself. While I may not be able to find a specific attribute or rationale for doing this, one should no more accuse me of being irrational for respecting another than they would for me respecting myself.

For Steven Hudson (1980), the kind of respect Henley is describing would be called “directive-respect,” a kind of respect that may have different qualities but on the whole is not considered “earned or merited”. He points to a difference in the verbs attached to the term respect to differentiate directive respect from “evaluative respect” which is “the sort of thing which is or is not merited” (72). Directive respect, Hudson asserts, can be demanded. A person has a right to demand respect for certain ideals, like the inherent value of an individual. In fact, to demand and to direct could be used synonymously. But one cannot demand evaluative respect. Instead, one commands respect by displaying certain qualities that are valued by others and evaluated to be respect-worthy.

Hudson also differentiates between *having* respect and *showing* respect, or the feeling of respect versus acting respectfully. Institutional- respect, a kind of directive respect paid specifically to institutions or persons who serve as representatives of institutions or ideals, may involve an attitude of alignment with an institution or idea, or it may not, but it will always involve a show of respect. Directives necessitate action, not feeling. I may feel respectful of the institution of marriage, or I may not, but refusing to

involve myself in an extramarital affair shows my respect for the institution, regardless of any evaluative respect I may or may not have for my partner. If I decided to participate in activities that go counter to the rules and expectations of marriage as a social and legal institution, I have *shown* a lack of respect and can no longer claim to *have* respect. In the contexts of health and medicine, the difference between having respect and showing respect have life and death consequences.

In “What does respect mean? Exploring Moral Obligation of Health Professionals to Respect Patients” Beach et al (2007) are also careful to point out that respect has both a “cognitive dimension” and a “behavioral dimension” (692). While the authors do not mention the different types of respect outlined by Hudson, they do recognize a difference between respecting an ideal, like autonomy, and respecting a person “as a person.” They offer a concept of “respect as recognition of the unconditional value of patients as persons.” Again, Kant’s original conceptualization of respect returns to remind us that acknowledgement of another person as subjective directs us to respect them, without any reference to merit or accomplishment. Beach et al seem to promote the attitude of respect over the actions and behaviors that reflect respect, noting that “actions and behaviors... are not a sufficient substitute for having a genuine attitude of respect” because what behaviors constitute respect are culturally and situationally bound (694). Admitting that either predicate of respect can occur without the other, Beach et al emphasize the need for both, but still seem to privilege belief.

Respect operates in the scholarship as an abstract ideal enacted relative to the social and political dynamics of a situation. Both universally desired as an ideal and

culturally bound as a practice, respect is difficult to wrangle together into one theory independent of all its situational exceptions. However, as a rhetorical concept, the use of respect can be much more focused and situationally adaptable. When enacted as a tool for coming to an agreement on treatment and behavior, as in the context of healthcare, respect has the potential to bring doctors and their most vulnerable patients together for a common purpose: improving the health outcomes of Black women.

Rhetoric(s) of Respect

I propose the term rhetoric of respect to describe an approach to agreement in interactions between women's health practitioners and their patients. A rhetoric of respect refers to a set of rhetorical tenets that comprise a way of coming to agreement between doctors and patients. The tenets of this rhetorical framework are acknowledgment, deference, and reciprocity. In my search for iterations of respect in cultural and scholarly literature, I found that respect – defined in this context as “Deferential regard or esteem felt or shown towards a person, thing, or quality” (2010, OED, #10) – is enacted through the three specific rhetorical positions of acknowledgment, deference, and reciprocity. Each of these positions shapes the trajectory of interactions between interlocutors in different ways that all add up to a way of acting that demonstrates respect.

As a rhetorical concept, respect is appropriate because it highlights areas of contention and addresses the cause as opposed to the symptom. Literature detailing the depth and breadth of situations in which doctors do not listen to their feminine presenting patients is not hard to find. Although the Today show is not an academic resource, their online series entitled “Dismissed” characterizes the public conversations around women

feeling generally dismissed by medical professionals. With pieces that include “It’s Not All in Our Heads: Women speak out how doctors dismissed their pain, downplayed their symptoms or simply sent them to a psychiatrist,” this series also highlights the depth and breadth of the problem and offers rhetorical strategies for being listened to.

From the academic side of things, Cathryn Molloy’s *Rhetorical Ethos in Health and Medicine* studies how patients establish ethos with physicians in situations where their ethos has been negatively affected by stigma related to mental illness or bias toward women. Seeing the concept of ethos as an effective theory through which to examine the rhetorical negotiations that occur in the context of health and medicine, particularly as it relates to believability, Molloy asserts that ethos, and the strategies patients use to build authority in their interactions with physicians, have a significant impact on the care they received and the accuracy of their diagnoses. She also offers the concept of recuperative ethos to describe the specific act of using informal everyday interactions to counteract the negative effects having an invisible or mental illness can have on their credibility. This lack of credibility is *kakoethos*, a term which Molloy offers as the antithesis of ethos. Molloy posits that certain rhetorical strategies can help women build the ethos they need to be listened to.

Ethos and *kakoethos*, as Molloy explain them, are absolutely at play in interactions between Black women and their doctors; however, as she also admits, racial bias and prejudice play a role in these interactions, and there is nothing a Black woman can, or should be expected to do, to convince their doctor not to discriminate against them. When race becomes a factor in these interactions, the responsibility for establishing

more credibility does not fall on Black women. Women's health care practitioners must take responsibility for establishing a productive relationship with their Black patients because of the history of medical racism and abuse that colors those situation. As I demonstrated in Chapter 4 on terministic screens, faulty constructions of race in health care discourse and research are rooted in essentialist conceptions of race that were drafted and proliferated by and in medical discourse. In other words, contrary to the dynamic that Molloy describes, where patients find themselves needing to counteract *kakoethos*, I argue that Medicine broke its relationship with Black women, and representatives of the institution are now responsible for fixing it.

Respect Makes Persuasion Rhetorical

I define rhetoric as the structure and practice by which progress is made toward agreement. It is meaning-making and involves persuasion, but we need to be careful about the who, how, and why of persuasion because persuasion without agreement is coercion. I find that the inclination to persuade patients without coming to agreement is inherently disrespectful because of its failure to treat the person as an end in itself and not a means to an end. In the pursuit of healing, doctors treat their patients and their bodies as a means to that end, without acknowledging the material reality of experiencing their current dis-ease. The patient's agreement is necessary for these interactions not to be coercive. In short, doctors' lack of respect for patients is a refusal to be truly rhetorical. Only through acknowledgement of the inherent worth of the patient as they are, and not as the doctor might want them to be, followed in turn by acts and language of deference

and reciprocity can doctors hope to earn back the ethos they presume themselves to have in interactions with Black women.

Three Tenets of a Rhetoric of Respect

Acknowledgement

I begin with acknowledgement because a rhetoric of respect begins with this action. Acknowledgement makes reciprocity and deference possible because it is the foundation upon which the other two concepts rest. For Michael Hyde (2005), acknowledgement makes way for “conscientia” or “knowing together:”

Acknowledgement, in other words, is a capacity of consciousness that enables us to be open to the world of people, places and things so that we can admit its wonders into our minds and then admit to others the understanding we have gained and that we believe is worth sharing. (23)

The key word in the above quote is “enables.” As a matter of rhetorical significance, acknowledgement is the beginning, and it establishes a field of play, as it were. In the process of coming to agreement, acknowledgment is something owed to another simply as a human being, the failure of which reveals the failure of one’s own humanity” (Stanley Cavell, 1999, p. 430). Cavell’s understanding of acknowledgement parallels Kant’s respect-for-persons in that it connects acknowledgement of an “other” with one’s own capacity for “human reason” (Kant, p. 49). Thus, one’s capacity for acknowledgement of others is directly correlated with their own inherent value. In other words, as the old African proverb goes, “I am because *We* are.”

The term should not be confused with recognition, however, or the idea of identifying something that is already known to the subject. Moreover, acknowledgement is more than checking a mental box or even offering verbal articulation of agreement with a set of facts. As a rhetorical concept, acknowledgement involves not only recognition of another person as inherently valuable but also an establishment of behavior shaped by that reality. In other words, one does not simply remind oneself that another person has inherent worth independent of any particular values we might put upon them. That is only the first step. The next step is to make sure one's demeanor and actions toward another always begin and end with that acknowledgement.

Hyde's commentary echoes what many of the women in my study seemed to feel about their relationship with their doctor: "Remaining unacknowledged is a slight to one's being" (p.26) He goes on to describe the state of mind caused by this betrayal: "Such disruption can move a person into a state of anxious wonder about his or her existence: 'What am I, what am I failing to do, what should I do?'" (p. 26). In one way or another, almost every woman I spoke to wound up asking herself similar questions, and their responses to their negative experiences were often bound up with the answers. For Delores who now has a good talk with every female member of her family about women's health care "to teach them how to advocate for themselves" (37:46), the answer was that she failed to ask the right questions or advocate for herself enough. She wants her family members to learn to make themselves acknowledged. Although her experience was a direct result of her doctor's failure to acknowledge her, the "state of anxious

wonder” their failure produced led her to believe that her ordeal was in some way her own fault.

Another example of the damage done when recognition is mistaken for acknowledgement can be seen in the use of land acknowledgements in email signatures, organizational documents, and public speaking events. Land acknowledgements are statements made, often before an event or somewhere in an organization’s public position statements, that identify the native tribe(s) that occupied an area of land before white colonists and the United States government arrived. An example of such a statement can be found on the University of Arkansas’s Fulbright College of Arts and Sciences website.

The Indigenous history of the land the University of Arkansas campus sits on goes back to time immemorial, and across that expanse of time, many successive groups have lived here and created sacred legacies in this area. Fulbright College acknowledges Indigenous peoples were forced to leave their ancestral lands, including the Osage, Caddo and Quapaw Nations with ties to Northwest Arkansas. We further recognize that a portion of the Trail of Tears runs through our campus, and that the Cherokee, Choctaw, Muscogee (Creek), Chickasaw and Seminole Nations passed through what is now Arkansas during this forced removal. We acknowledge all Indigenous teachers, researchers and all other residents in our community and region today. We proudly offer Indigenous Studies in our college and seek continuity and connection to the past as we look to the future with increased collaboration with Indigenous governments and entities. (para 6)

A statement such as the one above is meant as a gesture of respect. In the same way that Hyde (2005) describes, the statement admits to something and then shares the college’s new understanding with the public. However, as their own graduate student, who is Cherokee and the coordinator for Native and Indigenous peoples in the *Center for Multicultural and Diversity Education*, Summer Wilke, explains, “While every land

acknowledgment at the University of Arkansas at least mentions these nations, their people continue to live the consequences of upheaval and genocide.” Wilke goes on to explain that the land-grant which established the university was accomplished through the bad-faith treaties the US government established with those nations and then broke, repeatedly. In other words, these “acknowledgments” are truly only recognitions, admissions of facts already in evidence. A true acknowledgement, as I have asserted, only begins at recognition. It must go further into action. While the University of Arkansas’s statement ends by boasting that the college offers Indigenous Studies, that offering does nothing to return what was stolen or provide additional benefits as reparations.

Most recently, ACOG published their most recent statement of policy on “Racism and Obstetrics and Gynecology” (2022). The following excerpt serves as a recognition of a race as a strictly social construct:

Racism, not race, drives health inequities and leads to adverse health outcomes.

Race is a social category, not a biological or genetic condition that elevates risk for certain diagnoses and health disparities. Racism has been and continues to be systemically embedded into our society and the practice of medicine. Racial health inequities are the result of the upstream and downstream impacts of systemic racism on the lives, health and wellbeing of Black, Indigenous, Hispanic/Latino, Asian, Native Hawaiians, Pacific Islanders and other historically marginalized populations. Furthermore, intersections of other identities such as gender, sexuality, ability, religion, and others can further influence and multiply the impacts of racism on individuals and communities.

Racial and ethnic inequities in obstetrics and gynecology cannot be reversed without addressing all aspects of racism and racial bias, including sociopolitical forces that perpetuate racism. The actualization of an equitable health care system which serves all people can only occur through acknowledgement of the historical

context from which modern health inequities grew, including reproductive injustices. (n.p)

This statement defines race as a social category and explicitly renounces the rhetorical use of race as a risk factor. It also calls for “acknowledgment of the historical context from which modern health inequities grew” as a starting point and goes on to talk about the need “to work to overhaul unjust systems.” This statement by itself is still only recognition. Whether or not it serves as a true acknowledgement remains to be seen in individual interactions with OBGYNs and the outputs of health disparities research.

In a rhetoric of respect, acknowledgement begins the process of agreement by limiting the scope of deliberations to a certain version of reality, one where the patient and doctor have established their positionality and determined the rules of engagement together. For each decision made, a practitioner should be able to say, “After acknowledging X, we decided to adjust our approach in Y way which led to Z as our best option.” or something of that sort. The key here is that acknowledgement becomes the entry point for agreement, not the end. The next two tenets of a rhetoric of respect are not simultaneously necessary but also not mutually exclusive. In other words, a rhetoric of respect does not need to display all three tenets, but it must begin with acknowledgment and move into deference, reciprocity, or both.

Deference

The second tenet of a rhetoric of respect is no more or less important than the third, but it does necessarily come after acknowledgement, as I have explained.

Deference is defined in the OED as “Submission to the acknowledged superior claims, skill, judgment, or other qualities, of another.” (2) In many cultures, deference is automatically paid to the elders of a society because their experience and wisdom are highly valued. It occurs as just one way to show respect. To defer to the position of another means letting go of the need to be the authority or dominant participant in an interaction. Thus, even the most disciplinarian mother may bow her head and lower her tone when contradicted by her own maternal authority-figure (ie, Grandma).

I propose deference as a rhetorical action in the pursuit of agreement between doctors and patients. In the field of Rhetoric, deference has been reduced to little more than a positive framing of someone else’s belief or argument (Varpio 2018). In legal studies, judicial deference, refers to the tendency for judges to defer to previous interpretations of a law or statute. The legal context of deference is more relevant to what I propose than the rhetorical one; however, I will argue that the attitude and action of deference operate rhetorically in interactions between interlocutors.

Not to be confused with reverence, which functions almost entirely attitudinally, deference requires a pulling back of authority, something I understand will be difficult for doctors to do, as their ethos is largely built on the idea that their training and expertise grant them more authority over matters of health and medicine. Nevertheless, the rhetorical act of deference, operating as deferential language and rules of engagement, puts the patient in the authoritative position. I assert that because ultimately a patient has much more at stake in the success of any interventions meant to sustain their life and

health, doctors should defer to their decision-making when attempting to come to agreement about what actions to take.

Deference in this context does not mean allowing the patient to dictate the course of treatment. It does, however, mean engaging in deferential language, as I will describe in more detail later in this chapter, and in operating deferentially. This deferential language will likely begin as verbal acknowledgement of the patient's perspective, concerns, and ideas about the health issue at hand. It cannot end there, though. Deference must be acted out in practice, meaning that the patient is able to engage in good-faith efforts to understand what options are viable for a person in their position without feeling like they need to coerce or trick their doctor into ordering certain tests or avoiding certain treatment plans. For each decision made, a practitioner ought to be able to say "Acknowledging that my patient experiences X, although I think the issue is Y, we have decided to also investigate Z possibility." Here the key is not to do what the patient demands, but to defer to their perspective of the situation and consider the possibility that despite a lack of formal theoretical knowledge, a patient has experiential knowledge of their condition that carries more weight epistemologically, particularly from a Black feminist perspective. In this sense, deference to the patient is a Black feminist epistemological and rhetorical practice.

Reciprocity

Reciprocity is the buzzword in humanist research right now. Tossed around in calls for socially just research practices, reciprocity tends to describe a give-and-take relationship between the researcher and the subject of their research. In the Rhetorician as

an Agent for Social Change, Ellen Cushman (1996) provides a “self-reflexive rhetoric” of reciprocity where researchers establish rules of engagement for a reciprocal relationship with the communities they observe and analyze (16). Drawing on Bourdieu (1990), Cushman emphasizes that unless researchers are self-aware and self-critical about their positionality in a given research situation, they run the risk of developing oppressive power dynamics. In the process of trying to learn about a community, researchers often yield institutional power, and are therefore responsible for democratizing such powers. For Cushman, this democratization occurred in the form of appreciation for and deference to the decisions of her research participants. Pamela Tokoyashi and Katrina Powel propose, “understanding the relationship between researcher and research community as a contextualized process of negotiation and renegotiation” (396). For them and Cushman, the bounds and quality of reciprocity are co-constituted between two parties. In the same way Cushman, Tokoyashi, and Powel are attempting to avoid a “missionary activist” self-perception through reciprocity, doctors can actively avoid paternalistic behaviors through purposeful, reciprocal rhetoric.

The first step here, as with deference, is acknowledgment. Cushman describes a two-way acknowledgement, both of the other and of self. This acknowledgement is both a recognition and an establishment of equal standing. It requires that one acknowledge the other, but also that one acknowledge one’s self in relation to the other. This is the part of reciprocity that I suspect may be a special challenge for doctors because it forgoes intellectual distance. It specifically requires that the practitioner humanize themselves

along with their patients. In some cases, this self-reflective acknowledgement could be a recognition of personal implicit bias or privilege.

For the purposes of agreement between a doctor and patient, reciprocity means matching the energy of the patient beyond expected professionalism. In other words, if a patient has taken the time and energy to provide copious details about their condition as they see it, reciprocity dictates that the practitioner apply equal consideration in trying to understand those details. It also means being as open to receive as one is open to give, and this is where Bourdieu is so relevant because the assumption that the doctor does all the giving in their relationship with a patient creates an unequal power dynamic between the two, causing some patients to perceive a loss of agency, or a silencing.

To illustrate Bourdieu's point, Katrina expressed feeling silenced in her interaction with an OBGYN that she had originally thought she had a good relationship with. Katrina's surprise at the practitioner's sudden change of attitude was framed by the feeling that at some point Katrina's willingness to question her became unwelcome. The doctor was willing to participate in the give-and-take style of deliberations up to a point, after which the OBGYN refused to deliberate further. That refusal is only made available through the unequal power dynamic between patient and doctor. Later in this chapter, when I discuss the limits and scope of this theoretical heuristic, the details of Katrina's experience will show how a rhetoric of respect are most appropriate for counteracting the kind of power-fed disrespect that happens in situations where one party has more privilege and the other more to lose/gain.

Respect, not Respectability

At this point, I want to make a specific delineation between the rhetoric of respect that I propose and rhetorics of respectability, or respectability politics. Understood as a Black middle-class ideology, respectability politics refers to the idea that in order for Black people to achieve equality, we must prove ourselves worthy of respect. In other words, those who seek social equality with a dominant group must mold themselves to meet the standards of that dominant group in order to be perceived as respectable. Respectability politics is often at play in discourse surrounding instances of racialized conflict. For example, in the wake of Minneapolis Police's murdering of George Floyd, rhetorics of respectability included statements about Floyd's identity as a father and his religious faith, rhetorical moves to identify Floyd as someone who did not deserve to die. In different discussions, rhetorics of respectability are also used to convict Black victims of police violence rather than the police, making the claim that violence would not occur if the victims had been more 'respectful' of authority. Respectability, then, becomes a rhetorical tool of protection and uplift for Black people that requires no additional effort on the part of white folks, or as Frederick Harris (2014) notes, "the politics of respectability has been portrayed as an emancipatory strategy to the neglect of discussions about structural forces that hinder the mobility of the black poor and working class." (33). The rhetoric of respect that I propose runs counter to this ideology in that it begins with acknowledgement of the reality that Harris accuses respectability politics of

neglecting to discuss, namely the social and structural forces that oppress Black people and other marginalized groups.

The irony of respectability politics is that its face, for a long time, was Bill Cosby. As one of the first popularly successful Black comedians, Bill Cosby eventually became known for his role as “America’s Dad,” and in the decades that followed also garnered attention for admonishing Black parents for living in poverty for displaying a supposed lack of self-respect. At the NAACP’s (National Association for the Advancement of Colored People) 50th Anniversary Celebration of Brown vs. the Board of Education (2004), Cosby delivered the “pound cake speech” where he shamed Black women for having multiple children with different men, and for not “parenting.” He gurgitates:

I’m talking about these people who cry when their son is standing there in an orange suit. Where were you when he was two? Where were you when he was twelve? Where were you when he was eighteen, and how come you don’t know he had a pistol? And where is his father, and why don’t you know where he is? And why doesn’t the father show up to talk to this boy?” (n.p)

Cosby was drawing a causal connection between a mother’s absence in the home and the criminality of her children, but said nothing of an economic system that denies her the right to live in a better neighborhood or work less than two jobs to support herself and her children. He later went on to publish *Come on People: On the Path from Victims to Victors* (2007) a book where the first chapter is entitled “What’s going on with Black Men?” and subsequent chapters provide such sage advice as “keep the kids in school” and “keep the kids out of prison” (contents, ix). Ten years later, Cosby was convicted of aggravated indecent assault for drugging and then raping Andrea Constand and sent to prison (WaPo) and as Arica Coleman (2018) writes, “it was his betrayal of black America

as well as his devotion to politics of respectability that ultimately led to his downfall.” (n.p.) In other words, his claims of respectability earned him closer scrutiny, which revealed an ugly and violent character that could not be less deserving of respect.

Again, the irony of respectability politics is not lost on me, and I am not promoting that kind of rhetoric in this chapter. In fact, a rhetoric of respect is almost the opposite of a rhetoric of respectability because it places the responsibility on the respecer, not the object of respect. In other words, a Black woman does not need to earn the kind of respect I refer to, she is entitled to it by nature of her humanity. There are no conditions under which a Black woman, or any other woman, can find herself undeserving of respect in the context of her health care. Cosby’s vilification of Black mothers mirrors the kind of biases that negatively impact Black women’s experiences with OBGYNs regardless of their level of education or income.

The Rhetoric of Respect (or Disrespect) in Action

Now that we have a theoretical understanding of a rhetoric of respect, and we can clearly differentiate it from rhetorics of respectability, let us move into more practical illustrations that demonstrate disrespect and project possible alternatives that work through a rhetoric of respect. In what follows, I point out the details in three women’s narratives that represent instances of disrespect. Many of these instances are rooted in faulty rhetorical constructions of race, but race is not always the operative variable in consideration of respect. In fact, part of the value of a rhetoric of respect is that it is meant to override the influence of faulty terministic screens like race as a biological construct. This section focuses on three of the women in particular, but mentions

instances where other interviewees experienced a similar issue or provided insight about an issue. For each case, I highlight the quality of the disrespect and provide alternative actions that would have reflected a rhetoric of respect.

Samantha

Samantha's experience reflects a lack of all three tenets of rhetorical respect. Acknowledgement of Samantha's expertise as a woman living in her own body and as scientist, at any point during her pregnancy, would have changed the dynamic of her experience, one that was marked by a lack of deference and reciprocity. Samantha was pregnant with her second child when her OBGYN diagnosed her with gestational diabetes.

I don't remember the exact numbers... but let's say a normal range is like 5.7 and below. Mine was like 5.8 or 5.9... So it was slightly elevated, But I passed all the other [tests], So they're like, yeah you have gestational diabetes... So I met with a nutritionist. And then it kind of just started this ongoing issue related to the management of diabetes.

Samantha goes on to describe the actions she was directed to take and the OBGYN's disposition toward her situation.

They wanted me to check my blood sugar three times a day, every day. And so I was doing that... it didn't matter what I ate, my body would handle it fine. But my fasting blood sugars were always elevated by one or two points. I went on their diet, actually, my sugars went up, my fasting sugar went up. So whatever the diet that they recommend, well it just wasn't working. You know there was like, try eating snacks at night, try doing this, try doing that, try not eating this at dinner.

When none of the dietary strategies proved efficacious, her physician prescribed insulin.

So I went on insulin. And I took insulin for I think two or three days and it didn't do anything; there was no change in my fasting blood sugar. So then they were like ok we just need to up the dose, you're not getting enough. So I increase the dose. The night I increased the dose, that next morning my fasting blood sugar was down by like two points; it was in the range they wanted by like again one or two points, like a very small decrease. During that day I just got incredibly sick. I guess my sugar dropped out. I thought I was gonna either pass out or fall and take a nap. And its the kind of nap where I felt like I might not wake up...

One of the things they say is that if you feel unwell, take your blood sugar, see if it's low. And my blood sugar was in the 80's or 70s; it was low. But when I told them, they're like 'well a normal person would have felt fine. They would not have experienced what you felt, so just keep taking the insulin' (BW3, 1:02)

Up until this point, Samantha followed all the instructions her doctor gave. She followed the diet plan and she took the insulin; she increased the dosage when directed to do so.

But at the point where she expressed dis-ease with the treatment, her concerns were dismissed. Her practitioners did not reciprocate her open-mindedness or willingness to listen. They should have moved as quickly to consider alternative treatments or diagnoses as Samantha was to adopt whatever treatment was prescribed to her.

A statement that reflects reciprocity may have sounded something like, "I see that you reported these levels as causing discomfort and the symptoms you describe sound like a low-blood sugar episode. Although, most people would not experience what you did, let's consider different parameters for you." This statement does not immediately retreat from insulin as a treatment for diabetes, but it acknowledges Samantha's perspective and reciprocates her effort to find a solution. Because her practitioners did

not acknowledge or reciprocate her energy and instead continued to push for the original treatment plan, Samantha responded with her own refusal:

Yeah, that's a big hell no... No, I will not be doing that. So, I took myself off. And they were very displeased with that... But they kept insisting that I keep meeting with the clinic, and they're like 'you don't want to take your insulin?' No, it made me sick. And they're just like 'you really need it.'

Despite the displeasure of her OBGYN and their colleagues, Samantha refused to continue taking the insulin and began, "trying to figure something else out" because as she boasted in the interview,

I'm a whole scientist. I plotted my numbers and they were going down. It never got in the range they wanted, let's say they wanted a 95 and I was getting 96 and 97, where before I was maybe a 99 which depending on what doctor you see... under 99 is fine. So it was a sliding scale to begin with.

Samantha's confidence in her own analytical ability may not have been convincing to her diabetes clinic doctors, but their refusal to consider that her normal may be different than someone else's normal damaged their credibility with her in turn.

The gestational diabetes clinic failed to acknowledge Samantha by disregarding her communicated experience and refusing to reciprocate her efforts to investigate the issue more deeply. When Samantha expressed that her insulin caused an adverse reaction, instead of trusting her testimony, the clinic ignored her concerns and reiterated their position. To acknowledge Samantha as deserving of deference and reciprocity would have required a change in actions, but no such respect was paid, either by the clinic or her OBGYN. Thus, despite all the changes and treatments she submitted to, Samantha could not even get the clinic to consider a different way of interpreting her fasting blood sugar

numbers. In a reciprocal agreement, Samantha would not have been the only one trying to “figure something out:” her healthcare providers would have considered other possibilities with her. Samantha showed deference throughout the beginning of her ordeal, but when it became clear that her respectful actions would not be returned in kind, she stopped. She is fortunate that there was not some larger issue at hand because her OBGYN would not have discovered it, focused as they were on chastising her for not following their directives.

Bernice’s Story

The disrespect Bernice experienced was not incidental, she experienced her issue across multiple practitioners. For Bernice, the OBGYN’s problem was that they did not listen. Acknowledgement is to recognition as listening is to hearing. In the same way one can hear something but not be listening enough to respond appropriately, a person may recognize something without that recognition leading to an appropriate response. In Bernice’s case, her practitioners may have recognized that Bernice was averse to having a hysterectomy, but such recognitions did not lead to an adjustment in approach which would have constituted true acknowledgment. This failure to acknowledge Bernice’s perspective led to multiple instances of practitioners failing to reciprocate Bernice’s efforts to find a better solution and in one case looking for ways to refuse deference by trying to sneak in a full hysterectomy for what was meant to be much different procedure.

Bernice had just switched OBGYNs when she learned that she had fibroids. Upon her first meeting with the new doctor, she was informed almost in passing, ‘You know

you have fibroids, right?' To which Bernice responded "No, no one has ever told me that." (BW10, 1:30).

That was the first time, despite you now having gone to my gynecologist regularly once per year, sometimes twice a year because... I'd had an irregular pap smear years ago, and so I actually went more often than the normal recommended frequency. So all this time, this previous gynecologist had never mentioned fibroids to me. In fact I didn't really know much about them at the time.

This initial realization that Bernice's previous OBGYN did not share crucial information with her reflects a lack of reciprocity. Again, reciprocity involves a give-and-take relationship where both parties give and receive in equal measure. The term also refers to matching the actions and energy of the other in a given communicative situation.

Bernice's first doctor failed to give her the appropriate level of information despite Bernice's efforts to build a rapport with him.

Bernice had a myomectomy to remove the fibroids, and she did so knowing that they would come back in approximately three to five years because she knew she did not want a hysterectomy. And the OBGYN she had at the time, deferred to her judgment on the matter. However, the surgeon was a different story. Before her procedure, the surgeon asked her to sign a waiver allowing him to perform a hysterectomy if he deemed it was medically necessary. Despite his admonishments, she refused to sign the waiver. She details the situation below:

you know, we did the pre surgery, consults, consult meeting, and he talked me through what they were going to do. And then he was like, I'd like you to sign this consent form to elect to allow me to perform a hysterectomy while you're under general anesthesia. If I see any reason why I should have to do that. You know, my knee jerk reaction when the doctor hands you something the sign is like, Okay, I'll sign it. But something made me pause and go, I'm gonna think about this. And then I went home. And I thought about it, and I was like, I don't have to sign this, I'm not gonna sign this. And so I told him, I was like, I'm sorry, I'm not

consenting to that. You're gonna have to perform the myomectomy. I'm not consenting to hysterectomy at all, under any circumstances. And when I got out of anesthesia, and he came to do a follow up visit, he later I got, I can't believe I forgot about this. He actually low key complained about how long it took, he was like, wow, there were a lot more in there than I thought. And I thought this would be an hour, it really took like three hours to get all of them out. Then, later, one of his residents, one of his students because this was a teaching hospital. One of his resident students, or whatever they're called, kind of, like on the sly was like, I did a good job. He was basically like, 'you did the right thing by not signing that consent form, because he would have taken the fuck out of that uterus, if you had given him any opportunity to do that, just to make his golf game. You know, just because he was like, I scheduled this for an hour and it's gonna take too long, so just get the whole thing out.

Bernice called this surgeon out by name, and wanted me to name him in the dissertation because she was so emotionally affected by this experience. This surgeon's repeated attempts to go around Bernice's authority over her own body represent a disrespectful degree of disregard for Bernice's autonomy. Not only did he refuse to acknowledge her positionality as the decision-making party in the situation, but he also failed to defer to the authority that positionality imbued. Reciprocity is not the issue here, but acknowledgement and deference are.

Ten years later, her fibroids were back and bigger than ever before. She knew this would happen, but unlike the first set of fibroids, these were negatively affecting her quality of life:

I could feel them becoming bigger and way bigger than they've been and more, you know, just interfering with my comfort and my periods are really heavy and they were just becoming a nuisance. So I started to, you know, went and found another gynecologist. I found a couple gynecologists who were very old, very dismissive. At that time I was about 40. When I started meeting with this new set of gynecologists trying to find somebody who could give me an answer. I just was trying to figure out what my options were and every one of them were just like, 'oh, just have a hysterectomy'.

Bernice had misgivings about having a hysterectomy and found the dismissive attitude of the OBGYNs she met disturbing.

My mother had had a hysterectomy when she was in her 40s and she also had fibroids. And I was speaking to a coworker at the time who had had a hysterectomy. And basically every woman I knew that had had a hysterectomy were [sic] saying ‘don’t get a hysterectomy. Whatever you do, just don’t do it. It’s not worth it.’ That was kind of pushing me to just keep asking for opinions and asking for more opinions.

Bernice’s connection to other Black women framed her dilemma as more than an instance of fibroids. She began to notice the pattern of dissatisfaction with the common treatment for them.

Hoping things would change, she met with a younger Black woman OBGYN, but found her demeanor to be the most disturbing of those she had met. This physician dismissed her experience and displayed an almost shocking callousness when discussing the possibility of removing Bernice’s uterus, fallopian tubes, and ovaries.

I’m trying to explain to her that I was getting a lot of heartburn from my fibroids and she sort of condescendingly tells me that’s not possible because your uterus is down here. And I’m like, lady, I know where my uterus is. I don’t need an anatomy lesson! I’m telling you it’s growing upwards into my stomach. And she was like ‘we’ll have to do an ultrasound to determine that.’ And I said no, you actually don’t; you can feel it. And I laid back on the table and I was like, put your hand right here. You can feel it through my skin. So then she goes ok... well, we’ll get the ultrasound and we’ll look at the results. And then she ordered me a transvaginal ultrasound! Even though I pointed out physically where the fibroid was, which was in my abdomen.

Bernice felt like she had to do the doctor’s job because the OBGYN was being “sloppy.” Moreover, she felt like she had to defend her body against an unwanted procedure. Once the results of the ultrasound came in, the OBGYN followed the same procedure as the ones before, but with a relish that Bernice did not appreciate.

She very quickly was like, you should just get a hysterectomy. Look, you're 41. Get a hysterectomy. They're super easy. And she literally said these words, "They're my favorite surgery to perform. They're just so easy and you know fine and you'll be just on your way. And no problem. And I was just sitting there, aghast. Like this is getting ghoulish and absurd.

At this point, Bernice started doing research on the effects of pre-menopausal hysterectomies on mice and finding out there is some correlation with dementia. She also found interesting studies on the uterus's role in immunity and other bodily functions. In essence, her reproductive organs were becoming more valuable to her, the more doctors insisted on removing them.

Finally, Bernice returned to the original OBGYN that helped her. Insurance issues made her switch providers, but she fixed that issue and returned to the doctor who had shown her a modicum of respect. Bernice felt acknowledged by this doctor, mentioning that he empathized with her.

So I went back to the great gynecologist that I met when I first moved to LA when I switched my insurance and he was he is a white man, one of the best bedside manner and I've ever had in a doctor and he listened to me very carefully and he empathized with me and he said, you absolutely should never get a hysterectomy. He's like I've been practicing for. He's probably been practicing for 30 Maybe 40 years. He's like, I can't count the amount of children I've [delivered] after a myomectomy. I can count on one hand how many hysterectomies I have performed because I don't do them. They are usually highly unnecessary and they are only necessary in life threatening cases. And so and then he says, I'm like tearing up because like, I feel like this guy, like, saved my whole life. But then he says, You know, I think you're actually a great candidate for a new procedure called ... uterine fibroid embolization.

Out of 5 or 6 OBGYNs, only one bothered to provide any alternative to a hysterectomy. Only one acknowledged her humanity and deferred to her ownership of her own body. It may be tempting to accus Bernice of simply liking the doctor who agreed with her, but a rebuttal to that point would be to ask why Bernice should tolerate being in disagreement

with her physician? Bernice has given birth to a child since this period in her life. If she would have let even one physician overrule her authority over her own body, that child would not exist.

Bernice's story reveals layers upon layers of disrespect. From her first OBGYN's failure to disclose that she had fibroids to the OBGYN who described a hysterectomy as her favorite surgery, Bernice's experience shows that the advice from 'experts' like those on the Today show's webseries to change doctors if you do not get the care you deserve are not helpful. Bernice saw multiple doctors, and all but one treated her with disrespect. Only one OBGYN put as much effort into finding an acceptable treatment for Bernice as she did for herself. Only one put Bernice's health above their own convenience. The surgeon who wanted to perform a hysterectomy so he could make his golf game could not have acknowledged her as an inherently valuable person if he was willing to remove her organs against her wishes in the interest of time. I am not arguing that women never need hysterectomies or that subjective experience is necessarily more valid than a physician's expertise, but I do posit that practicing a rhetoric of respect would have steered her OBGYNs away from trying to force the procedure on her.

Instead, acknowledgement of her positionality as a Black woman, and the history that shapes her experience would have required a more tactful approach that included looking into alternative procedures. Her OBGYN could have googled 'new fibroid treatments' and that would have been an act of deference. Instead, looking through an analytical lens that already identifies her racialized body was inherently risky, her doctors chose what they felt was the path of least resistance.

Natalie's Story

Natalie's experience was a mix of being at once valued for her perspective and also dismissed as unqualified. Natalie's story provides another example of the difference between recognition and acknowledgement. As a mother having a fourth child, she had a wealth of experiential knowledge to share and she was asked to participate in a training group to give other practitioners some perspective of being a Black pregnant woman. However, when the time came to take a different action in deference to that perspective, her doctor failed to take actions that were shaped by Natalie's reality. While her participation in this group helped Natalie grow more confident in her own voice, before this experience, she said she felt she had not known how to assert her agency. However, in her fourth pregnancy, she recognized mental health symptoms that she knew were anxiety and depression and shared those symptoms with her OBGYN. She recounted:

So I had neonatal depression with the third. And I knew what it was, right? I had postpartum anxiety with the first. And I kind of knew that that might be a thing that could

happen. So I was aware of it with the third. Then when it happened. You know, I talked to my OB, and it was very much like, you're on your fourth child, just suck it up.

Natalie immediately saw her own experience within the larger context of Medicine's abuse of Black women because she studies Black women in her own research. She's well aware of the history and recounted several events in the middle of her story.

Natalie's account was so imbued with intersecting stressors and situations that it is difficult to include many direct quotes that do not contain several ellipses. On the one

hand, she was a professor in a department where the chair was male, white, and did not even have small children in his extended family. She gave birth to 4 children in 5 years. And she is filled with all this knowledge of systemic abuse of Black women. In another paper, I could make a case for generational trauma, but this is not the dissertation for that argument. I am providing this background information, so that when I add that her OB expressed concern over not being able to detect her fourth fetus's heartbeat, you may better understand how that news exacerbated an already highly stressful situation. Natalie was experiencing anxiety and depression before she had reason to worry about her unborn child's survival. She even apologizes at one point for being "all over the place with this story." At this point, I am being more respectful of Natalie's situation than her OBGYN was. Natalie continues her narrative:

This is so long winded, but it's just fucking crazy. The ultrasound tech is talking so much she's trying to find the baby's heartbeat on the monitor, right, she can't find the

baby's heartbeat. And, and so we're in this room for 45 minutes... and we're in this small ultrasound room with the tech, who turns out to be [Vice President] Mike Pence, his cousin. He's the vice president at the time, who is against, you know, abortion and reproductive rights....this stuff, too, right? ... I'm in the small ultrasound, they're not hearing my baby's heartbeat. And I don't even feel like I can even articulate what's rolling through my head because I know her politics, right. And I've also, you know, know her having her cousin's thoughts. I'm not gonna say that they're exactly hers. But it was just enough for me to be like, I just need to shut up, right.

Essentially, Natalie was in this emotionally and physically intense situation and had to contend with the political beliefs of her ultrasound tech at such a vulnerable moment. Acknowledgment on the part of the ultrasound tech would have meant contending with the fact that political alignments are matter of life and death for some people and that

they should not be discussed in a professional, medical atmosphere so casually. Instead, when Natalie was trying to sort out a mess of competing thoughts and concerns, one of those concerns was whether her OBGYN office was a safe place to make decisions about her own body and future.

It turned out that her OBGYN's heart rate monitor was ineffective at detecting her baby's heartbeat. When she went to the hospital later, the heartbeat was strong. However, that realization did not stop her OBGYN from making the same observation at her next visit and this time emphasizing that the baby was in mortal peril.

After they get me back into the room. And they call my husband, it takes him maybe like 20 minutes to get it to get to the office. And when he comes in my OB is at the tail end of telling me all the things that are wrong with the baby and all the things that could go wrong with this birth. And then Brian walks in, and he says, we're sending her to the hospital, your baby's not good. And then walks out. And I have a breakdown, right? So she's not explaining whatever it was to Brian, right. He just comes in, where she's [already] explained, you know, all the stuff, but those are her exact words 'your baby's not good'.

Natalie's OBGYN failed her in so many ways, all of which may have been avoided if the OBGYN had been purposely respectful in her practice. Acknowledgement of Natalie's situation should have steered her physician toward more considerate language. In

Natalie's case, the OBGYN did not necessarily disbelieve her or disregard her experience as much as she refused to let it alter her approach. In some ways, that position is worse. It reflects the larger disciplinary dissonance in the OBGYN field that keeps stopping at recognition. Natalie's OBGYN recognized that her experience was valuable, but failed to acknowledge Natalie's position in the way she communicated with Natalie.

The Scope and Limits of Rhetoric of Respect

As with many rhetorical concepts, the limits and scope are defined by elements of the rhetorical situation, like audience, author, and purpose. Obviously, everyone wants to be respected all the time, but applying a rhetoric of respect is especially necessary in specific situations. I see a rhetoric of respect as being most appropriate, or needed, in situations where one party has more privilege, and the other party has more at stake in the success of their interaction. Other examples might include the relationship between Police and the people they detain or arrest, and also the relationship between legislators and their constituents. In each of these situations, like the relationship between doctors and their patients, one party has all the privilege and ethos, while the other is in the position to deal with the consequences of whatever the outcome of their interaction is. For example, when a politician or legislator votes for a piece of legislation, they are exercising privilege not afforded to their constituents, but ultimately the law has more effect on the constituency than it does the legislator. Thus, when the legislator is in communication with voters, it is appropriate to apply a rhetoric of respect that acknowledges the needs and perspectives of voters, to defer to their wisdom on the topics that affect them, and to reciprocate the power their voters have invested in them by giving them opportunities to affect the legislative process either through meetings, projects, or townhalls. These actions provide an opportunity for the community to agree with what the legislator is doing; they make the legislative process rhetorical beyond official deliberations in assembly.

Another example is the relationship is between researcher and community partner or research subject. Again, we have a relationship where one party enjoys more institutional privilege, but the outcome of their research may have the most effect on the research subject or community partner. Cushman practices a rhetoric of respect in her work on “Rhetorician as Agent of Social Change” where she argues for reciprocity in the relationships between researchers and the communities they study or and work with. In describing her own reciprocal relationship with people in the community she was studying, she recounts the ways she put herself at the service of the community by providing writing help and access to university resources, and also how the community gave her access and helped her validate, or invalidate, her theories and analyses. She acknowledged their perspective as valuable as an end in itself, as opposed to a means to her research, and thus abandoned her own theories if her research subjects rejected them, deferring to their position. Not only is Cushman’s work a great example of how a rhetoric of respect can work in practice, but also of why a rhetoric of respect works especially well in situations where privilege and consequence have as seemingly inverse relationship as it relates to the parties involved.

A rhetoric of respect operates especially well in those situations characterized by unequal levels of privilege because the operative notion of respect is directive as opposed to evaluative. Both parties are responsible for showing respect, in any situation. However, in situations where privilege allows for a lack of acknowledgement, deference, and reciprocity, applying a rhetoric of respect becomes a deliberate practice of interpersonal social justice work. To review, Stephen Hudson outlines different types of respect, of

which the most important for our discussion are directive and evaluative. Directive respect operates within a law of human nature where a person can demand respect on the grounds that all people are inherently valuable. Evaluative respect is accorded to people on the grounds that they deserve it for some reason or another. As I see it, a rhetoric of respect is most closely modeled on Hudson's directive respect, the kind of respect that is expected because we are all human beings and that must be asserted in situations where social dynamics put that reality into question. In other words, this type of respect is most important when the understanding that it puts forth, namely the inherent value of individuals as individuals, could be otherwise disregarded in favor of other social paradigms or screens, like racist essentialism or colorblindness.

To illustrate, let us consider the situation of, Katrina's experience with her OBGYN. Katrina was experiencing severe bleeding and debilitating pain from uterine fibroids, and she agreed to have a hysterectomy to remove her uterus. However, when the day for her surgery came, her anesthesiologist described a different procedure than what Katrina had agreed to. When her doctor was called in to discuss the discrepancy, the OBGYN's response was to take advantage of Katrina's vulnerable position as a person in severe pain who was in need of the surgery she came in to have. Katrina recounts the conversation:

She comes in and she's like, you always ask too many questions. You always... 'like very accusatory, very angry, 'you ask too many questions'... I said well but you know you and I never discussed my cervix. I felt like it had been enough for me to take in that I've been a perfectly healthy woman and now you're saying – you know, it's one thing for me to wrap my mind around, okay I'm going to lose my uterus. And then you're telling my my cervix? My fallopian tubes, like no this is not okay. I should have been informed of this. She brings out a form and she says, 'well here it says... that if the senior doctor determines that these other

things need to be extracted –“ if its absolutely necessary, but this man [the anesthesiologist] is coming to me with the knowledge that all these items, these *body parts* [emphasis mine], are going to be removed. That’s two different things. I’m no dummy... ‘You ask too many questions, you get the surgery and add that other surgery, you get it today or you go.’

In other words, after admonishing Katrina for questioning the procedure, the OBGYN gave her an ultimatum, one that she was only able to give because of her privileged position as the physician and the one with access to the resources Katrina needed. That privilege gave the OBGYN permission to disregard Katrina’s concerns and force her to submit or deal with the debilitating consequences of not having the procedure she needed. If Bernice’s story is any indication, Katrina’s OBGYN may have just found it more convenient to take out the whole system. Afterall, two of Bernice’s doctors admitted that removing all the parts was much easier than just removing one part or just the fibroids. Remember, it was one of her doctor’s “favorite surgeries to perform because it’s so easy” (Bernice). Their positionality as doctors allows them to prioritize their own convenience over their patient’s quality of life, a rhetoric of respect does not.

A rhetoric of respect in this case would have begun with Katrina’s OBGYN acknowledging Katrina’s aversion to having a full hysterectomy and moving forward accordingly. That acknowledgement may not mean avoiding a conversation around having a full hysterectomy, but it would require that the main reason be more relevant than the doctor’s convenience. Remember, acknowledgement in this case requires more than an internal recognition that Katrina does not want her cervix, ovaries, or fallopian tubes removed; it also requires that the OBGYNs decision making process at least partially remove those as options, unless absolutely necessary. Practicing deference is

evidence of this level of acknowledgement. Using language like “I understand that you do not want to have those parts removed, so we will do everything we can to avoid that,” shows deference to Katrina’s position as the person with the most to lose without relinquishing the doctor’s ethos as an expert.

Further, this type of deferential language indicates an action that represents reciprocity between the doctor and the patient. In this case, the doctor is promising to put as much care into considering all the possible approaches to the patient’s care as the patient is. When a doctor expects to receive information, reverence, and obedience from patients – I other words trust – it is only reasonable that they reciprocate those observances. This is a matter of respect. Refusing to give Katrina all the information was a refusal to reciprocate the observances the OBGYN demanded from Katrina. Telling Katrina that she “asked too many questions” was a way of saying she did not deserve the information she was seeking, a way of shutting down avenues of reciprocity. Conversely, to apply reciprocity would have meant to observing the same edict to provide comprehensive information and return the reverence and obedience normally accorded to doctors because of their social privilege.

Conclusion

To summarize and conclude, the historical and contemporary treatment of Black women in medicine has been and continues to be disrespectful in its failure to acknowledge the social positionality of being Black in the US, its refusal to defer to the perspective of its most vulnerable patients (ie. Black and Brown women), and practitioners’ failure to reciprocate the good faith efforts their patients put forth toward

finding a solution to their health problem. These shows of disrespect often occur in interpersonal interactions between doctors and their Black women patients as a failure to listen to a patient's perspective or to look for alternative treatments when the first one proposed proves ineffective or problematic for the patient, as it did for Samantha. They can also come in the form of insensitive or unprofessional behavior as was the case for Natalie. And in their most horrendous forms, this disrespect can manifest as outright aggression toward Black women when they are in extremely vulnerable positions, as happened with Bernice and Katrina. Disrespect can most easily occur in situations where one party is afforded more privilege than the other. The unequal power dynamic makes it easy to recognize rather than acknowledge, or to flat out ignore the other's position or perspective. Power does that, and unwritten rules of civility allow that. A deliberately applied rhetoric of respect does not.

A rhetoric of respect purposefully inserts the active application of acknowledgment, deference, and reciprocity into situations where one party could neglect to do those things. Exercising a rhetoric of respect is a choice that reflects a commitment to equity. In a health and medicine context, a rhetoric of respect represents a tool for operating under a new terministic screen. Instead of continuing to see race as biological construct that makes some patients worthy of respect and others inherently unruly, a directive respect for the value of people as people supports a new understanding of race as a social predicament that shapes a person's experience of reality. A rhetoric of respect demand acknowledgment of that reality and offer guiding tenets for operating within it.

Acknowledgment as a prerequisite for respect is an appropriate starting point for any rhetorical negotiation between parties of inverse privilege and stake in the success of the negotiation. In situations where one party could very easily revert to old, disrespectful paradigms, a rhetoric of respect offers a framework for purposeful intervention in those old paradigmatic patterns. While that must always begin with acknowledgment, and should also involve some configuration of deference and reciprocity, a rhetoric of respect need not end there. This theoretical heuristic should not be static in its constitution but dynamic and adaptable to different social situations. I look forward to seeing other scholars take this framework up and add appropriate amendments as their local situations call for.

CHAPTER SIX: CONCLUSIONS

But first a personal reflection...

This is not the project I envisioned 4 years ago when I began planning a doctoral dissertation. I wanted to study health fairs as a site of rhetoric of health and medicine and see how community organizations approached health communication compared to larger health care institutions and how the two types of organizations worked together. In some ways, that project was a lot like the one I ended up with. It was also three projects in one. One project to better understand one side of an issue, and one to understand the other. Finally, a comparative analysis of the two. It seemed like a simple prospect from the start, to just look and see what the two sides were doing and how they could learn from each other. But that was before the pandemic that started in 2020 and continues today in 2022. Being in lock down eliminated the possibility of studying the rhetorical dynamics of a health fair. At least not one that operated in person, and there was a strong learning curve for transitioning in-person events into virtual ones. I had to scrap the project, and start over. But as frustrating and debilitating many of the pandemic conditions turned out to be, I am glad I sucked it up and did this work because it needed to be done. Still, at first, I really did not want to do it.

I did not originally want to investigate a specialty of health for which I had a traumatic impression because I thought it would bias my findings. Although I barely remember the actual experience of blood loss I described in the introductory chapter, the

reminder that my story was part of a larger problem made thinking through these issues an emotionally draining process. I avoided looking back at the interview transcripts for as long as I possibly could because they made me sad and angry and altogether destabilized. I hoped the anger would fuel my writing, and it did. There are parts of this dissertation I had to remove because they were too emotionally revealing, too angry, too defensive. There was no way for me to maintain an intellectual distance from the feeling of being uncared for, not just as an individual in a cold world, but as a person identified in society as having less worth than others.

Adopting a Black feminist epistemological stance helped me find the value in those feelings. Seeing my positionality as a Black woman with the privilege to do this work and the personal stake in its success as a positive attribute of the work helped me develop ideas and understandings of the issue of maternal health disparities in ways I never would have while studying health fairs. The findings in this dissertation represent not only a budding scholar's first contribution to her field of scholarship but also my personal commitment to caring about the work I do more than my academic journey. This dissertation represents my convictions and an internal paradigmatic shift that I want to share as a matter of service and responsibility – as a matter of respect for my professional and cultural communities. And so to conclude this dissertation project, this chapter will review the key findings of this dissertation research, discuss its contribution to the fields of Rhetoric of Health and Medicine and Health Communication, and envision paths for future research based on its discoveries.

Finding Answers to my Questions

My dissertation aimed to fill in a gap in HC and RHM scholarship where historically informed approaches to health disparities research belonged. Accordingly, I examined the ways in which medicine as an American institution helped inscribe the rhetorical construction of race and how those inscriptions color (pardon the pun) the way physicians interpret their Black patients today. I also looked to Black women as sources of better understanding on the subject because of their experience and positionality. By revealing the potential space for rhetorical theory and analysis to provide greater insight into the problem of health disparities, I hope to inspire other scholars in the rhetoric of health and medicine to take a long hard look at our potential to push praxis toward more equitable outcomes. Conducting a rhetorical analysis of knowledge building practices in obstetrics and gynecology helped reveal areas where research on Black Americans' experiences with American medicine would benefit from being deeply rooted in a Black feminist epistemological framework that values experiential knowledge.

To start filling the gap in disparity research, I followed three lines of investigation and tried to answer three research questions: (1) What rhetorical dynamics shape disciplinary discourse on Black women and socially situated health disparities in Obstetrics and Gynecology? (2) What are some rhetorical dynamics governing Black women's negative experiences with OBGYNs? (3) What lessons can be learned from Black women's experiences with OBGYNs and how might OBGYNs effectively employ rhetorics that treat Black patients in ways that patients perceive positively?

To answer the first question, I conducted a rhetorical analysis of the public facing and disciplinary discourse of the American College of Obstetrics and Gynecology. The Birthing While Black Congressional Hearing in May 2021 represented the public facing rhetoric of ACOG while publications for the last 10 years in ACOG's scholarly journal Obstetrics and Gynecology, also known as "the Green Journal" served to represent disciplinary discourse. My goal in these analyses was to better understand how rhetorics related to race shaped discourse around maternal health disparities and to look for opportunities to intervene rhetorically.

The analysis revealed that the rhetoric around Black motherhood helped shape the rhetorical dynamics in which the Birthing While Black hearing intervened. Participants in this hearing, accordingly, entered into conversation in which they repeatedly established and reestablished their positionality around those understandings of Black motherhood. One outcome of this constant renegotiation of the exigence itself made for public facing rhetoric on the part of ACOG that is at once caring and historically informed and also must make almost the opposite case for itself than what actually represents the truth. In other words, I found that because some participants in the hearing wielded their power in those proceedings in ways that were meant to reaffirm their understanding of reality – where in Black mothers are a problem – representative of ACOG has to briefly reposition themselves in closer alignment with the problematic understanding in order to push for legislation meant to address a different version of reality.

To answer my second research question, I interviewed 10 Black women about their negative experiences with OBGYNs and identified rhetorical trends across

testimonies and quoted them at length in the chapters that discuss them. Their testimonies offered perspective that lead to new rhetorical understandings of respect in medical contexts. My aim in those interviews was to better understand the rhetorical aspects of their experiences and how those experiences reflected larger patterns in the discourse and practice of obstetrics and gynecology.

What I found was that Black women's social positionality almost necessarily led to repeated recontextualizations of their narratives in the light of historical medical racism. When a physician refused to listen to their concerns or protests, they understood that experience as representative of a general disregard of Black women's voices, a collective social silencing that refused to acknowledge them as human. When doctors aggressively pushed women toward having hysterectomies or using birth control, the women I interviewed often interpreted those experiences along with their historical knowledge of North Carolina's eugenics movement. They understood their doctors as being intellectually lazy, yes. But it was also difficult not to suspect an underlying bias toward limiting Black reproduction. In other words, they could see their doctors as following a kind of medical script and that the script may have been written by eugenicists. The connections participants drew between their own experiences and the larger problems between Big M and Black women revealed areas where researchers can begin to frame their methods and agenda around the social construct of race as a factor in health disparities. Thus, I argue that Black women's understanding of how race influences their care opens avenues for a paradigmatic shift in researchers' disposition toward race in obstetrics and gynecology.

The answer to my last research question was built by looking at how information from the first two inquiries fit together. For this question, I looked for ways the rhetorical dynamics at play in medical and political discourse helped me better understand and contextualize the narratives of the Black women whose lives were up for discussion in those contexts. I also aimed to provide a heuristic for OBGYNs – and perhaps all doctors – to engage in more rhetorically effective and respectful interactions with their patients. For this purpose, I arrived at a rhetoric of respect which I think is the strongest contribution of this dissertation project.

I offer the term rhetoric of respect to describe an approach to agreement in interactions between women's health practitioners and their patients. A rhetoric of respect refers to a set of rhetorical tenets that comprise a way of coming to agreement between doctors and patients. The tenets of this rhetorical framework are acknowledgment, deference, and reciprocity. In my search for iterations of respect in cultural and scholarly literature, I found that respect can be operationalized through the three rhetorical enactments: acknowledgment, deference, and reciprocity. Each of these positions shapes the trajectory of interactions between interlocutors in different ways that all add up to a way of acting that demonstrates respect. Acknowledgement makes reciprocity and deference possible because it is the foundation upon which the other two concepts rest. My argument for deference is that because ultimately a patient has much more at stake in the success of any interventions meant to sustain their life and health, doctors should defer to their decision-making when attempting to come to agreement about what actions to take. Further, in the pursuit of agreement between a doctor and patient, reciprocity

means matching the energy of the patient. In other words, if a patient has taken the time and energy to provide copious details about their condition as they see it, reciprocity dictates that the practitioner apply equal consideration in trying to understand those details. I argue that these three tenets make up a rhetoric of respect that changes the persuasive aims of many medical conversations with doctors from one-sided and coercive to mutually efficacious.

A Rhetoric of Respect and other Contributions to the fields of RHM and HC

The findings of this research contributes to the fields of RHM and HC by offering a theoretical framework for practitioners and researchers to use to design more rhetorically informed approaches to studying socially situated health disparities. It addresses gaps in the current research on health disparities and offers tools for operationalizing a paradigmatic shift in research and practice in healthcare contexts.

As I have shown, a review of the current research in Health Communication (HC) reveals very little historically informed rhetorical study into how doctors' communication practices may influence the level of care they provide, or into how doctors can take an understanding of history into their interactions with Black patients. Despite the understanding that communication could not "control" patient behavior (Smith 1989, p.22), much of the reported goals in health communication research involve influencing patients to take certain actions, not doctors or researchers. As Kim et al (2010) show, a minimal amount of HC scholarship examines the sender of the information. Their review of articles published in Health Communication the journal from 1989 – 2010 identified

the major focus areas of research. In that period less than 10% of articles addressed senders rather than audience or message, included critique or “examined the interplay of power and control in the institutional structures of policy making organizations, structures of campaign design and implementations,” or that “investigated structures of health care delivery” (p. 491). Work that examines meaning-making in health and medicine contexts made up less than 1% of the canon. Instead, scholars in this field tend to focus on how to adjust messages and communication toward patients in ways that will lead to better health outcomes by encouraging some behaviors and discouraging others.

A glaring problem in the contemporary approaches to health disparities was their emphasis on persuading patients to act in specific ways, or teaching patients how to persuade their doctors instead of teaching doctors different ways of seeing their own practice within a broader understanding of history and social dynamics. This dissertation aimed to provide a strategy toward shifting that standard of research and practice and started that process by examining the role of rhetoric in shaping these misunderstandings. In that way, I endeavored to find the pain points where rhetoric could also intervene.

I suspect the scope-limiting aversion to critiquing doctors or the structures that facilitate their work is wrapped up in the scientific paradigms of objectivity and rationality and science’s role during the Enlightenment as a kind of replacement for religion which provides an order to life and death. Thus, questioning or critiquing the structures that place medicine on such a high pedestal may seem antithetical to the goal of creating order out of chaos. The idea that diagnosis of an illness involves persuasion from patient to doctor and not the other way around may be beyond the goals of HC

scholarship, but the role of persuasion in every facet of life is the crux of rhetorical inquiry. Nevertheless, RHM scholarship is noticeably quiet on the subject of racism in health and medicine. Although scholars like Cathryn Molloy, and Amy Koerber describe some of the racialized aspects of their research subjects in their work, they sometimes stop short of trying to intervene in those aspects, choosing instead to mark them as opportunities for someone else to do that research.

I understand the deficit in RHM research to be reflective of the field's demographic composition at present. A focus on positionality and an aversion to cultural appropriation or misinterpretation may put some White researchers off the subject of race and racism toward Black people as a site of inquiry. However, I also contend that the ultimate consequence of this hands-off scholarly position is a de facto denial of continued injustice. Nevertheless, I believed a rhetorical theory that helps explain African American experiences with American medicine would benefit from being deeply rooted in African American rhetorical traditions, traditions which have gone undertheorized RHM research. To that effect, I worked to contribute to the goal of doing more research in that area.

Study Limitations or Possibilities Yet Unrealized?

Like any dissertation, this one had its limits. For instance, the analysis of ACOG is specific to the last 10 years and focused mostly on materials available to the public. And Black at the OBGYN only includes narratives from 10 women, a relatively small number. These limitations are natural given the time, space, and resources available for this research. More importantly, however, they also signal opportunities for future work.

Thus, I maintain that what might be called limitations are actually possibilities not yet realized.

The rhetorical analysis portion of this project was limited by the use of passive research methods that did not require me to find information that was not already available. Without insider access to the discourse that happens within the field of obstetrics and gynecology, which I do not have, I can only make observations from the outside. My findings regarding the publication practices of *Obstetrics and Gynecology* were stymied by the limited search powers of the OVID database that contains digital versions of the journal. Because I had no way of directing the search results outside of choosing between the one issue and all the issues to search within, it took much longer to organize and sift through the collection of publications. Although I limited my own scope to 10 years, OVID does not provide a way to narrow the search in this way. I had to collect all the issues that contained particular key words and organize them chronologically using Zotero. The extra time and effort that took limited my ability to conduct a more nuanced analysis. I cannot imagine how long a project like this would have taken before CTRL + F.

Black at the OBGYN was initially hindered by a lack of experience and self-reflexivity on my part and the generalizability of findings in the study is limited by the number of women I interviewed. As I explained, initially, my approach to the research was too abstract, as I was attempting to maintain a certain intellectual distance and modeling my approach on the white masculinist dominated research training I had had up to that point, which was both inappropriate for the context and insufficient even if it had

been appropriate. This meant I had to circle back to the beginning and start over. While the second attempt to recruit participants was more successful, a result that I attribute both to the change in promotional strategy and the addition of compensation in the form of Amazon gift cards. Of course, that promotional strategy was limited by monetary resources, but more than that, it was limited by the time and emotional space I had at the time. I would have liked to interview more participants if I had the material and temporal resources. However, starting with a small number of interviews provided a guide for designing further studies. I can only speak to what these women shared with me, and the themes may not be generalizable because Black women are not a monolith. But as Collins explains in *Black Feminist Theory*, there are noted patterns common enough among most Black women in terms of positionality and social situation that I can make statements about the relationship between the social positionality of being a Black woman and the history of medicine, even if I cannot say *Black women experience X when visiting a women's health practitioner*

I still see the limitations in my rhetorical analysis as an opportunity for someone within the field to take up my call and apply the framework themselves, or for RHM scholars to build coalitions with OBGYN scholars and build research and praxis methods on a foundation of respect. And I see my work in Black at the OBGYN as a starting point for further research into the influence race has on Black women's approach to healthcare. As I will detail next, there are several research opportunities that come out of this dissertation project.

Ideas for Further Research

It is my position that this project's focus on better understanding the problem of maternal health disparities from a rhetorical perspective and offering a rhetorical intervention provides a foundation for building a larger research agenda. To that effect, I present the following research project ideas.

Multi-generational Group Interviews

Many of the women I interviewed discussed the effect medical racism and neglect had on the maternal figures in their lives and how that influenced their own positions and practices. Their second-hand testimonies sparked the idea that so much more could be revealed by speaking to the mothers and aunts of my participants. My own experience in communities of Black women and the types of rhetorical healing that take place in those spaces leads me to believe that group interviews would generate even deeper understandings of the lived and inherited experiences of Black women in the US healthcare system. This project would require a time and location for interviews, resources for mental health support, and a way of compensating women for their time. One of the outcomes of this research could be the establishment of a community partnership with organizations that support maternal health for vulnerable or marginalized groups. Another could be a more experientially-grounded theory of a rhetoric of respect.

A Rhetoric of Race in Medical Education Textbooks

This research idea is inspired both by my article with Elizabeth Caravella about designing culturally responsive health communication texts and by the rhetorical constructions of race I discovered in *Obstetrics and Gynecology*. This research would involve a content analysis of medical textbooks, looking for similar themes to those discussed in Chapter 3 of the dissertation. The goal of this research would be to examine the period in their professional development where aspiring medical professionals become initiated in the culture of medicine and look for rhetorical interventions that would help support the paradigmatic shift I have proposed in this dissertation, namely that conceptions of race in the educational literature would be purposefully established as social in nature. This project would require the cooperation of a medical education program and the resources to acquire textbooks for analysis. One of the outcomes of this project could be a set of standards for the discussion of race in medical textbooks.

In Summary

Although this is not the project I thought it would be at the start, it accomplished the goals I set forth. This project aimed to fill in a gap in HC and RHM scholarship where historically informed approaches to health disparities research were missing. To do that, I worked to answer three research questions: (1) What rhetorical dynamics shape disciplinary discourse on Black women and socially situated health disparities in Obstetrics and Gynecology? (2) What are some rhetorical dynamics governing Black women's negative experiences with OBGYNs? (3) What lessons can be learned from Black women's experiences with OBGYNs and how might OBGYNs effectively employ

rhetorics that treat Black patients in ways that patients perceive positively? I conducted a rhetorical analysis of the public facing and disciplinary discourse of the American College of Obstetrics and Gynecology and discovered that problematic rhetorical constructions of race and Black motherhood continue to influence the discourse on maternal health disparities in negative ways. In my interviews with Black women about their negative experiences with OBGYNs, I identified rhetorical trends across narratives, ultimately finding that the positionality of Black womanhood requires a level of social awareness that gave my participants insight not only into their own treatment but also into the racist systems that undergird their relationship with health care. To address the problem that they made even more clear and answer my last question, ultimately, I arrived at a rhetoric of respect as the major contribution of this dissertation project.

Although the rhetorical analysis portion of this project was limited by the use of passive research methods that did not require me to find information that was not already available, and my interviews with Black women were slowed down and limited by my novice adherence to an inappropriate epistemological framework and a lack self-reflexivity on my part, I still see these limitations as opportunities. I see my work in Black at the OBGYN as a starting point for further research into the influence race has on Black women's approach to healthcare and rhetorical analysis as an effective method for identifying where rhetorical interventions may be most impactful. I am excited to move forward with this work.

APPENDIX: INTERVIEW PROTOCOL

[BEFORE RECORDING]

Thank you for agreeing to interview with me today.

Before we get started with the interview, I just wanted to confirm that you read and understood the informed consent form that you signed. I am going to ask you to tell me about your experiences with OBGYNs.

This Zoom call will be recorded once we begin the interview. A copy of it will be saved on a password protected hard drive.

Some of your answers may be anonymously quoted in my dissertation. But your identity will not be disclosed. You may revoke your consent to be anonymously quoted at any time before the dissertation is completed by emailing me personally.

Are you ready?

I am going to begin recording now.

[BEGIN RECORDING]

The goal of this research study is to learn from Black women. Today, I'd like us to talk about any negative experiences you've had with OBGYNs or negative perceptions you may have of them.

I. Treatment from OBGYNs

A Since you did volunteer to participate in this study, is it safe to say that you have had a negative experience with an OBGYN?

B Would you say you've had one to a few negative experiences or that you are regularly dissatisfied with the care you receive from OBGYNs?

Follow-up

B1: [If just a one to a few,] Ok, can you tell me about your most memorable negative experience? Please, include as many details as you can remember.

B2: [If regularly dissatisfied,] Can you tell me more about that? Do you have a recurring problem with the OBGYN, or is it something new every time?

Is there a particular experience that stands out in your memory?

Do you have any thoughts on what is going on with your treatment?

- C** Was this the first time you have had that experience or similar?
- D** Why do you think you were treated that way?
- E** What instructions or advice would you give your physician on providing better treatment?
- F** Is there anything else you would like to add to the record?

II. History and Negative Perceptions

Thank you for all you have shared with me so far. I know this information is sensitive. At this point I am going to shift gears a bit because part of this research focuses on the justifiably negative perceptions some of us have of doctors generally and OBGYNs specifically.

- G** Are you aware of any stories or experiences in your own family around medical abuse or mistreatment by doctors?
- H** If you are comfortable sharing, what stories have you been told?
- I** Can you tell me a little bit about what you know medicine and Black people in the United States?

J1 [All answers except unfamiliar or unconcerned] How do you think your own experience connects to that history?

J2 [If not familiar/unconcerned] If you were to learn that the historical relationship between doctors and Black people in the United States has been marked by cruelty and abuse, would you be surprised?

- J** Is there anything else you would like to add to the record?

Thank you again for agreeing to interview with me. You've given me so much to think about today and I appreciate your perspective and your time. Now that we have completed the interview, I just need to verify some information with you so that I can get your Amazon gift card sent ASAP.

[Confirm contact information]

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