An Untold Story

Understanding the Black Maternal Mortality Crisis Through Preeclampsia, 1940-2020

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Abstract

The Black female maternal mortality crisis has roots stretching back to 1940, but until recently, it has struggled to get the recognition that it deserves. Over the past ten years, advocates, including Black women and their families, have been working to bring attention to the Black female maternal mortality crisis and shift the narrative around Black maternal health that has been perpetuated for the past 70 years.

Previous to the first acknowledgment of Black female maternal mortality in the U.S. in 1940, Black mothers struggled to be seen as equivalents to their white counterparts because of their race. This history stretches back to the Antebellum period, before 1861, when Black female slaves were frequently used for medical experimentation. This eventually led to the creation of scientific racism, which led to the promotion of racist medical ideals that would shape the treatment of all Black women going forward.

In conjunction with racist attitudes shaping the treatment of Black mothers, physicians and public health officials' historical attitudes towards maternal mortality as a whole also contributed to the present-day crisis. Historically, there has been an effort stemming from physicians and public health officials to diminish the maternal mortality crisis in the U.S. and portray it as "cured," even when in reality it was not. To do so, a triumphalist narrative was crafted around physicians and an individualized blame narrative was crafted around mothers. This narrative has placed even more blame on Black mothers.

These historical attitudes become even more apparent when looking at the history of preeclampsia in the U.S. Preeclampsia has disproportionality impacted Black women, but there is no scientific basis for why. Instead, looking at the longstanding social attitudes toward Black female maternal mortality helps us to better understand the disproportionate impact of preeclampsia for Black mothers.

This paper will explore how this individualized blame narrative around Black female maternal mortality and preeclampsia has been crafted over the last 70 years and how that narrative has started to be overturned by advocates over the last 10 years.

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Introduction

In November 2017, Whitney Polk, a first-time Black mother and Ph.D. student at Harvard, thought she had made it to the end of an arduous journey with the birth of her daughter, but in reality, the troubles were just at the point of escalation. Polk's pregnancy was not picture perfect. Throughout her pregnancy, she had complained about an irregular heart rate and shortness of breath, which only got worse as her due date approached. But, doctors assured her that her symptoms were normal and would resolve themselves after delivery, but that was not the case.[1]

After delivery, her heartbeat remained elevated and instead of receiving extensive post-natal care to address this problem, Polk said she felt dismissed throughout the entire postnatal care process even as she was, obviously, struggling to breathe and hold her baby. When the symptoms continued to get worse she saw her primary care physician and nurse practitioner, who both told her that she just needed anxiety medication. The next day she was admitted to the hospital and was diagnosed with postpartum preeclampsia[2].[3]

When she was admitted the doctors discovered that there were abnormalities related to her heart. After being prescribed blood pressure medication and seeing a cardiologist, Polk

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[1] Magazine, The New York Times. "Black Mothers Respond to Our Cover Story on Maternal Mortality." *The New York Times*, The New York Times, 19 Apr. 2018, www.nytimes.com/2018/04/19/magazine/black-mothers-respond-to-our-cover-story-on-maternal-mortality.html?action=click&contentCollection=Magazine&module=RelatedCoverage®ion=Marginalia&pgtype=article

[2] Postpartum preeclampsia is a serious complication related to pregnancy that primarily has to do with extremely high blood pressure.

[3] Magazine, The New York Times. "Black Mothers Respond to Our Cover Story on Maternal Mortality." *The New York Times*, The New York Times, 19 Apr. 2018, www.nytimes.com/2018/04/19/magazine/black-mothers-respond-to-our-cover-story-on-maternal-mortality.html?action=click&contentCollection=Magazine&module=RelatedCoverage®ion=Marginalia&pgtype=article

thought she was recovering. But, sadly she was not, and the extreme chest pain and shortness of breath returned. And, out of frustration, she took matters into her own hands and started researching her symptoms. She found a Facebook group for peripartum cardiomyopathy[4]. There, she found a physician, and contacted him with her Harvard email. The physician responded quickly and ordered her an MRI, which resulted in the diagnosis of peripartum cardiomyopathy. After receiving the diagnosis, Polk began to receive better treatment but still struggled physically and psychologically.[5]

Upon reflection, while writing a letter to the *New York Times*, she addressed that she believes that her Harvard email address and the racial anonymity it provided her, are what saved her. Because, she believes that the removal of implicit bias over email is what led the doctor to respond to her email so quickly and take her symptoms seriously. And, subsequently realized that her Black skin color almost killed her.[6]

Polk's story is not unique.

Maternal mortality is an issue that plagues women across the globe, despite the advent of new medical innovations. As maternal mortality rates (MMR) globally decrease, MMR in the U.S. continue to struggle to see substantial improvements. And, as a result the U.S. is viewed as

[4] Peripartum cardiomyopathy is a pregnancy-induced heart failure

[5] Magazine, The New York Times. "Black Mothers Respond to Our Cover Story on Maternal Mortality." *The New York Times*, The New York Times, 19 Apr. 2018, www.nytimes.com/2018/04/19/magazine/black-mothers-respond-to-our-cover-story-on-maternal-mortality.html?action=click&contentCollection=Magazine&module=RelatedCoverage®ion=Marginalia&pgtype=article

[6] Magazine, The New York Times. "Black Mothers Respond to Our Cover Story on Maternal Mortality." *The New York Times*, The New York Times, 19 Apr. 2018, www.nytimes.com/2018/04/19/magazine/black-mothers-respond-to-our-cover-story-on-maternal-mortality.html?action=click&contentCollection=Magazine&module=RelatedCoverage®ion=Marginalia&pgtype=article

one of the most dangerous places to give birth in the industrialized world;[7] despite its leadership in development of innovative medical technology, the MMR and near-death cases continues to hover at 17.4 deaths per 100,000 births.[8] This lack of progress, negatively disproportionately affects Black women, who are three to four times more likely to die from pregnancy related complications.[9]

Historically, maternal mortality has frequently been looked at as a racially homogenous issue, although the Black community has been negatively impacted in a disproportionate way. Consequently, this lack of attention has led to an uproar in the Black community from mothers, families, physicians and medical researchers over the past five years, leading them to ask questions such as: is it the mothers, physicians, medical systems or something else intrinsic to the U.S. that is causing the high MMR among Black women?

I will argue that, since the 1940s, when Black maternal mortality started being measured, physicians and public health officials have incorrectly been trying to find the "cure" to the problem of poor maternal outcomes by constructing an "individualized blame" narrative which places most of the responsibility on Black mothers, who have been seen as inherently incapable, because of their race, of being "good" mothers. This faulty construct has been especially prevalent in trying to explain the relatively high incidences of preeclampsia in Black women, despite a dearth of medical evidence linking the disease to

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[7] Linda Villarosa, "Why America's Black Mothers and Babies Are in a Life-or-Death Crisis." *The New York Times*, The New York Times, 11 Apr. 2018, www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.

[8] "NVSS - Maternal Mortality - Homepage." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 9 Nov. 2020, www.cdc.gov/nchs/maternal-mortality/index.htm.

[9] Rabin, Roni Caryn. "Huge Racial Disparities Found in Deaths Linked to Pregnancy." *The New York Times*, The New York Times, 7 May 2019, www.nytimes.com/2019/05/07/health/pregnancy-deaths-.html.

race. But over the last decade, Black advocates and experts in preeclampsia have focused on social issues as a primary cause of poor maternal outcomes, as opposed to individual medical issues brought about by the ignorance of Black mothers.

This thesis will examine how the issue of poor maternal MMR have been impacting women in the U.S. and the historical roots of the problem in the Black community through the lens of preeclampsia[10]. Next, the roles of patients, physicians, and advocates in the Black female maternal mortality crisis between 1940-2020 and how this has impacted Black mothers and the perception of the crisis at large will be examined. Lastly, an assessment how preeclampsia has impacted the Black female maternal mortality crisis over time and how the public understands Black female health.

In examining this history, this thesis will put into question long standing ideals and beliefs around Black female maternal mortality in the U.S. and its relationship to preeclampsia. In doing so, this paper will, as James Baldwin said, "tell the story. Make it real for those who refuse to believe that such a thing can happen/has happened/is happening here".[11]

This work is meaningful in contemporary context, because as physicians, researchers, politicians, and specifically, Black mothers and their families, continue to struggle to understand what is causing this problem and how to address it, this work will provide an analysis to illuminate the history of the issue and current trends.

The Maternal Mortality Crisis in the United States

[10] Preeclampsia a serious complication of pregnancy-related to hypertension
[11] Glaude, Eddie S. 2020. *Begin again: James Baldwin's America and its urgent lessons for our own*, 53.

As of 2018, the MMR[12] in the U.S. was 17.4/100,000 births compared to the U.K. where the MMR was 7/100,000 births.[13] Why is the United States' MMR significantly higher than the United Kingdom's, a country the U.S. is frequently compared to on the global stage? That is the question that many researchers, healthcare providers, and politicians grapple with. Some attribute it to the lack of uniformity that surrounds patient care in the U.S. For example, in Great Britain, doctors have created a standardized approach for diagnosing and treating preeclampsia, and due to this, they have seen a significant reduction in the number of deaths caused by preeclampsia; compared to the U.S. where there is no standardized approach for diagnosing and treating.[14] Additionally, many physicians in the U.S. rely on the antiquated idea that delivering the baby will solve all the problems, like in Whitney Polk's experience, where doctors told her that her condition would remedy after delivery.[15]

Overall, women in the U.S. have been feeling increasingly more anxious about pregnancy.[16] When Thea, 35, was 40 weeks pregnant, she went in for a prenatal appointment, where she found out that she needed an emergency cesarean section[17]. This came as a shock, because for the duration of her pregnancy, she had maintained good health and received regular

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[12] Maternal Mortality according to the Center for Disease Control is defined as, "A pregnancy-related death is defined as the death of a woman while pregnant or within 1 year of the end of a pregnancy – regardless of the outcome, duration or site of the pregnancy–from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes"

[13] World Bank. "Maternal Mortality Ratio (Modeled Estimate, per 100,000 Live Births) - Finland, Venezuela, RB." *Data*, 2019, data.worldbank.org/indicator/SH.STA.MMRT?end=2017&locations=FI-VE&most_recent_value_desc=false&start=2017&view=bar&year_high_desc=false.

[14] Taylor, Morgan. "What Information on Black Female Mortality Rates in the 1950s/60s and Present Day Tells Us About Maternal Mortality". 2018

[15] Taylor, Morgan. "What Information on Black Female Mortality Rates in the 1950s/60s and Present Day Tells Us About Maternal Mortality". 2018

[16] Linda Villarosa, "Why America's Black Mothers and Babies Are in a Life-or-Death Crisis." *The New York Times*, The New York Times, 11 Apr. 2018, www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.

[17] Cesarean Section is also known as a C-section

prenatal care. But, she had always felt like her healthcare team was more interested in protocol instead of her. Consequently, when she had her C-section she not only felt ignored, "[she] really felt like [she] was a piece of meat, like [she] was not being considered in this. It was all about the baby".[18]

Thea's story is not unique and is a part of a phenomenon that scholars have been discussing for over 70 years.

Why is Maternal Mortality in the Black Community Unique?

In April 2016, Kira Johnson, 39, and her husband were excited to bring their second child into the world. After delivering her baby via C-section, her husband noticed complications almost immediately. He alerted the medical staff that there was blood in her catheter and was promised that blood work and a CT scan would be done immediately, but this did not happen. After hours of waiting, she eventually received blood work that showed abnormalities, but once again no immediate action was taken. As her condition worsened and her husband pleaded for a CT, they were informed by hospital staff that Kira was not a priority. After ten hours, physicians took Kira back into the operating room and discovered that her abdomen was filled with blood. She died in the operating room. Kira died from the hemorrhage, but she also died from neglect and lack of medical care, on account of her race.[19]

Variations of Kira's story are common within the Black community, due to the unique place that Black women occupy in the U.S. Due to intersectionality, defined as

[18] Brooks, Kim. "America Is Blaming Pregnant Women for Their Own Deaths." *The New York Times*, The New York Times, 16 Nov. 2018, www.nytimes.com/2018/11/16/opinion/sunday/maternal-mortality-rates.html?searchResultPosition=108.

[19] Chuck, Elizabeth. "'An Amazing First Step': Advocates Hail Congress's Maternal Mortality Prevention Bill." *NBCNews.com*, NBCUniversal News Group, 26 Dec. 2019, www.nbcnews.com/news/us-news/amazing-first-step-advocates-hail-congress-s-maternal-mortality-prevention-n948951.

> A paradigm, rooted in the analysis of black women's experiences, that reveal that Black women are "doubly bound," due to overlapping layers of oppression, including racism and sexism; this paradigm asserts that race constructs the way women experience gender, and gender influences how women experience race.[20]

In *Stay Woke,* Tehama Bunyasi and Candis Smith highlight the unique way Black women have to go through the world carrying the burden of their sex and their race. And, due to intersectionality, Black women and their families can resonate with different parts of Kira's story, like micro aggressions[21], implicit attitudes[22] and misogynoir[23], even if their stories are nowhere near or more traumatic than Kira's.[24]

Micro aggressions, implicit attitudes and misogynoir along with other attitudes play a critical role in shaping the experience of Black women in the medical system. And, that is why it is critical to understand the historical background that had an everlasting effect on the care of Black women.

Preeclampsia in the Black Female Community

[20] Lopez Bunyasi, Tehama, and Candis Watts Smith. 2019. *Stay woke: a people's guide to making all Black lives matter*, 80.
[21] Micro aggressions are "brief remarks, vague insults, casual dismissals, and nonverbal exchanges that serve to slight a person due to the person's race"
[22] Implicit Attitudes are defined as, "unconscious associations between value-laden characteristics and/or stereotypes and various groups of people or things"
[23] Misogynoir, is defined as "the ways in which Black women are disrespected and disregarded in US society due to the combined forces of racism and sexism"
[24] Lopez Bunyasi, Tehama, and Candis Watts Smith. 2019. *Stay woke: a people's guide to making all Black lives matter*, 80.

Preeclampsia[25] and its associated conditions, eclampsia and HELLP syndrome[26] are some of the leading causes of preventable maternal mortality, in the U.S. [27] Preeclampsia is a hypertensive disorder, traditionally characterized by high blood pressure, but over time has begun to be recognized for other symptoms like, organ failure, severe headaches and changes in blood count. [28]

Due to the lack of understanding around preeclampsia, many mothers continue to be negatively impacted. Present-day, the causation of preeclampsia is, still, unknown, and this makes detecting, treating, and preventing the condition challenging and inhibits consensus from forming.[29]

Preeclampsia is not a modern-day complication. There is historical evidence of preeclampsia dating back to between the late 5th and early 4th century. But, this paper will be focusing on the history of the disease starting in the late 18th – early 19th century. [30]

By better understanding the history of preeclampsia, we can better understand the popularly held beliefs around the condition today. In the 18th C. Soissier de Sauvages

[25] Preeclampsia is defined as a "persistent high blood pressure that develops during pregnancy or the postpartum period that is often associated with high levels of protein in the urine or new development of decreased blood platelets, trouble with kidneys or liver, fluid in the lungs, or signs of brain trouble such as seizures and/or visual disturbances"

[26] Hemolysis, elevated liver enzymes, low platelet count (HELLP) syndrome, which is the most severe form of preeclampsia that occurs in 5-12% of preeclamptic patients

[27] Kelly, Cara. "What Is Preeclampsia? And Does It Still Kill Women in the US?" *USA Today*, Gannett Satellite Information Network, 27 July 2018, www.usatoday.com/story/life/allthemoms/2018/07/27/what-preeclampsia-and-does-still-kill-women-u-s/795635002/.

[28] Website. "Preeclampsia - What Is Preeclampsia." *Preeclampsia Foundation - Helping Save Mothers and Babies from Illness and Death Due to Preeclampsia*, 2020, www.preeclampsia.org/what-is-preeclampsia.

[29] Bell, Mandy J. "A historical overview of preeclampsia-eclampsia." *Journal of obstetric, gynecologic, and neonatal nursing : JOGNN* vol. 39,5 (2010): 510-8. doi:10.1111/j.1552-6909.2010.01172.x

[30] Ibid

distinguished, what is now known as, eclampsia from epilepsy. And, by the 19th C.[31], Physicians strongly believed that one of the best ways to treat the condition was through the preservation of the mother's health and increased removal of waste from the mother's body and that a failure to do so would lead to toxemia.[32]

In the early 20th C., researchers were able to make significant strides in understanding the pathophysiological changes associated with the condition. In 1903, the preeclamptic state was officially introduced into medical textbooks, and in 1966, preeclampsia was categorized under toxemias of pregnancy in the 13th edition of Williams Obstetrics. And, two primary methods of treating the disease began to develop in Europe, one was known for its more aggressive approach and the other for its conservative approach.[33]

Over time, Black women have seemed to encounter more repercussions from preeclampsia, even though there is no scientific basis for it. [34] Currently, some public health officials and physicians, such as Dr. Cynthia Berg, say this points to broader underlying social issues, that have led it to look like Black women get and die from the preeclampsia at a higher rate.[35]

Stereotypes developed during the Antebellum period[36], have laid the groundwork for Black women to be more susceptible to severe consequences from preeclampsia, today. One of

[31] During the 19th C., preeclampsia was known as puerperal convulsions and five main reasons were attributed to the cause. Those being, any mechanical or emotional stimulus applied in excess to the spinal centre, bloodletting, variations in the climate, irritation of the uterus, and toxic elements
[32] Bell, Mandy J. "A historical overview of preeclampsia-eclampsia." *Journal of obstetric, gynecologic, and neonatal nursing : JOGNN* vol. 39,5 (2010): 510-8. doi:10.1111/j.1552-6909.2010.01172.x
[33] Bell, Mandy J. "A historical overview of preeclampsia-eclampsia." *Journal of obstetric, gynecologic, and neonatal nursing : JOGNN* vol. 39,5 (2010): 510-8. doi:10.1111/j.1552-6909.2010.01172.x
[34] Block, Jennifer. 2007. *Pushed: the painful truth about childbirth and modern maternity care*. Cambridge, Mass: Da Capo Lifelong, 120.
[35] Ibid, 120
[36] Antebellum Period was between 1861-1865.

the most prolific is the idea that Black people naturally have hypertension[37]. This stereotype has led to the significant dismissal of Black people with concerns about their high blood pressure, since it is frequently associated with being natural.[38]

Building off of these stereotypes, several racial diseases also developed in the 19th century, which further perpetuated the idea that there are biological differences between the races. Racial diseases can be described as the idea that "people of different races suffer from peculiar diseases and experiences common diseases differently".[39] This idea, originally, helped to aid the widely held belief that Black people were innately inferior to white people. These elements of racialized medicine persist today and often can be used to defend inadequate medical care for Blacks, even as scientific evidence has come out to prove that there are no biological differences. [40]

Understanding the historical background of preeclampsia and the ways that racialized medicine, has worked to perpetuate ideas around Black women and hypertension will allow us to better understand the story of Black female mortality through the lens of preeclampsia.

[37] Hypertension is a form of high blood pressure.
[38] Roberts, Dorothy E. 2011. *Fatal invention: how science, politics, and big business re-create race in the twenty-first century*, 114.
[39] Ibid, 82.
[40] Roberts, Dorothy E. 2011. *Fatal invention: how science, politics, and big business re-create race in the twenty-first century*, 79

Chapter One

Introduction

In 1940, the Children's Bureau published one of the first scholarly reports on Black maternal mortality. The report was titled *The Health Situation of Negro Mothers and Babies in the United States* and was written by public health scholar, Elizabeth Tandy. The report analyzes data from 1936-1938, on Black mother and infant mortality. Black women did not just start dying from pregnancy in the 1930s, but the publication of this report serves as a milestone in the recognition of Black female maternal mortality as an issue.[41]

During slavery, Black women were seen as objects to do medical experimentation on. As seen in *Medical Bondage,* by Deirdre Cooper Owens, doctors used Black women before, during, and after pregnancies to learn more about the reproductive system and did so in a rather savage way. Dr. Thomas Weight describes how he treated one Black bondswoman as so, "Wright described how he had the woman's clothes cut away so that she lay naked in front of the other slaves who observed him as he patted her vagina to stem the bleeding. It was obvious he did not regard her as a member of 'the delegate sex'".[42]

Another controversial figure is Dr. James Marion Sims, who for a long time was known as the Father obstetric medicine. Marion's claim to medical fame was his development of a medical technique to cure fistulas,[43] resulting from childbirth. Sims choose to use slaves, who had no choice but to participate in his experimentations, to develop his technique. He acquired

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[41] Tandy, Elizabeth Carpenter. *The Health Situation of Negro Mothers and Babies in the United States ...* U.S. Children's Bureau, 1940.

[42] Cooper Owens, Deirdre Benia. *Medical bondage: race, gender, and the origins of American gynecology*. 2017, 27.

[43] Pregnancy related fistulas were a common condition at the time

eleven slave women and repeatedly performed this extremely painful procedure on them. Even though, anesthesia was commonly being used, Sims refused to use it and was one of the many scientists, at the time, who claimed that Blacks were less susceptible to pain than whites.[44]

The examples of Dr. Wright and Dr. Sims, provide imperative information about how race negatively impacted the medical treatment of Black people. Both highlight the fact that Black women did not receive the same type of medical treatment as white women, because the former were believed to be less than human. And, because of this, Black people were seen as ideal subjects to perform these inhumane procedures on.

Separately race and gender can negatively impact treatment. But, the intersection of race and gender can be particularly harmful. In *Killing the Black Body,* Dr. Dorothy Roberts explains how intersectionality has historically negatively impacted women of color. Historically, white women have been given the right to be mothers. Meaning that as long as they fit certain gender and class norms, their abilities to mother were never significantly questioned. But, historically, Black women have had to fight race, gender, and class norms to be seen as mothers. As, depicted in another statement from Dr. Wright, he did not see Black women as part of the "delegate sex", meaning that they were not truly women in his eyes and therefore did not deserve to be treated as women.[45] Roberts addresses that due to Black women's inability to conform to the image of an ideal woman, that they were never truly seen as mothers and instead were seen as profit making entities. Black women being seen as profit-making entities along with other pervasive images of

[44] Washington, Harriet A. *Medical Apartheid: The Dark History of Medical Experimentation On Black Americans From Colonial Times to the Present.* New York: Doubleday, 2006.
[45] Cooper Owens, Deirdre Benia. *Medical bondage: race, gender, and the origins of American gynecology*. 2017, 27.

Black women, enabled white slave owners and physicians to disregard Black women as being capable mothers.[46]

But, after slavery, Black people, specifically in the South, were no longer seen as profit making entities, so their health mattered even less. This led to white physicians and hospitals, particularly in the South, to deny Blacks medical treatment. This outright denial of treatment continued until the Freedmen's Bureau Act was established by Congress. And, even after legislation was put in place to combat this, equal care still was not guaranteed. As a result, the longstanding belief that Black women were not equal to white women persisted, along with the dual healthcare system, that treated Black people as second-class citizens.[47]

Before the late 19th century, women played a central role in the care of other pregnant women, typically in the role of midwives. As midwives, women would guide other women through the birthing process and this would, typically, allow for an entire female support group to be present, which allowed women to feel a greater level of autonomy over their own bodies and birth.

In the mid-1900s, there were a series of medical advancements that were changing the medical field across the country. One of the largest shifts, was the professionalization of medicine. For maternal care, the professionalization of medicine meant diminishing the practice of midwifery. Judith Leavitt discusses that previous to the shift, birthing had primarily been a female practice, but due to the shift it became increasingly male and medicalized.[48] As women began to get increasing amounts of their care at hospitals, women apart of the healthcare team

[46] Roberts, Dorothy E. 1997. *Killing the black body: race, reproduction, and the meaning of liberty*. New York: Pantheon Books.
[47] Matthew, Dayna B. *Just Medicine: A Cure for Racial Inequality in American Health Care*. 2015,17
[48] Leavitt, Judith Walzer. 1986. *Brought to bed: childbearing in America, 1750 to 1950*. New York: Oxford University Press.

were pushed out of the medical space. And, as an attempt to convince more mothers that it was safer to have their children in hospitals, male physicians had to discredit female midwives, as a way to promote that hospital practices were safer. This shift was particularly, detrimental for Black female maternal care. Black women who had, primarily, used community midwives to deliver their children, in the past, were now being pushed to use white male physicians. [49]

But to many women's dismay the hospital did not provide a significantly safer environment for childbirth, and because the majority of male physicians were more focused on the scientific aspects of birth, the women's more personal needs and wishes became an afterthought. In the hospital setting, clinicians often discredited or neglected women, putting their feelings to the side during pregnancy. [50]

Not only were the ways women were giving birth changing, the ways birth was being tracked and understood was also changing. In the 20th century, maternal and infant mortality was becoming a bigger issue in the United States. In 1917, states started forming maternal mortality committees to study the issue. And, in 1920, the National Committee on Maternal Welfare was established to analyze maternal deaths in every state, in an effort, to prevent maternal deaths by educating medical professionals and community members. Where physicians later came to the conclusion that maternal mortality was significantly worse in the U.S. than in other countries. But, the issue of Black maternal mortality was not formally addressed until the 1940 Children's Bureau report.[51]

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[49] Muigai, Wangui. "Something Wasn't Clean": Black Midwifery, Birth, and Postwar Medical Education in *All My Babies*." *Bulletin of the History of Medicine* 93, no. 1 (2019): 82-113. doi:10.1353/bhm.2019.0003.

[50] Leavitt, Judith Walzer. 1986. *Brought to bed: childbearing in America, 1750 to 1950*. New York: Oxford University Press.

[51] Marmol, J G et al. "History of the maternal mortality study committees in the United States." *Obstetrics and gynecology* vol. 34,1 (1969): 123-38.

In this chapter, **I will argue that between 1940 and 1960 there was a recognition of the maternal mortality crisis, in general, in the United States, but an overall ignorance of the Black female maternal mortality crisis as well as an oversimplification of complications like preeclampsia to protect physicians**. To make this argument I will analyze how the maternal mortality crisis was being examined between the 1940s and 1960s and how complications, specifically preeclampsia, were being addressed. Moreover, I will examine how Black females are brought into this discussion and identify how that conversation developed.

Maternal Mortality Crisis 1940-1950

In the 1940s, there were many changes taking place around maternal care. One of the main changes, was the move towards hospitalized births. By 1939, half of all births and 75% of all urban births, were taking place in hospitals. This was a drastic difference from what had previously been the norm. Moreover, with the majority of births moving to hospitals so quickly, many hospitals did not have sufficient time to plan how to handle the influx of mothers. This led to the development of several issues uniquely impacting mothers, like increased susceptibility to infections during delivery and postpartum. And, consequently the technology used during delivery was also changing. Some of the developments included the popularization of forceps and anesthesia, which radically changed childbirth. Anesthesia, specifically twilight sleep, took away the mother's role in the delivery process. Whereas, before, women had to take an active role in delivering their child, twilight sleep effectively put all the power in the physicians' hands. All contributing the decreased presence of empathy and hands on care present during birth.[52]

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[52] Wolf, Jacqueline H., and J. H. Wolf. *Deliver Me from Pain : Anesthesia and Birth in America*, Johns Hopkins University Press, 2009. *ProQuest Ebook Central*, https://search-proquest-com.proxy.library.upenn.edu/legacydocview/EBC/4398438?accountid=14707.

And, in 1948, the American Medical Association established the Committee on Maternal and Child Care. The committee was founded with the intention to improve MMR across the country, by analyzing data collected by each state. But, one of the hurdles in the way of this effort was the fact that there were still varying definitions and terminology, related to maternal mortality, which made understanding national trends difficult.[53]

States also developed their own maternal mortality committees, composed of local physicians, in an effort to understand what was contributing to maternal mortality locally. In Connecticut, between 1946-1950, the committee saw large changes in MMR. In 1946, physicians noticed that maternal mortality was a large issue and started trying to identify patterns between the treatments and deaths.[54] The committee looked at deaths caused by infections, toxemias, hemorrhage, pre-existing conditions, and other causes. The commonality that doctors noticed between all of these conditions, was that the majority of deaths were preventable, and the mothers would have benefited from earlier diagnosis and consist of prenatal care.[55] Also, noting that the patients and physicians needed to work together to improve maternal mortality rates.[56] This would include patients educating themselves about their bodies, their pregnancies, and not relying on the doctors as heavily to do the right thing.[57] And, by 1950, the committee had noticed

[53] Marmol, J G et al. "History of the maternal mortality study committees in the United States." *Obstetrics and gynecology* vol. 34,1 (1969): 123-38.

[54] Carl E. Johnson, "Five Year Study of Maternal Mortality and Morbidity in Connecticut, 1946-1950, Inclusive." *Connecticut State Medical Journal*, vol. 16, no. 11, Nov. 1952, pp. 809 - 816.

[55]Carl E. Johnson, "Five Year Study of Maternal Mortality and Morbidity in Connecticut, 1946-1950, Inclusive." *Connecticut State Medical Journal*, vol. 16, no. 11, Nov. 1952, pp. 809 - 816.

[56] Taylor, Morgan. "What Information on Black Female Mortality Rates in the 1950s/60s and Present Day Tells Us About Maternal Mortality". 2018

[57] Ibid

a decline in MMR, but a significant amount of the deaths that remained were ruled as unpreventable.[58]

In conjunction, the Minnesota's Maternal Mortality Committee came out with a study, with similar findings as the Connecticut study. When the Minnesota committee originally noticed how high the MMR was, they encouraged expecting mothers to see an OB instead of a family doctor and to start prenatal care earlier.[59] And, thereby, pushed mothers further towards formalized medical care. As a result, MMR in Minnesota declined to a level that led the committee to believe that they had "solved" maternal mortality. As a result, the committee and physicians began to focus their resources and efforts on infant mortality.[60]

Minnesota was not the only state that thought they had "solved" maternal mortality, many other states thought they had accomplished the same goal.[61] This resulted in mothers losing the attention they desperately needed.[62] The focus of care shifted to infants, but many of the proposed treatments to improve infant mortality rates were similar to those suggested for improving maternal mortality. When maternal mortality was the focus, consistent prenatal care was suggested, and when the focus shifted to infants, consistent prenatal care was still

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[58] Ibid

[59] "MINNESOTA Maternal Mortality Study; the Maternal Mortality Committee of the Committee on Maternal Health of the Minnesota State Medical Association." Minnesota Medicine. 37, no. 2 (n.d.): 131–135.

[60] Ibid

[61] Nina Martin and Renee Montagne, "Focus On Infants During Childbirth Leaves U.S. Moms In Danger." *NPR*, NPR, 12 May 2017, www.npr.org/2017/05/12/527806002/focus-on-infants-during-childbirth-leaves-u-s-moms-in-danger.

[62] Taylor, Morgan. "What Information on Black Female Mortality Rates in the 1950s/60s and Present Day Tells Us About Maternal Mortality". 2018

recommended, but purely for the sake of the baby.[63] Consequently, this changed the patient experience and led to gaps in maternal care.[64]

Black Female Maternal Mortality Crisis 1940-1950

By the 1930s, the issue of Black female maternal mortality had reached a point where it could no longer be fully ignored. And, this led to, Children's Bureau researcher, Elizabeth Tandy writing an extensive report[65] on Black mothers and children health. The report heavily focuses on Black birth activity in the south, which is logical since 214,000 of the total annual births were happening there. Additionally, the report also highlights how the majority of Black births were taking place in rural or poor areas, at 170,000 and 208,000 live births annually.[66]

The report also features how poor access to quality medical care impacted the Black community. It, initially, stated that more than half of Black births in the United States were taking place at home without medical professionals. The statistics mentioned in this report, illuminate how poor maternal mortality rates in the Black community could, potentially, be correlated to poor birthing conditions. For example, having less access to professional medical care or clean surroundings. But, does not address the societal barriers to access.[67]

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[63] Margaret Hickey, TOO MANY BABIES DIE. *Ladies' Home Journal,* 05, 1961. 43, https://proxy.library.upenn.edu/login?url=https://proxy.library.upenn.edu:2072/docview/1899001648?accountid=14707 (accessed October 6, 2018).

[64] Taylor, Morgan. "What Information on Black Female Mortality Rates in the 1950s/60s and Present Day Tells Us About Maternal Mortality". 2018

[65] The report was titled, *The Health Situation of Negro Mothers and Babies in the United States*. The report explains that in the 29 states where Black mothers were giving birth, that there were approximately 500 Black births a year, in each of those states.

[66] Tandy, Elizabeth Carpenter. *The Health Situation of Negro Mothers and Babies in the United States ...* U.S. Children's Bureau, 1940.

[67] Tandy, Elizabeth Carpenter. *The Health Situation of Negro Mothers and Babies in the United States ...* U.S. Children's Bureau, 1940.

Lastly, the report identifies the problem that Black MMR were drastically worse compared to their white counterparts. The report identified a variety of reasons for why, but they primarily all tie back to the idea that Black mothers are less likely to have proper education, good hygiene, or access to proper medical care, laying the groundwork for beliefs that would continue to impact the perception of Black mothers' health going forward. But, what the report fails to address is how the problem can be rectified. Setting the tone that this is an individualized problem not a societal one.[68]

Where Tandy's report focuses on Black birthing statistics nationally, simultaneously, during the 1940s, Black women were being seen as targets by northern hospitals, as hospitals continued to further medicalize birth. The midpoint of the Great Migration, 1940, correlated with the rise in hospital births. So, as Black women migrated to the north and faced a whole new set of societal norms, they also had to navigate changing medical norms. And, were seen as the perfect target by northern hospitals, because most of them were coming to the north without any medical advocates, so hospitals believed that it would be easier to convince them to have hospital births instead of white mothers, who had existing medical relationships in the north. Many hospitals in the north targeted Black pregnant women in an effort to get positive results that would encourage white women into hospitals. Once again, using Black women as experiments and exploiting their vulnerability.[69]

Six years later, in 1946, another piece was published on Black female maternal mortality, *The Maternal Welfare and the Negro*, by PF Williams. In this article, Williams is tasked with answering a series of questions, all tying back to why the Black MMR are significantly worse

[68] Tandy, Elizabeth Carpenter. *The Health Situation of Negro Mothers and Babies in the United States ...* U.S. Children's Bureau, 1940.
[69] *And the Results Showed Promise... Physicians, Childbirth, and Southern Black Migrant Women, 1916-1930; Pittsburgh as a Case Study*

than white MMR. Williams addressed how biological differences between the races play a significant role in varying complication rates. Williams briefly touches on the "pure" medical differences between Black and white mothers, by stating that Black women are more likely to have hypertensive diseases. The idea of "pure" medical differences is built off of traditional scientific racism beliefs.[70]

But, the majority of the article focuses on attributing responsibility to Black women for the social components of life, that were poorly impacting their health. Similarly, to Tandy, Williams addressed how most Black females lived in unhygienic rural and poor areas and how this correlated to poor health outcomes. But, Williams adds to the individualized narrative by attributing the issue of environment to Black women, because of their ignorance and eventually, going farther to establish that Black people have a lower moral code, neglect their children, have higher rates of illegitimate births, lower education, or a psychological basis. Similarly, to the report from the Bureau, this article puts the responsibility on Black women. [71]

Along with acknowledging how social aspects of life negatively impacted Black health, scholars were also aware of the lack of medical resources in the Black community and how that contributed to poor health. Black hospitals did not have nearly enough resources to properly meet the demand of Black mothers coming to deliver children, let alone handle complicated cases. Williams addressed that the medical education that Black physicians were receiving was substantially less advance than the education white physicians were receiving, which put them at an additional disadvantage. But, the framing of these facts in reports, like Williams', put the burden on Black people to figure out how to combat these issues. By acknowledging the issue

[70] WILLIAMS PF. MATERNAL WELFARE AND THE NEGRO. *JAMA*. 1946;132(11):611–614. doi:10.1001/jama.1946.02870460001001
[71] WILLIAMS PF. MATERNAL WELFARE AND THE NEGRO. *JAMA*. 1946;132(11):611–614. doi:10.1001/jama.1946.02870460001001

and not addressing any proposed solutions, public health officials began to define Black maternal mortality as an individualized problem, not a societal one.[72]

Overall, the responsibility in the 1940s, was significantly more on the mothers than the physicians. Similarly, to the Connecticut and Minnesota maternal mortality reports, these public health officials work to construct a narrative that points the responsibility away from the physicians. But, from the reports, it is apparent that there is a tendency to put increased amounts of blame and responsibility on Black mothers.

Preeclampsia 1940-1950

Leading up to the 1940s and through the 1950s, there was a greater focus on puerperal death[73]. But, physicians were making note of other pregnancy related complications, one of them being toxemia, otherwise known as preeclampsia.[74]

When looking at deaths caused by complications, like toxemia, there was an obvious discrepancy between the rates of Black and white mothers passing away. In 1946, it was reported that the Black puerperal death rate was more than double the rate for white women.[75] But, there was a lack of specific statistics relating to the rate Black women were dying from toxemia. But, the *Maternal Welfare of the Negro*, identifies that Black women were three times more likely to develop hypertensive diseases than white women. And, it is possible to infer that this increases

[72] WILLIAMS PF. MATERNAL WELFARE AND THE NEGRO. *JAMA.* 1946;132(11):611–614. doi:10.1001/jama.1946.02870460001001

[73] Puerperal Death is related to puerperal sepsis. Puerperal sepsis is an infective condition that develops in a mother after childbirth, typically in the genital tract.

[74] Carl E. Johnson, "Five Year Study of Maternal Mortality and Morbidity in Connecticut, 1946-1950, Inclusive." *Connecticut State Medical Journal*, vol. 16, no. 11, Nov. 1952, pp. 809 - 816.

[75] WILLIAMS PF. MATERNAL WELFARE AND THE NEGRO. *JAMA.* 1946;132(11):611–614. doi:10.1001/jama.1946.02870460001001

the probability of developing toxemia or preeclampsia, because they are related to hypertension.[76]

Between 1940-1950, there was a large focus on how the environment impacted maternal health. During this period, the hyper focus on sterility, led to one of the primary focuses on maternal health being how hygiene impacted the possibility of complications and diseases developing, during pregnancy. Scholars, like Tandy and Williams, attributed higher rates of complications, in the Black community, to poor hygienic habits related to their poor living conditions.[77] In the *Maternal Welfare of the Negro*, Williams makes several generalizations about how Black females' environments were impacting their health during pregnancy. All in all, Tandy and Williams attribute the poor economy and poor nutrition of Black people, to the reason why Black women are more predisposed to developing complications related to toxemias during pregnancy.[78] Similarly, to the analysis on why Black maternal mortality was so high, the onus for why Black women are more likely to develop complications like toxemia, was put on the Black women.

Black Female Maternal Mortality 1950-1960

Entering into the 1950s, race was at the forefront of issues in the U.S., as overt segregation in the south, began to be combated by Black activists. Segregated medical care in the south, along with poor facilities and resources available to Blacks, contributed to poor health

[76] WILLIAMS PF. MATERNAL WELFARE AND THE NEGRO. *JAMA.* 1946;132(11):611–614. doi:10.1001/jama.1946.02870460001001
[77] Ibid
[78] WILLIAMS PF. MATERNAL WELFARE AND THE NEGRO. *JAMA.* 1946;132(11):611–614. doi:10.1001/jama.1946.02870460001001

outcomes.[79] So, as the Civil Rights Movement picked up in the 1950s, one of the main areas of contention was around hospital desegregation.[80] Desegregation was seen as one of the first steps toward getting Blacks, in the south, better access to care. But, even as desegregation began to take place, white hospitals found ways to combat those efforts. Some of the ways they were able to do this, was by converting rooms that would have been for several people into private rooms and refusing hospital privileges to Black physicians.[81] Segregation had been the norm for so long and racist attitudes had been so normalized, that people in the south, generally, abhor the idea of breaking down those long-established barriers.

One of the main conflicts of interest against the hospitalization movement was midwifery. Even as more women moved towards hospitals for birth, up until the 1950s, midwives were still attending to the majority of Black births in the south, which was seen as a major problem. And, midwives held an important role in the Black community, so even as, medical officials continued to blame high infant and maternal mortality rates on them, Black women continued to choose midwives over hospitals. Southern medical officials saw their popularity as a poor reflection on the state and were therefore, willing to go to any extent to villainize Black midwives. However, even as white medical officials in the south, slandered Black midwives, they still did not want Black mothers in their hospitals.[82]

Simultaneous to pushing Black mothers towards hospitals, OBGYNS along with public health officials, like Elizabeth Tandy, continued to insist that maternal mortality had been cured.

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[79] Nelson, Jennifer. *More Than Medicine: A History of the Feminist Women's Health Movement*.2015,20
[80] Ibid,19
[81] Ibid,20
[82] Muigai, Wangui. "Something Wasn't Clean": Black Midwifery, Birth, and Postwar Medical Education in *All My Babies*." *Bulletin of the History of Medicine* 93, no. 1 (2019): 82-113. doi:10.1353/bhm.2019.0003.

In the Iowa maternal mortality report from 1953-1954, the majority of the deaths were reported to be unpreventable since the women went into the pregnancies with diseases, like diabetes or high blood pressure.[83] Additionally, many deaths were ruled to be due to, "inadequate prenatal care" or "uncooperative attitudes with doctors", and were therefore, also ruled as unpreventable, since it was deemed that physicians could not alter mothers attitudes towards them.[84] Unlike the deaths related to sepsis or infection which were seen as the responsibility of the doctors, unpreventable deaths were seen as the responsibility of the mothers.

Examining the two categories for the causes of death demonstrates how responsibility and blame were placed on mothers and doctors. The deaths that were ruled as preventable were the responsibility of the doctors to prevent. Marking the death as preventable on maternal mortality reports actually benefits the doctors and protect them from being seen as incompetent physicians. Classifying the death as preventable gives the doctor room to defend themselves and say that they can learn how to correct that mistake.[85]

As opposed to the majority of deaths that were ruled unpreventable. Marking these deaths as unpreventable, also protected the doctors, by removing the doctor and his skills from death and putting the mother closer to the cause. In the deaths that were ruled as unpreventable, some had notes about the mom being uncooperative with doctors and not starting prenatal care early enough, in these cases, the blame/cause of death seems more the responsibility of the mother instead of the doctor. Even though the deaths were ruled as unpreventable, including the portion about being uncooperative and not being diligent about prenatal care, leads to a "what if" feeling

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[83] "IOWA MATERNAL Mortality, 1953-1954; Cases Edited and Summarized by the Maternal Mortality Reviewing Board." *J Iowa State Med Soc.*, vol. 47, no. 5, May 1957, doi:10.1787/888933152589.
[84] Ibid
[85] Taylor, Morgan. "What Information on Black Female Mortality Rates in the 1950s/60s and Present Day Tells Us About Maternal Mortality". 2018

for anyone reading the report. Leading one to think that there is a possibility that if the mothers had been cooperative or started prenatal care earlier, that the outcomes could have been different and leave the doctor removed.[86]

By 1955, 95% of births in the U.S. took place in hospitals, and technology and methods that had begun to gain more popularization in the 1940s had become the norm.[87] At a public forum on 'motherhood', in 1957, Dr. Edward David[88] made the claim that "no other field in medicine had made greater progress in the last 20 years than obstetrics…labor has become so safe that women should not have to consider it a hazard".[89] Dr. Davis' attitude was not unusual at the time, similarly to the records from the Maternal Mortality Committee in Minnesota, many physicians believed that maternal mortality was cured in the 1950s. A lot of this false sense of confidence stemmed from the ability to shift blame away from physicians. Moreover, white areas of maternal mortality saw improvement, but little attention was paid to the crisis that was developing in Black communities.

Doctors dictated the majority of medical decisions and other medical staff like nurses also greatly impacted the care that mothers received, in the 1950s.[90] From an interview with Jean Clark, a Black woman, and who was pregnant in 1959 and 1960, the influence doctors had over

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[86] Taylor, Morgan. "What Information on Black Female Mortality Rates in the 1950s/60s and Present Day Tells Us About Maternal Mortality". 2018

[87] Wolf, Jacqueline H., and J. H. Wolf. *Deliver Me from Pain : Anesthesia and Birth in America*, Johns Hopkins University Press, 2009. *ProQuest Ebook Central*, https://search-proquest-com.proxy.library.upenn.edu/legacydocview/EBC/4398438?accountid=14707.

[88] Dr. Edward David was a professor, chairman of the Department of Obstetrics and Gynecology and Chief of Services, at Lying Hospital, in New York City

[89] Ibid

[19]Hickey, Margaret. TOO MANY BABIES DIE. *Ladies' Home Journal,* 05, 1961. 43, https://proxy.library.upenn.edu/login?url=https://proxy.library.upenn.edu:2072/docview/1899001648?accountid=14707 (accessed October 6, 2018).

patients care is displayed. Clark was born in New Rochelle, New York, in the 1940s. She is from a rather atypical, highly religious, middle-class family.[91]

While at college, she met her first husband, James Taylor, and got pregnant with her first child. Since she chose to stay in school during her pregnancy, the first doctor she saw was in Kansas, but her primary gynecologist (OB) was in New Rochelle, New York. Due to this, she did not have a chance to receive proper prenatal care from an obstetrician until she went home for summer break. She ultimately delivered her first child in New Rochelle, New York, in June of 1959 in New Rochelle Hospital. When she got pregnant with her second child in the fall of 1959, she was still in college and therefore went to a family doctor in Kansas first, then her OB in New Rochelle once when she came home for a break. Ultimately though, she delivered her second child in Kansas.[92]

There were stark differences between these two deliveries, and she attested them to the medical systems in both hospitals. When it came time to deliver her first child in New Rochelle, New York, she said the hospital was run more like a factory. There was such a high volume of patients coming in that the delivery team did not have time to listen to her wishes. She had wanted to have a natural birth, but her medical team said that they did not have enough time to wait for her to deliver, so they put her to sleep and delivered her first child by C-section. She experienced the same lack of patient care when she attempted to breastfeed her first child in the hospitals, the nurses did not have the patience to wait for her to learn how and told her she had to bottle feed instead, even though it was against her wishes. Her experience in the New Rochelle hospital left her feeling frustrated, and dismissed as a patient. These feelings are what led her to

[91] Taylor, Morgan. "What Information on Black Female Mortality Rates in the 1950s/60s and Present Day Tells Us About Maternal Mortality". 2018
[92] Jean Clark, [Oral History Interview with Author] October 3, 2018

compare the hospital to a factory, there was no personal component to the delivery. It was all about getting the baby out and then getting them out of the hospital. She chose to deliver her second child in Kansas and noticed stark differences between the two experiences. In the smaller hospital, where most doctors were family doctors, she felt like she was able to have her voice heard, because there was less of a rush and factory feel to the delivery. [93]

The improvements in technology in maternal health, for example, improvements in pain management, greatly improved techniques around delivery but did not necessarily benefit the mother's care, and in this case, led to the mother's voice being silenced.

Preeclampsia 1950-1960

Between 1950-1960, physicians in maternal mortality communities focused on preventable causes of death, like sepsis that developed during delivery. During this time, physicians on these committees worked to "cure" maternal mortality, and a lot of the work went towards moving the responsibility away from physicians and onto mothers, as the majority of deaths continued to be ruled as unpreventable.

And, this attitude is reflected in the lack of literature on preeclampsia during the 1950s. During this period physicians struggled to determine the etiology of preeclampsia.[94] The lack of evidence suggest that they did not pay particular attention towards preeclampsia, because it could point towards physicians' incompetence. Instead they focused on pushing the responsibility onto mothers, particularly Black mothers. As they could say that the complication was due to mothers' incompetence.

[93] Jean Clark, [Oral History Interview with Author] October 3, 2018
[94] Bell, Mandy J. "A historical overview of preeclampsia-eclampsia." *Journal of obstetric, gynecologic, and neonatal nursing : JOGNN* vol. 39,5 (2010): 510-8. doi:10.1111/j.1552-6909.2010.01172.x

Conclusion

As maternal mortality gained more traction in the public health space in the 1940s and maintained a keen interest, through the 1960s, Black women continued to slip through the cracks. Most of the scholarship being produced by maternal mortality committees between 1940-60, focused on how to divert the fault away from physicians, by categorizing the causes of death, as preventable and unpreventable. The categorization of deaths in this way was in an effort to depict the physicians as heroes and put more blame on mothers. But, overall more responsibility was placed on Black women than white women.

The state maternal mortality committee reports provided a vast amount of information on white mothers' maternal mortality but failed to recognize Black mothers' maternal mortality. However, in the report from the Children's Bureau and *Maternal Welfare of Negros*, information on Black female maternal mortality was produced. But, the tone of these articles was vastly different than the tone of the maternal mortality state committee reports. These reports focused on how Blacks were inherently predisposed to having worse pregnancies due to their incompetence.

White women were struggling to get the maternal care that they needed and have their needs listened to by their doctors at this time. But, the white female bodies were respected and valued enough to be written about in public articles. The information provided to help women in these articles is clearly for white women who have access to qualified physicians who will pass on the information from the studies.

From the lack of public information about Black maternal mortality, it is possible to infer that the Black female body was valued lesser than the white female body.

Additionally, because it was "easier" for physicians to understand what was happening in the white female maternal mortality space, in tandem with, overarching, racist attitudes further distancing the legitimacy of the Black maternal mortality crisis, maternal mortality became defined as a white female problem. Therefore, as maternal mortality rates went down in the white community, physicians were able to say that maternal mortality was cured, and start to shift the focus towards infant mortality. Even though reports from the Children's Bureau and *Maternal Welfare of Negros,* stated that there were serious issues among Black women, the larger public health committee chose to take no further actions.

Chapter Two

Introduction

In the 1960s, the common notion among physicians that maternal mortality had been "cured" continued to be perpetuated. Among this belief, ideas centering around, broader, health discrepancies between races continued to be discussed. By 1960, pressure from civil rights groups was starting to yield significant results. The Civil Rights Bill of 1964, The Voting Rights Act of 1956, and the Fair Housing Act of 1968, were all examples of some of the most notable legislation passed during this decade. Additionally, this decade was marked by several other events that brought Black people together in a unified interest towards achieving equal rights. Some of those moments being, the March on Washington, The March from Selma to Montgomery, the formation of the Black Power Movement, and the assignations of MLK and Malcolm X.

Even though, these events did not directly deal with maternal rights for Black women, they all had runoff effects on Black maternal mortality. As a result of the passage of the legislation mentioned above, other major events around desegregation, and shifting attitudes towards Blacks, many consider the 1960s to be the decade of progress. The mass changes in overt segregation across the country allowed Blacks in the United States to progress in areas like education, occupation, and purchasing power. Nonetheless, scholars argue that even though Blacks were able to greatly progress, this progress did not happen evenly across the Black population, so while some Black people were able to progress greatly, some's lives only changed marginally. Approaching the 1960s, Blacks were universally disadvantaged compared to whites, and legislation passed during the decade was unable to make significant changes to this disadvantaged nature, by the end of the decade. This is because longstanding racist attitudes

remained unchecked, like unfair treatment in hospitals, despite legislation to address practices like segregation. Therefore, despite certain improvements in Black lives, successful integration remained unaccomplished.[95]

Some scholars saw the lack of integration as a sign that the decade of progress may not have had that much progress. Blacks faced this inhibition of true integration across multiple facets of their lives, and that inadvertently impacted their health.[96] As more Blacks moved up north, during the Great Migration and began to progress financially, they were unable to seamlessly integrate into the middle class, like European immigrants had.[97]

When Blacks migrated to the north, they were still seen as members of the lowest caste in north, similarly, to how they had been seen in the south. And, due to this, even Blacks with some wealth and education, had a hard time obtaining "contacts" and "know-how", which were key to navigating northern society. And, eventually, as more Blacks moved to the north, they were systematically guided towards the same neighborhoods, and those areas became known as "Black Ghettos". The 1960s did lay the groundwork for substantial progress amongst Blacks, but it also laid the groundwork for the further establishment of social inequalities.[98]

In the 1960s, MMR in the United States had dropped dramatically, and many physicians saw this as a sign that maternal mortality had been cured. But, the records they were going off of were not flawless. One of the primary issues was information collection. The records that the state maternal mortality committees created did not go into delineating what was happening to

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[95] Farley, Reynolds, and Albert Hermalin. "The 1960s: A Decade of Progress for Blacks?" *Demography*, vol. 9, no. 3, 1972, pp. 353 – 370. *JSTOR*, www.jstor.org/stable/2060859. Accessed 9 Nov. 2020.
[96] Nelson, Jennifer. *More Than Medicine: A History of the Feminist Women's Health Movement*. 2015, 20
[97] Drake, Clair. "The Social and Economic Status of the Negro in the United States." *Daedalus* 94, no. 4 (1965): 771-814. Accessed June 25, 2020. www.jstor.org/stable/20026946.
[98] Drake, Clair. "The Social and Economic Status of the Negro in the United States." *Daedalus* 94, no. 4 (1965): 771-814. Accessed June 25, 2020. www.jstor.org/stable/20026946.

white mothers and non-white mothers, specifically Black mothers. So, this leaves us to question if maternal mortality was cured for Black mothers as well? Furthermore, data collection, in general, was flawed. One of the main flaws was that it was just based on birth and death certificate information, so if a mother had delivered a baby and there was either an issue with the birth or death certificate or one was completely lacking this would result in a flaw with the records that were being shared by the State Maternal Mortality Committees. Along with too many physicians believing that maternal mortality had been cured, trends established in the previous decade were being solidified like births in hospitalized and highly medicalized birthing processes.[99]

In this chapter, **I will argue that between 1960 and 1980, despite large shifts in legislative attitudes towards desegregation, there was still a struggle to truly integrate Blacks into society, which allowed social attitudes that blamed Black mothers for their poor health to further develop along with solidifying racist beliefs around preeclampsia. In addition to, members of the medical community further separating themselves from responsibility, by stating that prenatal care was the "cure" to issues in maternal care and saying that it was the mothers' responsibility to get that care**. To make this argument, I will analyze how socioeconomic status impacted Black mothers between the 1960s and 1980s and laid the groundwork for social determinants of health, then how the failures to truly integrate continued to negatively impact the care Black mothers received and how preeclampsia played a role in solidifying social and medical differences between Black and white mothers.

[99] Marmol, J G et al. "History of the maternal mortality study committees in the United States." *Obstetrics and gynecology* vol. 34,1 (1969): 123-38.

Black Female Maternal Mortality 1960-1970

In the 1920s and 1930s, a theory called the *Matriarch and Black Unwed Mother* theory developed. This theory centered around the idea that Black female pathology inhibited Black mothers from successfully being incorporated into families, because of their sexual depravity. This theory, further, insinuated the idea that Black women were not equivalent to white women, because of their inability to sustain traditional relationships. The theory was reincarnated in the 1960s, to inhibit Black female progress by pushing them into a social norm. This theory did so by reinforcing that Black women were not meant to be mothers and therefore, did not deserve or need the same rights as white women. White sociologists at the time, like Daniel Patrick Moynihan,[100] used this theory to establish that it was Black women's fault why Black families failed and therefore, why the Black population had failed to advance. Black women were said to have destroyed their families in two ways, by demoralizing Black men and transmitting a pathological lifestyle to their children, that reinforced poverty and antisocial behaviors.[101]

Simultaneously, the Eugenics movement was revived in the 1960s, which further enforced the subjugation of Black women. Scientists, like Arthur Jensen and William Shockley, promoted the idea that there was a genetic explanation for racial differences. As the Civil Rights movement successfully led to legal reform, that gave Blacks greater access to housing, jobs,

[100] Daniel Patrick Moynihan popularized the Matriarch and Black Unwed Mother theory in 1965, in his paper titled *The Negro Family: The Case of National Action*. In this paper, Moynihan argued that the Black matriarch was the largest inhibitor for Black culture and Black people being able to sustain themselves in a white environment without white assistance. Moynihan's argument further perpetuated the blame narrative, by blaming Black women, the most subordinate members of Black society, for the failure of Black families and culture. This theory went along well with President Lyndon Johnsons War on Poverty, which attacked the Black family structure as the root of Black poverty.

[101] Roberts, Dorothy E. Killing The Black Body: Race, Reproduction, And The Meaning Of Liberty. New York : Pantheon Books. 1997, 16

welfare benefits, and political participation, white Americans focused on reengineering social norms in the United States, to continue inhibiting Black people.[102]

As white America was trying to sanction Blacks, Black scholars were working to combat these views. In an article from the *Chicago Defender*, in 1967," 'No Such Thing as a Negro'" Professor Says", Dr. Charles H. Wesley[103] discussed how he was teaching Black men how to combat the perception of being a "Negro"[104]. Dr. Wesley, addressed how detrimental the falsehoods associated with the Negro, had been to Black Americans. These falsehoods had made it, nearly, impossible, for Black people to be seen as worthy of American privileges like, the right to live in whatever neighborhood they choose or to proper healthcare. And, this led to a trickle-down effect throughout Black communities, which has inhibited them from progressing in society. Scholars, like Dr. Wesley, encouraged Blacks to overturn these images. But, this cannot be done by Blacks alone and will require white Americans also accepting that the beliefs surrounding the American Negro are false.[105]

The falsehoods associated with the Negro impacted maternal and infant mortality, due to the trickle-down effect. Dr. Wesley stated, that erasing this falsehood was key dismantling the two-class system of healthcare. Even though, Black female maternal mortality was not the focal

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[102] Roberts, Dorothy E. Killing The Black Body: Race, Reproduction, And The Meaning Of Liberty. New York : Pantheon Books. 1997, 16

[103] Professor Wesley was a professor at the Tuskegee Institute and the director of the Association for the Study of Negro Life and History.

[104] In Dr. Wesley's opinion, the idea of the "negro" had been created by white people in the United States.

[105]"'No Such Thing as the Negro' Professor Says." *The Chicago Defender (National edition) (1921-1967)*, Jun 10, 1967, pp. 27. *ProQuest*, https://proxy.library.upenn.edu/login?url=https://www-proquest-com.proxy.library.upenn.edu/docview/493337440?accountid=14707.

point of Dr. Wesley's argument, his decision to address the discrepancy between white and Black infant and maternal mortality rates, calls to attention the pressing nature of the issue.[106]

The two-class healthcare system is something that both, Black and white Americans were beginning to notice in the 1960s, but their perception and understanding of what the two-class healthcare system was varied. Where Blacks saw it as something that was built off of false beliefs, many whites believed that it was due to Blacks' ignorance. As a result, a collection of public health officials, physicians, and doctors came together for an interview, to address what they believed caused poor health in Blacks. One physician exclaimed, "it has always amazed me that Negroes are so complacent about health care. Don't they know that their babies are dying every year because of the lack of adequate care". From the tone of the physician's remark, it is apparent that there is disdain towards Blacks, especially the mothers. Because there is an assumption that Blacks are willfully putting themselves into the position to harm themselves and their offspring.[107]

In tandem, there was also an overwhelming understanding that there needed to be better community health programs in place. White people, typically, believed that these programs were needed to combat Black ignorance. Whereas, Black people believed that these programs were needed to combat societal structures, that had historically held Blacks back and combat, historical, distrust of the medical establishment. A nurse explained to the *Chicago Daily Defender*, that "negroes are kept out of the mainstream of medicine". This isolation from the

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[106]"'No Such Thing as the Negro' Professor Says." *The Chicago Defender (National edition) (1921-1967)*, Jun 10, 1967, pp. 27. *ProQuest*, https://proxy.library.upenn.edu/login?url=https://www-proquest-com.proxy.library.upenn.edu/docview/493337440?accountid=14707.

[107] BETTY WASHINGTON Daily Defender, Associate Editor. "Negro Complacency Blamed for Health Care Shortcomings: But 'Medical Power Structure' also Rapped." *Chicago Daily Defender (Big Weekend Edition) (1966-1973)*, Jan 20, 1968, pp. 1. *ProQuest*, https://proxy.library.upenn.edu/login?url=https://www-proquest-com.proxy.library.upenn.edu/docview/493468374?accountid=14707.

mainstream allowed medical inequalities to fester and eventually skyrocket, leading to severe health disparities, like maternal mortality. The nurse also mentioned that the current medical structure in the U.S. was based off on blaming patients for their conditions, and this was more prevalent with Black patients. This further defends the individualized narrative.[108]

As Black health was becoming increasingly discussed, maternal mortality was still widely viewed as "cured". Edith Anderson and Arthur Lesser wrote *Maternity Care in the United States Gains and Gaps,* in which they explained the "massive" improvements that had taken place in maternal mortality and simultaneously, calmly, promoted that Black health was drastically worse. And by 1964, the MMR had dropped by 3.4 times and reached an all-time low. Anderson and Lesser attributed several reasons to the decline in the MMR including, improvements in social, economic, and environmental factors, advances in maternal science like blood typing and antibiotics, the increased accessibility to hospitals. But, they were unable to explain why this large gap was developing between the races. The lack of inclusion of details for this topic, further speaks to the notion that "fixing" the gap was not the responsibility of society, but the responsibility of individuals. Therefore, society does not need to propose anyways to fix it, and can push the responsibility onto Black mothers. [109]

Throughout the 1960s, state maternal mortality committees estimated that between 50-75% of maternal deaths could be prevented by adequate maternal care. At the center of these

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[108] BETTY WASHINGTON Daily Defender, Associate Editor. "Negro Complacency Blamed for Health Care Shortcomings: But 'Medical Power Structure' also Rapped." *Chicago Daily Defender (Big Weekend Edition) (1966-1973)*, Jan 20, 1968, pp. 1. *ProQuest*, https://proxy.library.upenn.edu/login?url=https://www-proquest-com.proxy.library.upenn.edu/docview/493468374?accountid=14707.

[109] Anderson, Edith H., and Arthur J. Lesser. "Maternity Care in the United States Gains and Gaps." *The American Journal of Nursing*, vol. 66, no. 7, 1966, pp. 1539–1544. *JSTOR*, www.jstor.org/stable/3420127. Accessed 9 Nov. 2020.

changes was the medicalization of birth. As more births took place in hospitals, the campaign to slander non-physicians' delivery babies continued, as they began to be referred to midwives as untrained "granny" midwives. And, as fewer midwives delivered children, the number of total OBGYNs doubled. But, what was not acknowledged is that even as these improvements took place widely, the effects were not distributed evenly among white and Black women. And, Black women from a lower socioeconomic status were able to reap even less of the benefits of reformed healthcare. Even so, the overarching narrative was that maternal mortality was "eradicated".[110]

Consequently, as the focus on maternal mortality declined, the focus on infant mortality increased. In 1961, an article, titled, "Too Many Babies Die", brought to light the discrepancy that the U.S. is one of the wealthiest and most advanced countries but even so, the infant mortality rate was rising. The author, Hickey focused on the fact that most of these deaths were preventable and could be prevented by regular visits with the same physicians, prenatal care, trained maternity nurses, and nutritionists. Thereby, starting the perpetuation of the idea that prenatal care was the answer to the infant mortality question and perpetuating the idea that prevention and pregnancy experiences are a monolith. But, this focus still excluded Black women, as maternal and infant mortality was, primarily, defined by white women.[111]

The promotion of the necessity of prenatal care only continued to be further perpetuated. In 1968, a study was published by the Public Health Records, that attributed adequate prenatal care to curing infant and maternal mortality. Moreover, stating that mothers who did not receive

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[110] Anderson, Edith H., and Arthur J. Lesser. "Maternity Care in the United States Gains and Gaps." *The American Journal of Nursing*, vol. 66, no. 7, 1966, pp. 1539–1544. *JSTOR*, www.jstor.org/stable/3420127. Accessed 9 Nov. 2020.

[111] Hickey, Margaret. TOO MANY BABIES DIE. *Ladies' Home Journal,* 05, 1961. 43, https://proxy.library.upenn.edu/login?url=https://proxy.library.upenn.edu:2072/docview/1899001648?accountid=14707 (accessed October 6, 2018).

prenatal care were primarily Black. And, were unable to, due to their own ignorance and lack of personal responsibility. Further pushing the responsibility on Black mothers and away from society. By doing so, this narrative thereby, ignored the fact that having access to adequate prenatal care relied on having access to adequate health care, which many Black women struggled to get, due to systemic racism.[112]

Even though maternal mortality was no longer seen as a primary concern by physicians and public health officials, physicians were still interested in talking about the history of the issue, in an effort to promote the physician triumphalist narrative. In 1969, Dr. Jose MarMol, Dr. Alan Scriggins, and Dr. Rudolf Vollman wrote *After Office Hours, History of Maternal Mortality Study Committees in the United States*, and they examined how over the past 30 decades the U.S. was able to "cure" maternal mortality. [113] Attributing this success to the formation of maternal mortality committees and their ability to bring a level of seriousness to the issue and put physicians at the center of care. Many of the committees, by the end of the 1950s, had determined that preventable causes of maternal mortality could be cured by giving the physicians more control of the mothers' bodies.[114] But, "unpreventable" maternal deaths were still high, but not the responsibility of physicians.[115]

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[112] Ruth I. Fox, et al. "Determining the Target Population for Prenatal and Postnatal Care." *Public Health Reports (1896-1970)*, vol. 83, no. 3, 1968, pp. 249 – 257. *JSTOR*, www.jstor.org/stable/4593263. Accessed 9 Nov. 2020.

[113] Marmol, J G et al. "History of the maternal mortality study committees in the United States." *Obstetrics and gynecology* vol. 34,1 (1969): 123-38.

[114] Taylor, Morgan. "What Information on Black Female Mortality Rates in the 1950s/60s and Present Day Tells Us About Maternal Mortality". 2018

[115] Marmol, J G et al. "History of the maternal mortality study committees in the United States." *Obstetrics and gynecology* vol. 34,1 (1969): 123-38.

By writing triumphalist narratives like this, it promotes the idea that physicians did all that they could to "cure" the maternal mortality crisis. And, consequently, this places the responsibility for any outliers on mothers.

The discussion around maternal mortality, specifically in larger white-centric publications, focused on glorifying the United States' triumphant defeat of an issue that was not only negatively impacting women and children, but also ruining the U.S.' standing globally, as a scientifically advanced nation. But, in the few publications that did focus on the outliers, the responsibility was put onto the women, and even more, responsibility was put on them if they were Black and/or poor.

Preeclampsia Between 1960-1970

Aforementioned, during the 1960s, the vast amount of attention that had been focused on the maternal mortality crisis had begun to shift. As physicians pushed the idea that they were doing everything possible to prevent maternal mortality and thereby, attributing faults in maternal care to mothers. Consequently, as this happened, the attention physicians, public health officials, and the general public paid towards pregnancy-related complications also diminished. The diminishing attention towards these complications can be traced back to the false belief that maternal mortality had been cured.

When complications were discussed they were discussed in the context of prenatal care. Even so, the conversation had not completely come to a halt. In the 1963 article, “Expectant Moms, Should Guard Against Toxemia”, prenatal care and regular appointments are seen as essential for the treatment of preeclampsia, at the time referred to as toxemia. Thereby, putting the responsibility to prevent and catch preeclampsia on mothers, since, in theory, they should be

in control of what prenatal care they get. By pushing this narrative, the general public is able to forget how societal structures impacts a women's ability to get adequate prenatal care and the individualized narrative is perpetuated.[116]

Overall, the understanding of preeclampsia only improved marginally between 1950-1960. This stagnation points to the shift in focus on maternal mortality, generally, in the U.S. at the time. Furthermore, through the 1960s, we continue to see a monolith approach to maternal mortality and related complications, like preeclampsia. Even though, in previous decades there had been an increased focus on racialized medicine through preeclampsia, during the 1960s, this shifted to focus more on "hiding" the concerns surrounding preeclampsia and maternal mortality, by putting the responsibility on women to prevent preeclampsia.

Black Female Maternal Mortality 1970-1980

In the 1970s, the conversation around race and maternal mortality had dramatically shifted from what it had been in the past two decades. Throughout the 1950s and the 1960s, the conversation around race and maternal morality was predominately focused on racialized medicine and the assumption of Black ignorance, to explain and blame Black women for their poor maternal outcomes. The conversation in the 1970s still involved racialized medicine and Black ignorance, but instead used the ideas to defend the idea that Black women were unworthy of being mothers, at all.

During the Progressive Era, the Eugenics movement had taken off again, and the purpose of it was to stop "unfit" mothers, specifically Black or mothers from lower socioeconomic

[116] Andelman, Samuel L. "Expectant Moms Should Guard Against Toxemia." *Chicago Daily Defender (Daily Edition) (1960-1973)*, Jan 02, 1963, pp. 15. *ProQuest*, https://proxy.library.upenn.edu/login?url=https://www-proquest-com.proxy.library.upenn.edu/docview/493948733?accountid=14707.

background, from having children. And, in the 1970s, ideas from the Eugenics movement continued to be perpetuated. Consequently, the use of contraception was on the rise. The simultaneous occurrences of these two events taking place was not a coincidence. The increasing popularity of using contraceptive, partially, relied on the rise of eugenics and the idea that some women were unfit to have children. The push to prevent "unfit" mothers to have children peaked in the 1970s, specifically targeted Black women.[117]

Throughout the 1970s, government-sponsored family programs increased along with the rise of Medicaid. These programs, specifically those in urban environments, encouraged Black women to use birth control and in some cases, pushed sterilization. Government and public health officials sought to push policy and other initiatives to reduce Black women's fertility. Researchers began to push the idea that if the government financially supported the procreation and delivery of children, that the government should have the them the right to strip parents of the right to produce more. These ideas had a profound impact on the perception of Black women of lower socioeconomic status, who relied on the government's financial support to take care of their children and finance their medical care. And, conjointly with existing attitudes, built off of racism, led to Black mothers being viewed as less than. [118]

The continued diminishment of Black women in the public eye preserved the idea that Black women were to blame for the failure of the Black community and could not be successful mothers. Consequently, during the 1970s, sterilization became the most rapidly growing form of birth control in the United States. This led to Black women being routinely sterilized without

[117] Roberts, Dorothy E. Killing The Black Body: Race, Reproduction, And The Meaning Of Liberty. New York : Pantheon Books. 1997, 56
[118] Ibid, 98

their knowledge. This breach of trust, led to Black women beginning to worry about using family planning programs, because they feared they were a means to racial genocide.[119]

Preeclampsia Between the 1970-1980

Although the conversation around maternal mortality had remained rather muted compared to the 1950s, the conversation around prenatal care and the role it played in the development of toxemia[120] continued, as it prolonged the narrative that mothers were responsible for their infants and their own health outcomes. And, despite the, general, conversation around Black motherhood being centered around stopping Black motherhood, one of the larger conversations among the Black community was centered around preeclampsia.

During the 1970s, the conversation surrounding preeclampsia was not solely taking place in medical circles, it was frequently taking place in the popular media and not just solely women's magazines. Many articles primarily focus on the importance of prenatal care and blood pressure monitoring. During the 1970s, the primary way of diagnosing preeclampsia was still by detecting high blood pressure. And, these publications pushed the idea that all women had the responsibility to go to their physicians to monitor their blood pressure regularly. Continuing the notion that prenatal care was the "universal" cure. Additionally, as the condition became more understood, certain conditions were deemed to intensify the risk of development, including hypertension, kidney issues, age, and other socioeconomic factors. Overall, what these articles did, most of all, was promote heroism among physicians. [121]

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[119] Ibid, 98

[120] Toxemia is also known as preeclampsia

[121] Bryans, Charles I. "The Expectant Mother: High Blood Pressure during Pregnancy."*Redbook*, vol. 136, no. 4, 02, 1971, pp. 20-20, 28. *ProQuest*, https://proxy.library.upenn.edu/login?url=https://www-proquest-com.proxy.library.upenn.edu/docview/1876372131?accountid=14707.

Because the etiology of the disease remained unknown, physicians and public health officials promoted that prenatal care was essential to controlling and understanding preeclampsia, specifically. But, the only known "cures" at the time were early delivery of the baby or in extreme cases termination.[122] These articles[123] do not put mothers at the center of concern. The consequences addressed are focused on infant and therefore, put additional responsibility on the mothers to protect their infants from the consequences of toxemia. [124]

As the relationship between prenatal care and preeclampsia was further discussed, so was race. OBGYNS and Health columnist began to focus on socio-economic status and how it contributed towards the development of preeclampsia. A prime example of this is the article "A Toxic Threat to Your Pregnancy"[125], where women who are unable to get prenatal care are villainized, even though the ability to get proper care is out of their control, since it relates back

[122] "TOXEMIA OF PREGNANCY." *Redbook*, vol. 140, no. 4, 02, 1973, pp. 76-76, 78. *ProQuest*, https://proxy.library.upenn.edu/login?url=https://www-proquest-com.proxy.library.upenn.edu/docview/2016376836?accountid=14707.

[123] Toxemia of Pregnancy and Expectant Mothers: High Blood Pressure During Pregnancy, both have gentle and reassuring tones. From the history of Red Book, it is possible to infer that the target audience for these pieces was middle and upper-class white women, who had access to prenatal care and did not need to be as worried about the socioeconomic factors. The purpose of the article is to bring their attention to a condition that was not well understood, but not to increase their concern exponentially. The introduction of the impact of poor socioeconomic factors serves more to comfort the white mothers reading the article since they do not fall into that demographic. By differentiating how white and Black mothers feel about preeclampsia, also separates the blame and responsibility put on white and Black mothers. Substantiating that Black mothers are more to blame for their poor outcomes.

[124] "TOXEMIA OF PREGNANCY." *Redbook*, vol. 140, no. 4, 02, 1973, pp. 76-76, 78. *ProQuest*, https://proxy.library.upenn.edu/login?url=https://www-proquest-com.proxy.library.upenn.edu/docview/2016376836?accountid=14707.

[125] Unlike Dr. Bryans and Dr. Gorbach's articles, Dr. T.R. Van Dellen, in the Chicago Tribune, from 1973, titled, *A Toxic Threat to Your Pregnancy*, did not provide any of the comforts that the Red Book articles did. Dr. T.R. Van Dellen's article was not being written for a magazine geared towards motherhood or women, due to the brash tone.

to a structural society issue. Black women were especially villainized and thereby characterized to be more predisposed to preeclampsia, because of their inability to get proper care.[126]

Besides theories associated with racialized medicine, that theorized reasons why Black women were more predisposed to high blood pressure and toxemia, during the 1970s, the blame narrative was perpetuated, by placing the blame on Black women for their poor maternal outcomes. In the Black community, the conversation around toxemia/preeclampsia continued to expand, because of how disproportionately it was impacting Black mothers.

Preeclampsia was increasingly being discussed in publications geared towards Black women, like *Essence*. The purpose of these articles was to inform Black mothers about the severity of preeclampsia and the lack of improvements that had taken place over the last 20 years, in terms of understanding and treatment. Since this information, historically, had not been easily accessible to them, because of racial barriers. One *Essence* article profiled a Black neonatal nurse who died from preeclampsia. Her choice to do this calls into question the ignorance stereotype that was often applied to Black women and the reason why they had more complications during pregnancy. [127]

The articles in Black publications provide much deeper information about preeclampsia compared to the articles in white publications, pointing to the fact that many Black women were still unable to receive the same quality of health care as white women due to discrimination, so many of them relied on articles like these to get information about complications like preeclampsia. Furthermore, it is addressed that there is the increased prevalence of preeclampsia

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[126] Van Dellen, T.R. 1973. "How to Keep Well: A Toxic Threat to Your Pregnancy." *Chicago Tribune (1963-1996)*, Nov 04, 1-d9. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/170992857?accountid=14707.

[127] Holmes, Anne. "ECLAMPSIA--A THREAT TO YOUR PREGNANCY." *Essence*, vol. 4, no. 12, 04, 1974, pp. 34-34, 82. *ProQuest*, https://proxy.library.upenn.edu/login?url=https://www-proquest-com.proxy.library.upenn.edu/docview/1815453503?accountid=14707.

in the Black community, even though there does not seem to be a genetic component to the disease. This brings back the common point; namely, the role of wealth. In "Eclampsia – A Threat to Your Pregnancy", Anne Holmes stated that "death from eclampsia is almost unheard of among white middle-class mother…[and] is more prevalent among colored races, but this prevalency may reflect economic and dietary factors rather than genetic susceptibility" and later concluded that it may be a disease of poverty. Holmes, contributes to the Black mother blame narrative, by perpetuating the idea that the prevention of higher rates of preeclampsia in the Black community, hinged on the behavior of Black women and their efforts to break the poverty cycle. [128]

Even though the article does show that the disease is not just a disease of poverty, by profiling the Black nurse, the notion that having a poor economic standing and therefore, having poor living habits, increases the probability of developing preeclampsia, further defends the belief that Black women are unfit to be mothers, because of their poor social and economic standing.

Conclusion

Even though the decades between the 1960s and 1980s were characterized as progressive, in some ways they were far from that for Black women. Although Black people gained more rights overall, these rights did not necessarily guarantee that Black people would receive the same treatment as white citizens. As Black people gained more rights through the passage of different legislation, in the south and the north, Black people were confronted with opposing

[128] Holmes, Anne. "ECLAMPSIA--A THREAT TO YOUR PREGNANCY." *Essence*, vol. 4, no. 12, 04, 1974, pp. 34-34, 82. *ProQuest*, https://proxy.library.upenn.edu/login?url=https://www-proquest-com.proxy.library.upenn.edu/docview/1815453503?accountid=14707.

forces when it came to integrating them into society. This opposing force made it difficult for Black people to reap the benefits of a "white" society.

This disconnect between what was happening in the general public and what was happening in the Black community, becomes incredibly clear when looking at how it played out amongst Black healthcare. Throughout the 1960s, as Black people were supposedly gaining equal access to healthcare, but the quality of health, generally, in the Black community was still viewed poorly. So, the blame had to go on Black people, specifically women, and their innate disregard for hygiene. The perception in the medical and public community, both white-dominated, at the time, was that Black people choose to be in an environment that did not allow them to have good health. This viewpoint ignores the fact that for many Blacks, no matter how much they tried certain aspects of their living they had little to no control over due to systemic racism.

The perception of how Blacks valued their health influences the perception of Black mothers. In the 1960s, maternal mortality was widely considered to have been a problem of the past, as many physicians believed that it had been cured. So, as maternal problems continued to exist amongst Black women, the conversation shifted even more towards blaming Black women for maternal mortality issues in their community. And, as we moved into the 1970s the primary defense was that Black women should not have children, and birth control and sterilization became a primary means of stopping Black women from having children, even if it was against their wishes. In addition to the argument around Black mothers being unfit to mother, there was also a complimentary conversation occurring stating that Black women are more likely to end up in teen pregnancies, and this increases the probability of them having severe complications.

Between the 1960s and the 1970s, the skewed conversation around preeclampsia, demonstrates how dedicated physicians and public health officials were to continue the progress narrative. But by the early 1970s, the conversation around preeclampsia was gaining traction once again, but unlike the way it had in the 1950s, through medical journals, this time it was primarily through everyday sources of media, like the newspaper. But, the conversation taking place was incredibly different depending on the audience.

Generally, the conversation focused on reassuring white women that preeclampsia should not be a pressing concern for them, because they "valued" their health and did not rely on the government for their care, and emphasized that Black women should be concerned, because of their predisposition to the disease. And, therefore physicians, public health officials, and the general public shifted away from just blaming "scientific" reasoning for the reason why Black women were more predisposed to preeclampsia and put additional blaming on Black women themselves for their poor health outcomes.

Chapter Three

Introduction

In the 1980s, the criminalization of Blackness, and specifically Black motherhood continued. And, so did the conversation around how financial status tied to the "right" to be a mother. During the 1970s, sterilization had become the primary form of birth control, particularly among poor Black women.[129] Between 1970 and 1980, the sterilization cases increased from 200,000 to 700,000.[130] And, as sterilization continued to be used throughout the 1980s, specifically among Black southern women, Black women began to further develop a distrust of the medical system.[131] This was speared by the belief among Black women that they were being routinely sterilized without their consent.[132] Along with increased sterilization, the crack epidemic, which took off in the early 1980s, only gave more fuel to the argument that Black women did not deserve to be mothers. Since the crack epidemic was characterized as a Black problem, this along with the idea that Black women were welfare queens, led to policymakers, public health officials, physicians, etc. to continue to push the idea that Black women did not deserve control over their bodies, let alone to be mothers.

The conversation around maternal mortality in the 1980s, continued to ride the coattails of the idea that maternal mortality had been cured. Therefore, as issues persisted, proper attention to mothers was diverted or sugarcoated. In the past, the public conversation around maternal mortality was that the issue was no longer as severe or possibly cured. And, in the 1980s, the conversation diverted to focus on infants, looking at mothers as a side-effect to infant

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[129] Roberts, Dorothy E. Killing The Black Body: Race, Reproduction, And The Meaning Of Liberty. New York : Pantheon Books.1997, 90
[130] Ibid, 90
[131] Ibid, 90
[132] Ibid, 90

mortality. An example of this, is Marcia Saft's 1984 *New York Times* article, "New Effort to Keep Babies from Dying". Saft discussed how infant mortality was rising in larger cities and how this could relate to incompetence among mothers. Even though, Saft does not mention Black mothers in her article, she adds to the Black mother blame narrative. She does this by primarily focusing on urban areas that were characterized for having large numbers of Blacks and enforcing that it is the responsibility of mothers to educate themselves about prenatal and postnatal care. And, goes even farther to solidify that it is not the states problem, because the states can only make resources available, not get women to use them. In doing so, she ignores all of the societal structures that have been put in place to inhibit Black mothers from accessing these resources. And, once again, the conversation around maternal health becomes further removed from mothers and shifts to focus on infants and increase the blame narrative.[133]

Even as the conversation on maternal mortality diminished, the conversation around preeclampsia could not be ignored, because of the impact it had on infants. So, medical and public health officials reframed the conversation to, almost, purely focus on infant health and attribute responsibility to mothers.

As the conversation around preeclampsia expanded in the medical community, widely distributed sources, like female-centric magazines, typically targeted towards white women, continued to further engage in the conversation. In these magazines, authors used their voices to inform expecting mothers about the general dangers, to infants, surrounding pregnancy and some of the more catastrophic complications, like preeclampsia. And, as the issue continued to worsen

[133] Saft, Marcia. "New Effort to Keep Babies From Dying." *New York Times*, 2 Dec. 1984, p. 23, www.nytimes.com/1984/12/02/nyregion/new-effort-to-keep-babies-from-dying.html?searchResultPosition=125.

among Black women, authors in Black female magazines, like *Essence*, began to frequently write articles informing Black women of the concerns uniquely facing them. But, these authors, primarily, used these articles to downplay the concern for mothers and focus on the concerns of infants.

In this chapter, **I will argue that between 1980 and 2000, physicians continued to uphold the prenatal care narrative, directing attention away from maternal care by focusing on infant mortality. Furthermore, the negative mass public views of Black mothers' rights to motherhood, continued to be perpetuated and in tandem provided physicians, public health officials, and the mass public with more evidence for why Black women should be to blame for their poor outcomes.** To make this argument, I will analyze how the medical triumphalist attitude towards maternal mortality in the United States neglected the severity of the crisis. As Black women continued to be villainized in the public eye to make them seem less worthy of motherhood, and their maternal health continued to get worse, the Black community took the matter into their own hands in order to protect mothers.

Black Female Maternal Mortality Crisis 1980-1990

Starting off in the 1970s, Black women were becoming increasingly portrayed as welfare queens by the public media. One of the primary cases of this was the 1986 CBS special, *The Vanishing Family: Crisis in Black America*. Where Bill Moyer focused on how "moral depravity" in the Black community profoundly impacted children through Black mothers. Reports like these did more than characterize Black women as welfare queens, they characterized them as unfit mothers and the source of all Black societal problems. The case of unfit motherhood was built on the idea that Black mothers were reliant on the state, had poor relationships with their children's fathers, and had increased sexual promiscuity and laziness.

These characterizations particularly negatively impacted Black mothers in urban settings. Similar to the Children's Bureau report from 1940, these publications were not a call for help. They were more so used to villainize Black women and, further, remove them from discussions surrounding motherhood, since, they, in the view of popular culture, did not deserve to be mothers.[134]

In the 1980s, the depravity in Black health was undeniable, but the reason behind it remained less clear. The Secretary's Task Force on Black and Minority Health explored this in their 1986 report. The report addressed that in 1984, statistics had come out noting that overall the health and life expectancy for all Americans had continuously been improving, but that the ability to live fulfilling and healthy life was not the same for all Americans. And, the biggest discrepancy was between Black and white Americans. Pointing to the known fact that Black Americans were more likely to experience diseases, disabilities, infant mortality, and have a life expectancy, that was, on average, five years less than white Americans. Similar to reports from the 1940s, 50s, 60s, and 70s, the problem is identified but no plans are proposed for how to address it. Thereby, further emphasizing to the public that it was not the medical community's responsibility to "fix" the issue, since it had been characterized as an individual problem, instead of societal.[135]

Throughout the 1980s, the medical and public health community continued to dismiss any responsibility for the Black health crisis and crafted a narrative that continued to villainize and attribute responsibility to Black people, specifically, Black mothers, by blaming them for all

[134] Roberts, Dorothy E. Killing The Black Body: Race, Reproduction, And The Meaning Of Liberty. New York : Pantheon Books.1997, 151

[135] *Report of the Secretary's Task Force On Black & Minority Health.* Washington, D.C.: U.S. Dept. of Health and Human Services, 1985.

of the health inequalities impacting the Black community. And, concurrently, maternal mortality continued to be a downplayed topic in the U.S.

During the previous decades, there had been a common opinion, specifically in the public health and medical communities, that maternal mortality was an issue of the past. But, in the 1980s, maternal and infant health issues were becoming more apparent, as complications during pregnancy and delivery, like preeclampsia, were becoming exigent. But, as physicians, public health officials, and, generally, reporters, increasingly, discussed the issue they framed it as something that only mothers could control and continued to primarily focus on infant health. And, in 1985, the U.S. Agency published the "Cause for Concern on Infant Mortality", in the *New York Times*.[136] In this study, Rebert Pear explained that there is an emerging problem with infant mortality rates, in the U.S., and specifically among urban Black women. Once again, Black urban women are called out. And, therefore, the responsibility increases on Black women, as the problem of Black infant mortality is individualized and attributed to the behavior of Black mothers.[137]

Between 1979 and 1986, maternal mortality dropped by 32%, but this was still below the goal set in the prior decade. Officials were aware of this "miss" but, were not pressed to put their efforts towards "fixing" it. One example of this, is public health official Lisa Koonin, who reported that this "miss" was no longer a focus for the medical community and, therefore, once again pushes the responsibility away from physicians and onto mothers, citing that unmarried women were more likely to experience maternal mortality, which was highly associated with

[136] Pear's article was featured on the front page, as the center article, on that day's issue of the New York Times. The placement of the article calls to attention how pressing of an issue infant mortality was in the United States, in the 1980s.

[137] Pear, Robert. "'CAUSE FOR CONCERN' ON INFANT MORTALITY SEEN BY U.S. AGENCY." *New York Times*, 5 May 1985, p. 1, www.nytimes.com/1985/05/05/us/cause-for-concern-on-infant-mortality-seen-by-us-agency.html.

Black women. This furthered the narrative that Black women were unfit to be mothers and that women who experienced maternal mortality were more likely to be less educated and not have received proper prenatal care.[138]

The conversation around prenatal care goes hand in hand with the conversation around infant mortality. Both work in tandem to put the responsibility on the mothers, to protect their children from dying and thereby, lower the infant mortality rate in the U.S. In an effort to push attention towards infant care and away from maternal care, conversations around the issue started to separate infants and mothers. Even though, during pregnancy they are essentially one entity. A primary example of this, is the 1982 study on newborn intensive care, by Dr. Nigel Paneth. Dr. Paneth focused on how prenatal care makes pregnancy safer for infants but does not discuss how it affects maternal health and concludes that substantial, prenatal care can effectively lower the probability of infant mortality and the need for infant intensive care units. By leaving mothers out of the narrative, it enables the audience to further distance themselves from the concern of poor maternal outcomes. This shift in attitude leads to the audience, which in this case is the medical community, to focus on infant care. And, it allows them to continue believing that the problem of maternal mortality is "fixed".[139]

Simultaneous to the conversation happening in the medical community, popular media outlets, primarily those directed towards white women, began to address maternal mortality, and

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[138]Pear, Robert. "'CAUSE FOR CONCERN' ON INFANT MORTALITY SEEN BY U.S. AGENCY." *New York Times*, 5 May 1985, p. 1, www.nytimes.com/1985/05/05/us/cause-for-concern-on-infant-mortality-seen-by-us-agency.html.

[139] Paneth, Nigel,M.D., M.P.H., Kiely, John L,M.A., M.Phil, Sylvan Wallenstein PhD., Michele Marcus M.P.H., Pakter, Jean,M.D., M.P.H., and Susser, Mervyn, MB, BCH,D.P.H., F.R.C.P.(E.). 1982. "Newborn Intensive Care and Neonatal Mortality in Low-Birth-Weight Infants: A Population Study." *The New England Journal of Medicine* 307 (3) (Jul 15): 149-155. doi:http://dx.doi.org.proxy.library.upenn.edu/10.1056/NEJM198207153070303. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1872273138?accountid=14707.

continued to spin the story to focus on infant mortality. For example, Maria Hunt wrote an article[140] for *Good Housekeeping*, focused on emphasizing that pregnancy was a bigger risk for infants than mothers and that mothers were gambling their infants' lives. In 1988, *Good Housekeeping* and *Parents* magazine both published articles directed towards pregnant women, presumably white, about the dangers pregnancy posed to their infants. But, the inability to explain why pregnancy is a higher risk for infants and a gamble of their lives, brings to light a number of questions, the primary one being does pregnancy, generally, put a mother or baby at a greater risk?[141]

Describing the varying levels of risk between infants and mothers, was a large conversation in the 1980s. Looking at Paula Hillard's article, in *Parents Magazine*, she discussed how some pregnancies are a bigger risk than others. These articles dash the notion that pregnancy is natural and, therefore, safe. They also aid in increasing buy-in that pregnancy is worse for infants than mothers, by focusing on the worst infant outcomes, like premature birth, stillbirth, neonatal death and miscarriages. Therefore, explicitly telling the audience that pregnancy is putting infants' life at risk but not the mothers. Hunt's inability to identify why the risk for infants is more important than the risk for mothers, brings into question, if there is a difference between the two or if it is an attempt from the medical community and general community to deter focus on mothers?[142]

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[140] At the center of the article is a picture of two infants. Bringing the reader's attention to infant health and putting maternal health in the background. Additionally, the headline of the article is that mothers know they are putting their lives at risk, but did not realize what danger they were putting their infants in.
[141] Maria, Vida Hunt. 1988. "THE BIGGEST GAMBLE OF ALL." *Good Housekeeping*, 07, 54-57. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1896260765?accountid=14707.
[142] Paula, Adams Hillard. 1988. "High-Risk Pregnancy." *Parents*, 09, 160-160, 162. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1898983042?accountid=14707.

In a further effort to individualize the problem, there is a general heightened expectation that women should be able to prevent poor outcomes, by having a prior knowledge of their pre-existing conditions. In the 1980s, it was widely understood that preexisting conditions like high blood pressure and diabetes increased the risk of negative complications and outcomes in pregnancy. Continuing the conversation around the importance of prenatal care, sources like Hillard's article, focus on methods to protect infant health and essentially, ignore the mothers'. The focus on infant health is extremely clear when Hillard addressed preeclampsia and the only negative impacts she addresses are preterm labor or miscarriage. These sources are intended to encourage women with pre-existing conditions, to reconsider getting pregnant. Once again, putting the responsibility on mothers to not only protect their health while pregnant but, also, their future children's. [143]

The legitimacy of the maternal mortality crisis in the U.S. continued to face challenges concerning recognizing the severity of the issue. And, the female Black community continued to face the combined effects of the poor view of Blacks and the, general, disregard towards the maternal mortality crisis. The effects of these conversations spread outside of targeting adult Black women but, to target Black adolescent females. In the 1980s, commentators were increasingly discussing how the poor ethics of Black women were influencing Black female teenagers and leading them to get pregnant more than white female teenagers. In Luchina Fisher's article, "Cutbacks Pose a Threat to Pregnant Black Teens", the idea of Black dependency on the government plays a central role. Similar to the CBS special focused on Black mother maternal mortality, they work together to create the narrative that the Black community

[143] Paula, Adams Hillard. 1988. "High-Risk Pregnancy." *Parents*, 09, 160-160, 162. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1898983042?accountid=14707.

has allowed itself to become reliant on the government and this has led to poor health in the Black community.[144] This argument around the reliance on the government connects to an increase in Black teen pregnancy, because the poorer the Black family is the less likely the family will have proper "morals", because they are more likely to rely on the government and this will lead to teens getting pregnant. Further making it a Black issue, that only Black mothers can solve.[145]

Moreover, during the 1980s, Black writers were using Black popular media sources to bring attention to Black female health, since it was, often, ignored in most popular media sources. Similarly, to how *Parents Magazine* and *Good Housekeeping* were providing information for white women, *Essence Magazine* played a similar role for Black women. Throughout the 1980s, *Essence Magazine* published a collection of articles focused on the hardships of pregnancy for Black women and actions Black women could take to combat them. Many of these articles were used to provide Black women with the knowledge, that presumably, a physician would have provided them. The necessity involved in writing articles like these, points to the inequity in care that Black women were receiving in white medical systems. Articles like these, on the surface, seem only beneficial as they equip Black women with the tools they need to improve their care. But, in reality, they are also perpetuating the "individualized" conversation, by telling Black women that they can have "safe" pregnancies if, they go out of their way and take on more responsibility. [146]

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[144] Fisher, Luchina. "Cutbacks Pose Threat to Pregnant Black Teens." *Black Ink*, 4 May 1986, p. 7.
[145] Ibid
[146] Lillian, Frier Webb. 1987. "Surgery during Pregnancy?" *Essence*, 01, 18. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1876750649?accountid=14707.

This further defends the idea that Black inequalities in health are a Black problem that only Black women can solve.

Preeclampsia 1980-1990

Mekdes Taylor had already had four children before 1986, and those four children had been born in Ethiopia before she had immigrated to the United States. Upon immigrating to the U.S. Mekdes knew that race was going to impact her life in a way it never had in Ethiopia. But, the reality she faced was more than she had mentally prepared for once she got to the United States. And one of the catalyzing experiences she had that led to these expectations was the birth of her two next children.[147]

In 1986, Mekdes became pregnant with her next child. At this time, she was living in Brewster New York with her three older children and her husband. Upon reflection, Mekdes noted that "[she] was aware that she had access to a different type of privilege than the average Black women at the time". And, this was due to her socioeconomic status and the resources that afforded her during her pregnancy. But, even her privilege could not protect her from the complications that awaited her. Her pregnancy was classified as high risk early on due to age, hypertension, and excess bleeding, which led her to be hospitalized three times. Due to this throughout her pregnancy, she stayed close to her physicians and demanded constant care. Luckily for her, the medical team she encountered throughout this pregnancy was relatively understanding, but Mekdes believed that her financial status played a large role in the treatment that she received and still strongly believes that if she did not have that status that she would not have made it through the pregnancy.[148]

[147] Mekdes Taylor, [Oral History Interview with Author], June 24th, 2020
[148] Mekdes Taylor, [Oral History Interview with Author], June 24th, 2020

But, her financial status was not able to provide her as much comfort during her next pregnancy in 1988. Similarly, to the last one, she was classified as high-risk due to age, hypertension, gestational diabetes, and bleeding once again. But contrary to her previous pregnancy, this one had far more complications. Up until she was twelve weeks pregnant, she was still getting a regular period and only found out she was pregnant because she had the symptoms of pregnancy and eventually went to see her physician, where she found out she was already four months pregnant. From that point on the trouble only got worse. Throughout her pregnancy, she went to the emergency room multiple times as the bleeding continued to get worse, and upon admission, multiple times, she was greeted by disdain and unpathetic attitudes by the hospital staff where she was told that her issues "were not anything serious", that her concerns were "unwarranted", and that she was "lucky that her baby was not stillborn". All of these comments were the last thing a pregnant concerned woman needed to hear as she was entering the hospital with severe bleeding and fearing for her baby and her own life. She had initially chosen to go to a university hospital in New York City, because she feared that the local hospital, in a predominately white area, would not treat her correctly due to her race. But, even in more diverse settings, she continued to deal with hardships due to her race. Throughout the pregnancy, physicians were unable to diagnose the underlying issue that was leading to a laundry list of complications and instead focused on just treating the immediate issues and observing.[149]

The inability to address the overall issue led to Mekdes delivering eight weeks early in a hospital in Allentown, Pennsylvania while on vacation in the Poconos. She was admitted, because she had become experiencing extreme bleeding due to a placenta abruption and low hemoglobin which was leading to her bleed out. Upon being admitted she noticed that for the

[149] Mekdes Taylor, [Oral History Interview with Author], June 24th, 2020

first time everyone in the hospital staff was white and that she was an anomaly to them. On top of the life-threatening complications she was facing, she remembers the whole experience as "weird". She and her daughter spent five weeks in the hospital receiving treatment, and whenever her husband or other family members could not be there she remembers being constantly questioned. Nurses made fun of her, because of her name, her accent, and questioned her about her African heritage, because she did not look like the stereotypical image with a "plate in her lips".[150]

Mekdes attributes her and her children's survival during both of these pregnancies to three things, her socioeconomic status in the U.S., her confidence, stemming from her educated background, and her advocates. Without these factors, Mekdes believes that the outcomes of her pregnancies would have been very different. Additionally, at the end of both pregnancies, she never found out what the underlying issue was that attributed to her extreme complications and now wonders if she could have been experiencing preeclampsia. But, a combination of the healthcare systems' disregard for women of color, missteps around caring for women with complications during pregnancy, and lack of knowledge around preeclampsia, were all contributing factors to the horrific experience Mekdes Taylor had.[151]

Through the course of the 1980s, the conversation around hypertension during pregnancy and preeclampsia was growing, and it was being discussed more in medical journals and popular media outlets. In the 1980s, the understanding of preeclampsia was incredibly loose, by definition it involved high blood pressure after 20 weeks of gestation.[152] But, it was clear that it

[150] Mekdes Taylor, [Oral History Interview with Author], June 24th, 2020
[151] Mekdes Taylor, [Oral History Interview with Author], June 24th, 2020
[152] Breathett, Khadijah, et al. "Differences in Preeclampsia Rates Between African American and Caucasian Women: Trends from the National Hospital Discharge Survey." *Journal of Women's Health*, vol. 23, no. 11, 2014, pp. 886–893., doi:10.1089/jwh.2014.4749.

was a major issue as it was noted, by Dr. Leon Chesley PhD[153], as the leading complication in the United States. But when discussed, the discussion primarily focused on how it negatively impacted infants.[154]

The conversation happening in popular media outlets mirrored this. Articles in *Parents' Magazine* emphasized the increasing risk preeclampsia posed infants but, also, emphasized that it could be "cured".[155] The centerpiece of articles, like Hillard's "Preeclampsia", is monitoring high blood pressure. Once again tying back to the conversation around the importance of prenatal care. Additionally, pushing the idea that failure to correctly monitor high blood pressure is neglect on behalf of mothers and not physicians. But, while this idea is perpetuated, the conversation around barriers to access is, widely, ignored.[156]

There continued to be an air of mystery surrounding the understanding of preeclampsia, through the 1980s. The focus on monitoring high blood pressure and neglect on behalf of mothers, was used to instill a sense of fear and guilt in mothers, by identifying preeclampsia as a "disease of neglect",[157] and not neglect on the part of physicians, but on the part of the mothers "who do not understand the importance of regular parental visits" or are not able to identify possible symptoms. [158] The idea of a "disease of neglect", further perpetuates the triumphalist narrative surrounding the physicians, as it explains that the goal is "regular prenatal care", where

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[153] The Journal of Nurse-Midwifery, is different from other obstetric medical journals, because it is catering to the interest of nurses and midwives, a group typically seen as more progressive.
[154] Chesley, L. "Hypertensive Disorders in Pregnancy." *Journal of Nurse-Midwifery*, vol. 30, no. 2, 1985, pp. 99–104., doi:10.1016/0091-2182(85)90116-8.
[155] Paula, Adams Hillard. 1983. "Preeclampsia." *Parents*, 02, 82-82, 85. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1866665402?accountid=14707.
[156] Paula, Adams Hillard. 1983. "Preeclampsia." *Parents*, 02, 82-82, 85. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1866665402?accountid=14707.
[157] Ibid
[158] Mekdes Taylor, [Oral History Interview with Author], June 24th, 2020

physicians can "solve" the problem and, concurrently, perpetuates the idea that Black women are simultaneously the only ones who can solve the problem but are too ignorant to.

In combination with the idea that preeclampsia was a "disease of neglect", there was also a push to oversimplify the complications. This was done to perpetuate the triumphalist narrative surrounding physicians and the blame narrative surrounding mothers, by emphasizing the importance of prenatal care. This oversimplification is done by diminishing the concerns of the mothers by making the maintenance of complications during pregnancy sound simple, by saying it was just about being aware, being a healthy weight, having a healthy diet, and having a physician. Which from Mekdes' experience, we know are not necessarily the generic prescriptions needed for a healthy pregnancy. Since, Mekdes had access to physicians and was doing everything possible to take care of her physical condition.[159] Nevertheless, many, like Hillard, maintains the defense that maintaining a healthy pregnancy relies on those steps, which revolve around the responsibility of mothers. This plays into the general narrative around maternal health, at this time, focusing on the infant. Instead of addressing all of the ways that hypertension can negatively impact the mother, Hillard focused on all the ways that hypertension can negatively impact the infant.[160]

In many of the articles published by public officials and popular media, like *Parents Magazine*, there is consistent discrepancy around understanding preeclampsia, highlighting high levels of confusion. A primary example, are two articles written by Hillard four years apart. In one, she emphasized all the extreme dangers associated with the complication and in the latter,

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[159] Mekdes Taylor, [Oral History Interview with Author], June 24th, 2020

[160] Paula, Adams Hillard. 1988. "Hypertension and Pregnancy." *Parents*, 08, 157-158. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1896234893?accountid=14707.

she promoted the diminishing narrative surrounding maternal health. But, what is consistent is the promotion of the triumphalist narrative and the lack of advice geared towards women, as to how they can take steps to understand their health and protect it. And, overall putting the responsibility on mothers to get prenatal care to protect their infants' health.

Along with the increasing publications surrounding hypertension and preeclampsia during the 1980s, the conversation around race and preeclampsia continued to be addressed. Physicians and public health officials worked to perpetuate the idea that biological differences were the cause of higher occurrences of preeclampsia in Black women, but they struggled to develop evidence to defend this claim. As a result, researchers at the time turned to look at Black women's actions and used these to defend why there were higher rates of preeclampsia among Black women. One of the primary faults attributed to Black women, was their lack of knowledge, generally, around maternal health, and specifically, about preeclampsia. Even though it is possible that many Black women did lack information about preeclampsia, researchers at the time applied that, general, assumption to all Black women to defend the legitimacy of the Black female blame narrative.[161]

The conversation amongst physicians and regular individuals about what causes this disparity continued, throughout the 1980s. In the medical community, like in Dr. Baha Sibai's article, it is promoted that the understanding of preeclampsia is improving, like the identification of HELLP syndrome. But, another common discussion in the media was the discrepancy in statistics between Black and white women in the U.S. but, there is a lack of concrete evidence as to why this exists. But, so many physicians, like Dr. Sibai, still play into the historical

[161] Breathett, Khadijah, et al. "Differences in Preeclampsia Rates Between African American and Caucasian Women: Trends from the National Hospital Discharge Survey." *Journal of Women's Health*, vol. 23, no. 11, 2014, pp. 886–893., doi:10.1089/jwh.2014.4749.

conversation of scientific racism, by stating that race influenced the way preeclampsia impacted women of different races.[162]

In 1985, it was identified that Black women were two to three times more likely to develop chronic hypertension but, that the incidences of developing it across the two races were relatively similar. And, therefore, Black women were identified to be more likely to die from preeclampsia. But, physicians continued to struggle explaining the differences between outcomes from preeclampsia between Black and white women. And, some physicians, like Dr.Chesley, concluded that there was no clear evidence as to why Black women are more likely to experience severe cases and/or die from preeclampsia and that it may be connected to the fact that there is still a substantial knowledge gap around preeclampsia, which consequently makes treatment less effective. But, the main premise of the argument was that it was up to mothers to understand their genealogy and history so that they will not get pregnant if they have preeclampsia.[163]

Black Female Maternal Mortality Crisis 1990-2000

After Robin Smith married her husband in the 1980s, she and her husband tried to get pregnant for six years and struggled to get pregnant, but in 1993 she successfully got pregnant. Because she had struggled to get pregnant for so long, she and her husband wanted to do everything possible to protect the pregnancy. So, she decided to go with a Black male physician who she felt put his patients' care above everything. Her experience with her physician turned out to be a positive one as she felt like her physician's race played a key role in the positive

[162] SIBAI, BAHA, et al. "Pregnancy Outcome in 303 Cases With Severe Preeclampsia." *Obstetrics & Gynecology* 64.3 (1984): 319-325. Journals@Ovid Full Text. Web. 30 June. 2020. <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=ovfta&NEWS=N&AN=00006250-198409000-00004>.

[163] Chesley, L. "Hypertensive Disorders in Pregnancy." *Journal of Nurse-Midwifery*, vol. 30, no. 2, 1985, pp. 99 – 104., doi:10.1016/0091-2182(85)90116-8.

treatment that she received. But, outside the four walls of her physician, her race did negatively impact the treatment she received while pregnant. When she went into labor and went to the emergency room she was seen by a nurse who she described to be "nasty, mean and horrible". When Smith expressed her concerns and the fact that she was nervous, the nurse coldly responded that "it was just a baby" and that she could relate, because she had a cat. The poor treatment went beyond being emotionally hurtful, the nurse also physically hurt her by inserting her catheter in aggressively and wrong. Throughout the time Smith was with the nurse, she knew that the nurse was treating her badly, because of her race and when she reported it to her Black physician, the physician immediately stopped allowing her on his service.[164]

In the 1990s, the general public continued to have negative opinions of Black people, due to negative attitudes initially developed in the mid-1960s, like those that assumed that Black people, overwhelmingly, abused government assistance programs. In a study from 1990, it was that found that 78% of white Americans believed that Blacks preferred to live on welfare. This attitude towards Blacks taking advantage of the government and being unable to sustain themselves, extended past traditional welfare programs but, also infiltrated the way medical professionals, public health officials, and the general public perceived Black women on Medicaid.[165]

Not only did the perception of Black women continue to get worse throughout the 1990s, but the perception of Black children also continued to worsen. The media began to portray Black children as, not only, being susceptible to corruption from their mothers but, also incapable of contributing anything positive to society, further fueling attitudes to not protect Black lives. All

[164] Robin Smith, [Oral History Interview with Author], July 1st, 2020
[165] Roberts, Dorothy E. Killing The Black Body: Race, Reproduction, And The Meaning Of Liberty. New York : Pantheon Books.1997, 17-152

of this came to a head as government officials and medical practitioners began to portray Black reproduction as a crime. Throughout the 1990s, there were multiple cases of Black women who were on welfare, being offered the option to either get Norplant, an implant used for birth control, or serve a longer prison sentence. Using contraception as a means to get out of federal punishment, further enforced that the idea that the government should have control over Black women's bodies, because they were incapable of making responsible decisions on their own.[166]

Attention continued to be directed towards infant mortality, in the 1990s and placing blame on mothers for their infants' health, as well, became more solidified. In 1991, President Bush worked to campaign to raise funds to fight against infant mortality. But, both sides of Congress ultimately rejected the proposal. Bush's proposal focused just on financing infant care, at the expense of general maternal care.

If Bush's plan had been approved by Congress, funds that were originally intended to go to underwrite programs for pregnant women and poor children, would have been reallocated towards, just, funding efforts to eliminate infant mortality in the United States, leaving vulnerable pregnant women without proper care and, further, fueling maternal mortality. Even though, Bush's initial campaign did not get approved by Congress, Congress did eventually appropriate $25 million towards infant mortality during that fiscal year. This campaign is the prime example of how the government, public health officials, medical practitioners, and the general public were separating maternal care from infant care, and making the mothers' health secondary to the infants.

Sonja Smith was born in 1958, and when she got pregnant in 1995, she could still remember the stories her mother had told her about her experience in the segregated hospital while

[166] Roberts, Dorothy E. Killing The Black Body: Race, Reproduction, And The Meaning Of Liberty. New York : Pantheon Books.1997, 17-152

pregnant. So, Smith was always focused on having Black care, meaning having Black physicians looking after her. So, previous to her pregnancy she found a Black female OBGYN in New York City. She developed a longstanding relationship with this OBGYN and felt like this allowed her to truly understand what Smith needed from a physician and what her medical concerns were. So, when Smith became pregnant for the first time in 1985, she was incredibly confident in the care she would receive. But, like Smith, when she was separated from her physician her experience took a radical turn for the worst.[167]

When Smith was admitted to the hospital to deliver her first son, her physician was on vacation but another practitioner from her physician's practice was able to deliver her son and through her delivery, she had a good experience. But, once she had delivered, the level of care she received downgraded. Leading up to her pregnancy Smith had arranged to be in a semi-private room, but after her delivery, she was not taken there. Instead, she believes that the nurses put her into the communal ward after pregnancy, because they assumed that she was a lower socioeconomic woman on Medicaid, because of her race and therefore could not afford to be put in a semi-private room. During her time in the communal ward, she felt like the nurses treated her like a second-class patient and very coldly. One of the primary ways they did this was by waking her up when she was trying to rest and then guilting her into feeling like an inadequate mother, because she was tired and not prepared to do everything for her baby. But, when her primary OBGYN, eventually, arrived at the hospital, her physician immediately corrected what had been done wrong. She was moved into her semi-private room and had hands-on personal care from that point on. Upon getting out of the hospital Smith saw an article in the *New York Times* about well-off Black women receiving substandard treatment in hospitals.[168]

[167] Sonja Smith, [Oral History Interview with Author] July 3, 2020
[168] Ibid

As the conversation surrounding, general, maternal mortality and maternal care continued to shift during the 1990s, towards infant mortality, the conversation around Black female maternal mortality also continued to develop, as lack of responsibility and poor socioeconomic status were used to blame Black women for their poor medical outcomes. Articles, like Dr. Kathy Sanders-Phillips, further perpetuated the necessity of prenatal care and negligence on behalf of women who did not receive proper treatment. Furthering the idea that increased prenatal care was the primary form of preventing infant mortality, for all mothers, that originally developed in the 1960s. What these articles add to the conversation, is that minority women are two to three times more likely to seek out prenatal care in later stages of pregnancy or not at all. This can be due to a lack of finances to afford adequate care and a lack of trust in the medical system, which puts them and their infants at greater risk.[169]

Along with scholars engaging in the conversation around Black maternal and infant mortality, widely read publications, like the *New York Times*, began to cover Black female maternal mortality more. The increased conversation, in sources like the *New York Times*, illustrates that Black female maternal mortality was becoming an issue more widely discussed about in the white sphere. Articles, like Sheryl Gay Stolberg's "Racial Divide Found in Maternal Mortality", address the long-standing issues around Black maternal mortality, but portray it as if the issue is new. Thereby, ignoring the fact that Black women had, historically, been given the primary responsibility for their health so that the problem could not be seen as the responsibility of the physicians. Articles like these, bring to light that Black women are four times more likely to die than white women, a statistic first noted in 1945, and that the three leading causes of this

[169] Sanders-Phillips, K, and S Davis. "Improving prenatal care services for low-income African American women and infants." *Journal of health care for the poor and underserved* vol. 9,1 (1998): 14-29. doi:10.1353/hpu.2010.0364

are preeclampsia, hemorrhage, and embolism.[170] But, what is missing in these articles, is that these long-standing issues had been ignored over the past 50 years and what the consequences of that are.[171]

One major shift that took place in the late 1990s, was the incorporation of the Black female voice, but certain negative characterizations remained the same. In Stolberg's article, "Black Mothers' Mortality Rate Under Scrutiny", she uses the story of a mother Deborah Edwards to explain the situation. The incorporation of the Black female voice is important, because it gives Black women the platform to share their story. But, in Stolberg's article uses the Black voice to perpetuate historical trends and put responsibility on Black mothers instead of long-standing inequalities. Stolberg contributes to the skewed narratives that Black women are a homogenized group, incapable of responsibility and monitoring their health. The general negative connotation surrounding Black mothers remains pervasive, like having poor health, relying on government and being ignorant.[172]

Physicians, public health officials, and reporters who focused on public health, like Stolberg typically put the responsibility of poor MMR on women but, put additional pressure and responsibility on Black women for their even worse MMR. They did this by villainizing Black women and making it sound like it was their fault for their deaths, by attaching it to things that

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[170] Stolberg, Sheryl Gay. "Racial Divide Found in Maternal Mortality." *New York Times*, 18 June 1999, p. 24, www.nytimes.com/1999/06/18/us/racial-divide-found-in-maternal-mortality.html?searchResultPosition=8.

[171] Stolberg, Sheryl Gay. "Racial Divide Found in Maternal Mortality." *New York Times*, 18 June 1999, p. 24, www.nytimes.com/1999/06/18/us/racial-divide-found-in-maternal-mortality.html?searchResultPosition=8.

[172] Stolberg, Sheryl Gay. "Black Mothers' Mortality Rate Under Scrutiny." *The New York Times*, The New York Times, 8 Aug. 1999, www.nytimes.com/1999/08/08/us/black-mothers-mortality-rate-under-scrutiny.html?searchResultPosition=5.

only they could "control" like their weight, nutrition, age, and health. And, because of the lack of testimony, there is little evidence to combat this depiction.

The conversation around Black female maternal mortality continued to develop within the Black community. Through the 1990s, Black writers continued to publish articles in *Essence* that encourage Black women to educate themselves, so that they can combat their physicians' short-fallings. Again, blame and individualistic attitudes masquerade as advice. But, some of these articles also pull the "rosy curtain" away for Black mothers and force them to acknowledge the unique position they hold in society, for example, facing discrimination in the work place, because of their gender and race. Holding this unique position leads to them incurring additional stress that can only negatively impact their pregnancies.[173]

Preeclampsia 1990-2000

Throughout the 1990s, and approaching 2000, the focus away from maternal mortality and onto infant mortality continued and became even more prevalent when looking at literature on preeclampsia. In addition, to the focus around maternal health dissipating, there was a lack of new knowledge developing surrounding preeclampsia. Throughout the 1990s, the tactics for treating preeclampsia remained relatively the same as physicians continued to focus primarily on hypertension and the idea that the primary form of treatment was delivery. The one substantial development that occurred was that the classification of preeclampsia was updated. Preeclampsia had previously been grouped under a hypertensive disorder associated with pregnancy, the revision grouped it under pregnancy-related hypertension. And, even with this change in

[173] "Fighting Pregnancy Discrimination." 1996.*Essence*, 03, 48. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1876778245?accountid=14707.

classification, the primary treatment methods remained the same, and the primary responsibility remained on the mothers.[174]

Through the 1990s, there continued to be a stunting in knowledge around preeclampsia. This is evident in Dr. Joyce Roberts[175] article, that addressed that the most troubling aspect of the disease is the lack of understanding around it. This awareness around the lack of knowledge led to a higher reliance on prenatal care as the main way to prevent severe cases. And, by 1994, it was already determined that any test that had been developed by this time were insufficient and were unable to provide any substantial evidence of success. Moreover, a similar idea remained concerning the relationship between race and preeclampsia. Even though there was a lack of evidence it was still strongly upheld that Black women were more likely to succumb to preeclampsia, because of their personal choices.[176]

When Dr. Lisa Brooks got pregnant with her first child in 1997, she felt confident in what her pregnancy experience was going to be, but she still wanted to take certain measures into her own hands. So, she ended up seeing a Black male physician. Brooks described her pregnancy as being relatively uncomplicated, besides her excessive weight gain and finding out that she was borderline diabetic during her fifth month. But, at her last check-up with her physician before delivery things deteriorated quickly. When she went in for her appointment her physician noticed

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[174] Bell, Mandy J. "A historical overview of preeclampsia-eclampsia." *Journal of obstetric, gynecologic, and neonatal nursing : JOGNN* vol. 39,5 (2010): 510-8. doi:10.1111/j.1552-6909.2010.01172.x

[175] Dr. Joyce Roberts was a nurse and midwife who holds a PhD. She was the President of the American College of Nurses and Midwives, a member of the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN), Sigma Theta Tau, a Fellow in the American Academy of Nursing and of the American College of Nurse-Midwives. She served on NIH Research review panels, was on the Board of the National Perinatal Association, as a member of the ACOG Committee on Obstetrics, was on the Medical Health Advisory Board of the Society for the Advancement of Women's Health Research, the Advisory Board of the Frontier Nursing Service, and was on the National Commission on Nurse-Midwifery Education that was convened by ACNM.

[176] Roberts, J. "Current Perspectives on Preeclampsia." *Journal of Nurse-Midwifery*, vol. 39, no. 2, 1994, pp. 70 – 90., doi:10.1016/0091-2182(94)90015-9.

that her blood pressure was dangerously high and was immediately sent to the hospital where she was diagnosed with preeclampsia. By the time she got to the ER, her blood pressure had gotten drastically worse, and her physician decided that she had to be induced, because delivering the baby was seen as the only way to get her blood pressure under control. But, even after delivery, her blood pressure got even worse and she was put into a medically induced coma for 72 hours. During this time, what should have been a happy moment was a moment felt with fear, because her family did not know if she was going to make it or not. When reflecting on this experience she noted that the main thing she learned was that you cannot always listen to doctors even when you trust them and that you need to listen to your own body and be proactive about measuring your health.[177]

Conclusion

Since the end of the 1950s, physicians and public health officials projected the narrative and claim that maternal mortality was no longer an issue. In the 1980s, as complications surrounding maternal mortality were becoming unignorable, instead of turning the focus back to maternal mortality, physicians and public health officials shifted to focus on infant mortality. And, in doing so. they put additional blame on mothers to "fix" the infant mortality crisis.

Moreover, the villainization of Black mothers in the public eye continued. This villainization was spurred by the preconceived notion that Black mothers were nonmaternal figures. And even if they were, they were “welfare” queens, unable to provide for their care and their eventual children.[178] The foundation of this villainization originated in the 1960s, and when it did it

[177] Lisa Brooks, [Oral History Interview with Author], June 20th, 2020
[178] Roberts, Dorothy E. Killing The Black Body: Race, Reproduction, And The Meaning Of Liberty. New York : Pantheon Books.1997, 17-152

primarily stayed within the public health community, but by the 1980s, the conversation became widely known within the general public. This conversation could enter homes, particularly wealthy white homes, when the CBS news segment aired in 1986.

From this point, the conversation continued to expand to encompass Black children as well. A variety of scholars and commentators on the problem extended the initial diagnosis that Black mothers were unfit mothers to encompass the failure of Black children. This was rationalized at the time by stating that the negative characteristics of Black mothers were passed onto Black children through pregnancy and then raising the child, therefore the children were, almost, by default degenerate. Some scholars took this analysis to mean that Black children were unable to contribute anything positive to society.[179]

This belief tied in with the historical notion that Black mothers were not equivalent to white mothers, creates a powerful defense for the lesser treatment of Black mothers in the United States medical system. In addition, to the developing attitude that Black mothers were unfit to be mothers and that their children were not positive additions to society, the general attitude that focused on infant mortality, also further allowed the treatment of Black mothers to be even more subpar. This is seen through the testimonies of Mekdes Taylor, Robin Smith, Sonja Smith and Dr. Brooks, where their concerns and symptoms were often made light of until they got to a drastic point or another superior physician stepped in to advocate for them.

[179] Roberts, Dorothy E. Killing The Black Body: Race, Reproduction, And The Meaning Of Liberty. New York : Pantheon Books.1997, 17-152

Chapter Four

Introduction

In the 2000s, the venture to depict Black women as the villains of American society continued. In tandem, the well-established motive to deter responsibility from physicians and the maternal mortality crisis carried on. But, unlike in the past decades, in the 2000s, the rise of the advocates' voice began to break through, in an effort to shift the individualized blame narrative surrounding Black female maternal mortality.

Throughout the previous decades, medical professionals, public health officials, and the broader public had the misconception that maternal mortality was not an issue in the U.S. or at least was not a pressing one. They, commonly, saw it as a foreign issue that only had a significant effect on developing countries. This perception of maternal mortality would not shift until after 2010, when it became impossible to ignore that maternal mortality was a public health issue in the United States.

Over the past two decades, physicians were concerned about preeclampsia, because of the negative impact it had on infants. And, in 2000, the pressing concern became centered around the fact that there was still a profound lack of knowledge around the etiology and treatment of the disease. Due to this, most of the treatments for the disease were more reactive than preventative.[180] Up until 2016, physicians primarily relied on high blood pressure and proteins in urine to make the diagnosis for preeclampsia, but this was extremely limiting and left many women without proper care or diagnosis.[181]

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[180] Bell, Mandy J. "A historical overview of preeclampsia-eclampsia." *Journal of obstetric, gynecologic, and neonatal nursing: JOGNN* vol. 39,5 (2010): 510-8. doi:10.1111/j.1552-6909.2010.01172.x

[181] Website. "Home - Preeclampsia Foundation." *Preeclampsia Foundation - Helping Save Mothers and Babies from Illness and Death Due to Preeclampsia*, 2020, www.preeclampsia.org/.

Among medical professionals and the broader public's understanding of preeclampsia, the relationship between blood pressure and race was still highly contested, in the early 2000s. Historically, there had been long-held assumptions that Black people naturally had higher blood pressure, than white people, and therefore, were more susceptible to blood pressure complications.[182] These long-held beliefs within the medical community and the broader public were founded on racialized medicine.

One of the sources of this long-held belief is the slavery hypothesis. In 1983, the slavery hypertension hypothesis was proposed by Dr. Clarence Grim and Dr. Thomas Wilson[183], and in 2007, the hypothesis was renewed when Oprah and Dr. Oz confirmed the legitimacy of the hypothesis. The basis of the hypothesis is that Africans who survived the middle passage were able to do so by holding more salt in their bodies, and this elevated their blood pressure permanently.[184]

By 2011, the slavery hypothesis had been debunked by scientists and medical professionals. But, scholar, Dorothy Roberts explains that, even so, many other scientists, medical professionals, and, even, the general public are still quick to defend the theory. [185] And, because of the number of scholars who still defend it, it is still mentioned in several medical textbooks, without reference to the refutation. [186] The attachment to the slavery hypothesis

[182] Roberts, Dorothy E. Killing The Black Body: Race, Reproduction, And The Meaning Of Liberty. New York: Pantheon Books, 1997.
[183] Clarence Grim was a physician who studied hypertension in the white and Black community, and Thomas Wilson was a physician who studied racialized medicine.
[184] Roberts, Dorothy E. *Fatal Invention: How Science, Politics, and Big Business Re-Create Race in the Twenty-First Century*. 2011, 113
[185] Roberts, Dorothy E. *Fatal Invention: How Science, Politics, and Big Business Re-Create Race in the Twenty-First Century*. 2011, 115
[186] Ibid, 115

reveals how racialized medicine continues to infiltrate out modern healthcare system and impact Black people and, specifically, Black mothers.

The compound effects of the historical schools of thoughts surrounding race, laid the groundwork for the modern Black female maternal mortality crisis. Many physicians, specifically between 2000 and 2015, have been against the idea that implicit bias impacts the care they give or contributes to racial disparities in health. Even though, there were studies, like Brian Smedley's report *Unequal Treatment*, that provided comprehensive evidence that health disparities corresponded to the unequal treatment minorities received from medical professionals in the U.S. Showing the medical communities need to hang onto the individualized Black female blame narrative, even when evidence showed that the blame was not theirs to bear. [187]

During the early 2000s, as the maternal mortality crisis in the United States continued to gain more traction and awareness, the Black female maternal mortality crisis often remained sidelined. The lack of recognition for the Black female maternal mortality crisis in the United States can be tied to the, historical, dismal of the problem and the attachment to the idea that Black women were to blame for their health inequities.

In this chapter, **I will argue that over the past 20 years, there has been a positive shift in the understanding and perception around the Black female maternal mortality crisis, and this shift can be tied to broader changes in social and cultural movements, like Black Lives Matter, that have drawn attention to the issue, especially preeclampsia. As a result of this advocacy, medical professionals and the general public now better understand the broader implications of the individualized blame narrative that had developed over the past 70 years.** To make this argument I will examine the roles of patients, physicians, and

[187] Matthew, Dayna B. *Just Medicine: A Cure for Racial Inequality in American Health Care*. 2015, 57

advocates in the Black female maternal mortality crisis between 2000-2020. Specifically looking at how each of these actors has played a role in calling attention to and dismantling the individualized blame narrative. Furthermore, how this has impacted Black mothers, the perception of the crisis at large, and where there are continuities and discontinuities. I will examine how advocates played a role in opening up space for discussion and, particularly, Black female narratives about maternal care. Lastly, I will look at how these trends have impacted the medical community and the general public's understanding of what it means to have preeclampsia as a Black woman.

Black Female Maternal Mortality Between the 2000-2010

In 1999, Bethany Matthews had her first experience with the medical system, as a mother. Matthews was a young woman at the time of her first pregnancy but came from an upper-middle-class background in New York City. Matthews is a Black woman with a college education, so at the time of her first pregnancy, she was aware that she needed to do her research about how to best prepare for her pregnancy. Because of Matthews' background, she never had any fears about the medical system. She had always had access to the best care and did not expect anything less for her pregnancy, so she ended up selecting one of the top female OB/GYNS in the city. Throughout her pregnancy, she felt like she received high-quality care from her physician. The physician was hands-on, caring, and had great communication, which helped Matthews to feel confident throughout her pregnancy. But, at about 35 weeks she began to experience Braxton hicks and her baby had stopped moving, so she went into New York-

Presbyterian to be examined, and when she arrived, she experienced something she never had before.[188]

Once she was admitted, she was not given a preliminary exam and was told to just wait. She ended up just waiting, in a general room, for three hours, without any acknowledgment. As she sat there, her symptoms only got worse and, eventually, she went ahead to get water in an attempt to quell her symptoms. And, while doing this was confronted by a white nurse, who proceeded to yell at her for drinking the water, roll her eyes at her, and overall, just speak to her disrespectfully. At that point, Matthews knew what was happening, this nurse had assumed that because she was a young Black pregnant woman that she was uneducated and on welfare, of some sort, and this had led the nurse to treat Matthews like a second-class patient. When Matthews realized this she immediately confronted the nurse about her assumption and reported her to her physician which resulted in the nurse being let go from the hospital.[189]

Matthews got pregnant for the second time, in 2007, and this time she was older and more experienced with the medical system, due to her first pregnancy. Prior to this pregnancy, she knew that her race could cause her to be treated as less than, so she took extra precautions to protect the quality of care she received. One of these measures was making sure that she had her mother and sister with her, while she was at the hospital, so they could be additional advocates for her. Everything had been going well until she was induced and was told that she had received an epidural. As she sat in the room after, supposedly, receiving her epidural, her and her family keep hearing a being noise. As the noise continued they flagged it to a nurse multiple times, who brushed it off, and it was only acknowledged when her physician came in and noticed that the

[188] Bethany Matthews, [Oral History Interview with Author], July 25th, 2020
[189] Bethany Matthews, [Oral History Interview with Author], July 25th, 2020

machine that administered the epidural had no batteries and that is why it had been beeping. This meant that Matthews could no longer get an epidural, because she was too far into her labor.[190]

Once again Matthews' race negatively impacted her care while pregnant.

From Matthews' narrative, it is possible to infer that in the 2000s, implicit bias was still deeply infiltrating medical practices. Even though, many medical professionals and members of the general public, at the time, would like to believe and argue that implicit bias did not affect the care that Black women received. But, during the early 2000s, the topic of racialized medicine and the use of racism in medical practices was beginning to gain substantial traction. And, this created increased discord, since many still believed that implicit bias in medicine was not necessarily negative.

In the early 2000s, not only were some physicians' adamant that they did not have implicit biases, some argued that it was necessary for practicing good medicine. Dr. Sally Satel defends the use of racially profiling patients while practicing medicine, in a *New York Times* article. In the article, Dr. Satel says, "in practicing medicine, I am not color-blind…I always take note of my patient's race. So, do many of my colleagues. We do it because certain diseases and treatment responses cluster by race…when it comes to practicing medicine stereotyping often works".[191] The defense that Satel puts up about practicing racialized medicine is incredibly dangerous, especially since by the 2000s, extensive research had come out saying that race did not influence diseases. The use of racialized medicine, perpetuates the idea, that biologically, Black and white people cannot be treated the same way and provides physicians with a defense for treating Black patients differently, and typically more inadequately, than white patients. Even

[190] Bethany Matthews, [Oral History Interview with Author], July 25th, 2020

[191] Satel, Sally. "I Am a Racially Profiling Doctor." *The New York Times*, The New York Times, 5 May 2002, www.nytimes.com/2002/05/05/magazine/i-am-a-racially-profiling-doctor.html?auth=show-sso-confirmation-link-apple.

so, the defense for racialized medicine persisted throughout the 2000s, and had a significant impact on Black pregnancies.

Even though, during the 2000s, there was evidence to refute racialized medicine, the practice of it was still there, and in some cases, was very overt. In 2007, an article was published in the *American Journal of Obstetrics and Gynecology*, that reported that Black women were more likely to develop pre-term babies. [192] With studies like these that state that there probably is some genetic component to "underlies the public health problem presented by the racial disparity in preterm birth".[193] Some, physicians' loyalty to racialized medicine, can be seen as their attempt to keep the blame for the Black female maternal mortality crisis off of them. By saying that the Black female maternal mortality crisis is due to a genetic component, means that physicians could do nothing to stop it.

As racialized medicine and implicit bias continued to be contentious topics, in the 2000s, the primary focus on infant mortality also continued. Between 2000-2010, there was a significantly larger focus on infant mortality compared to maternal mortality, specifically between the 2000 and 2010. This meant that even when doctors were focused on improving mothers' health, it was primarily just to improve the infants' health. In 2010, Dr. Kevin Ryan reflected on how infant mortality rates were able to significantly drop 16% between 2005-2011. He attributed it to changes in maternal care. Dr. Ryan stated, "In years past, the key was access to early, high-quality prenatal care. We're looking more and more at addressing the whole life cycle of girls and young women, not just focusing on the period of pregnancy. That's going to be

[192]Roberts, Dorothy E. *Fatal Invention: How Science, Politics, and Big Business Re-Create Race in the Twenty-First Century*. 2011, 115
[193] Ibid, 112

critical to our success in continuing to improve birth outcomes".[194] This statement seems beneficial to mothers, but, in reality, it further solidifies the idea that improving maternal care should be directly tied to infants. This attitude leads to mothers being left vulnerable after the birth of the baby.[195]

But, simultaneously, increasing coverage was being devoted to maternal mortality abroad, through the early 2000s. And, this, therefore, perpetuated the idea that maternal mortality was not an American issue, but an international one.[196] But, by 2010, the issue domestically was becoming too immense to turn a blind eye to. Consequently, public health contributors and journalists, like Clyde Haberman, began to write articles questioning the status quo around maternal health, in the United States. Articles, like Haberman's, burst the bubble of safety and idealism, surrounding pregnancy, that had been perpetuated, since the 1950s. He directly addresses that the common understanding in the United States, that maternal mortality was not a pressing issue domestically, could no longer be accepted. To strengthen this claim, in 2010, it had been revealed that the U.S. ranked 50th on the United Nations ranking for MMR, behind almost all industrialized countries and countries that were considered to be less advance, like Serbia and Slovakia. Providing an example of how the conversation around maternal mortality

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[194] Goodnough, Abby. "U.S. Infant Mortality Rate Fell Steadily From '05 to '11." *The New York Times*, The New York Times, 18 Apr. 2013, www.nytimes.com/2013/04/18/health/infant-mortality-rate-in-us-declines.html?searchResultPosition=60.

[195] Martin, Nina, and Renee Montagne. "Focus On Infants During Childbirth Leaves U.S. Moms In Danger." *NPR*, NPR, 12 May 2017, www.npr.org/2017/05/12/527806002/focus-on-infants-during-childbirth-leaves-u-s-moms-in-danger.

[196] Grady, Denise. "Maternal Deaths Decline Sharply Across the Globe." *The New York Times*, The New York Times, 14 Apr. 2010, www.nytimes.com/2010/04/14/health/14births.html?searchResultPosition=41.

was drastically changing, but also show how Black people, specifically women, still were not having their voices widely heard.[197]

Preeclampsia 2000-2010

In 2001, Terry Coffey, a white nurse in Westchester County, New York, was pregnant for the first time and was admitted to the hospital at 27 weeks. She had been admitted, because her physician had noticed that her blood pressure had reached dangerous levels, and her physician feared that her life could be in danger. Even after being told that she was being diagnosed with preeclampsia, Coffey remained relatively unbothered, even though, she understood the severity of her condition. But, she did not fully understand the gravity of the situation until three days later, when her symptoms got drastically worse. When she reflected on the experience, she stated that "it all happened so fast, I don't think I realized how much danger I was in". She ended up having a C-section that saved her and her son's life. Coffey's physician's attention to her medical status illustrates that a shift within the medical community was taking place, around how they viewed preeclampsia and its impact on the mother's health, instead of solely the infant's health.[198]

Preeclampsia had been something talked about in the past decades, but in the past decade, the narrative focused on oversimplifying the condition or playing it off as something that predominately negatively impacted infants, but by the early 2000s, this preconceived notion was being challenged, as maternal mortality domestically was beginning to be looked at, again, as a serious issue. [199] And, this increase in awareness can be linked to changes in the way the medical community was understanding preeclampsia. In 2000, The National High Blood Pressure

[197] Haberman, Clyde. "On a Clock, a Grim Toll of Mothers." *The New York Times*, The New York Times, 21 Sept. 2010, www.nytimes.com/2010/09/21/nyregion/21nyc.html?searchResultPosition=116.
[198] https://www.nytimes.com/2001/07/10/health/dangerous-complication-of-pregnancy-becomes-more-common.html?searchResultPosition=8
[199] Ibid

Education program reported that there were revisions to the preeclampsia classification criteria; the condition previously had not been classified as a hypertension disorder. [200] This change in classification changed the way the disease was perceived. And, this change in perception allowed the disease to gain a more concrete classification of symptoms.

Even though the etiology remained unknown in the 2000s, the improvement in the understanding of the disease, consequently altered the way physicians understood the disease and how to treat it. The increased accessibility to understanding the disease helped to increase the awareness around it. But, as we can see from Coffey's story, the awareness of the disease was there, but mothers, even those in the medical community, like Coffey, still lacked the understanding of the severity. Additionally, Coffey is a white woman, which means she does not have to worry about being stereotyped for her race and having them impact how her blood pressure was perceived during her pregnancy.

In concurrence with more attention being placed on mothers in regard to preeclampsia, there was also an effort to expose what pregnancy and delivery *really* were like. An example of this is in Jennifer Block's book *Push,* where she highlights the positives of the experience but also examines the negatives that come along with being pregnant. Block's decision to engage in this conversation in her book, illustrates how the advocates' role was beginning to come to the forefront in the 2000s, as they challenged the preconceived notions, that pregnancy and delivery were not as dangerous for mothers as infants.[201]

One of the primary things that comes to light in these, almost exposé, like articles, is the danger of preeclampsia to mothers. These publications directly contradict previously believed

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[200] Bell, Mandy J. "A historical overview of preeclampsia-eclampsia." *Journal of obstetric, gynecologic, and neonatal nursing : JOGNN* vol. 39,5 (2010): 510-8. doi:10.1111/j.1552-6909.2010.01172.x

[201] Block, Jennifer. *Pushed: The Painful Truth About Childbirth and Modern Maternity Care*. Cambridge, Mass: Da Capo Lifelong. 2007, 120

notions, by stating that the Black female maternal mortality crisis is more of a societal problem than individual. Which goes against the idea that the reason why Black people ended up with worse health outcomes was because of their Blackness. And, also contradicts the idea that race is the reason why Black women were more likely to contract preeclampsia. In an interview with Dr. Cynthia Berg, she states that "there is no biological reason for this to happen…it suggests that we need to be looking at things like access to care, quality of care, and broader social issues". Books like Block's, presents a new school of thought that was beginning to be heard and accepted. And, by doing so, challenges the blame and individualized narrative that had surrounded Black women, in previous decades. Recognition, specifically, around the unequal treatment of Black women, specifically in terms of preeclampsia, was becoming increasingly discussed.[202]

Changing Perception of Black Female Maternal Mortality Leading Up to Present Day

In 2007, Dr. Joneigh Khaldun, a Black emergency department physician, and director of the Detroit Health Department had her first child via C-section. Immediately after delivery, Dr. Khaldun informed her physicians that she was suffering from excruciating headaches, but her concerns were repeatedly brushed off. After three weeks of continuous headaches, she informed a resident, at the hospital she worked at, that she would be coming in and would need a CT. After ordering her own CT she was able to diagnose herself with a life-threatening brain bleed.[203]

[202] Block, Jennifer. *Pushed: The Painful Truth About Childbirth and Modern Maternity Care*. Cambridge, Mass: Da Capo Lifelong. 2007, 120

[203] Magazine, The New York Times. "Black Mothers Respond to Our Cover Story on Maternal Mortality." *The New York Times*, The New York Times, 19 Apr. 2018, www.nytimes.com/2018/04/19/magazine/black-mothers-respond-to-our-cover-story-on-maternal-mortality.html?action=click&contentCollection=Magazine&module=RelatedCoverage®ion=Marginalia&pgtype=article

Dr. Joneigh Khaldun went through this traumatic experience in 2007, but she was not able to broadly share her story until 2018, when the *New York Times* published a series of letters from Black mother's responding to the Black female maternal mortality crisis.

Why are we s increasingly hearing Black women's voice now?

Black Female Maternal Mortality Between 2010- 2020

Deidre Johnson, a Black mother of two, in good health, with degrees from Princeton and Yale, almost died twice from complications and neglectful maternal care. After the birth of her first son, she developed HELLP syndrome (a serious complication related to high blood pressure). When she first noticed her high blood pressure and alerted her healthcare team to it she was told that "you people usually have higher blood pressure", but luckily, she had her father there who was able to advocate for her and contact another OB-GYN who took her condition seriously. For her second pregnancy, she decided to take extra precautions. She chose to go to a hospital that specialized in complicated births and thoroughly researched HELLP syndrome so that she could effectively communicate with her physicians. But despite her efforts to avoid another life-threatening experience, she was unable to. After her second delivery, she tried to explain to physicians what was going on with her body even using terms like, vascular headache and asking for her urine proteins to be checked, but again her concerns were brushed off. It took her family threatening to sue the hospital for her condition to be taken seriously. Neither her Princeton nor Yale degree or extensive knowledge of her condition could save her, but her race almost cost her, her life, again.[204]

[204] Magazine, The New York Times. "Black Mothers Respond to Our Cover Story on Maternal Mortality." *The New York Times*, The New York Times, 19 Apr. 2018, www.nytimes.com/2018/04/19/magazine/black-mothers-respond-to-our-cover-story-on-maternal-

Deidre Johnson did not receive exceptional care, but she did get to share her story, in own her voice, promptly. Between 2010-2020, there is a significant rise in Black mothers having their voices presented in widely distributed newspapers. By incorporating mothers' and their families' voices, these publications were able to avoid homogenizing and degrading Black women. Instead, they highlight the differences between the women and highlight that they are intellectual, responsible, and most importantly, are human. But, this narrative was still skewed, since lower socio-economic Black women still struggled to have their voices heard through the distribution of these platforms. Nevertheless, these stories were able to provide support to fact that there were serious issues in the way Black mothers were being treated in the medical system.[205]

Deidre Johnson's story highlights, how Black mothers, were directly confronting the individualized blame narrative that had been being constructed since the 1950s. Deidre shares a narrative that calls attention to implicit biases stemming from racism and the practice of racialized medicine. Nevertheless, there has been a shift in awareness around the dangers of practicing racialized medicine and how implicit biases are still impacting the care Black women receive throughout pregnancy and how this can lead to negative consequences. And this shift in awareness can be traced back to the growing role of the advocate.[206]

The New York maternal Mortality Summit, in 2018, serves as another key milestone in the recognition of the Black female maternal mortality crisis. Dr. Crear-Parry the CEO of the

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mortality.html?action=click&contentCollection=Magazine&module=RelatedCoverage®ion=Marginalia&pgtype=article

[205] Magazine, The New York Times. "Black Mothers Respond to Our Cover Story on Maternal Mortality." *The New York Times*, The New York Times, 19 Apr. 2018, www.nytimes.com/2018/04/19/magazine/black-mothers-respond-to-our-cover-story-on-maternal-mortality.html?action=click&contentCollection=Magazine&module=RelatedCoverage®ion=Marginalia&pgtype=article

[206] Ibit

National Birth Equity Collaborative (NBEC) attended the conference to address the issue. The largest takeaway from her statement was that Blackness should not be seen as a medical risk, but that racism should be seen as a medical risk, because racism has created a structure of inequalities inside and outside of the medical system that all seem to have an impact on the care that Black women receive. Dr. Crear-Perry goes on to address that race is a social construct and that as more people, including physicians and public health officials, use race to defend certain medical outcomes that they reinforce the accuracy of the practices. Directly going against the historical notion that Black female maternal mortality is an individual issue instead of societal. Contributors to the conversation, like Dr. Crear-Parry, are necessary components in changing the, nearly, cemented belief that Black women were to blame for their health disparities.[207]

There have been very few notable changes in the experiences that Black women have had with maternal care they received, between 2010-2020. But, there are notable changes in the roles that Black mothers, their families, healthcare teams, and contributors play in the Black female maternal mortality crisis, in the present day. As the veil around maternal health and Black maternal health began to be lifted, unveiling the, historical, societal roots of the Black female maternal mortality crisis, that increasingly put Black mothers at risk today.

One of the most notable changes is that Black women and their families are going into their pregnancies with pre-existing knowledge of the risk. Many Black women are forced to come to the reality that their pregnancies may be filled with fear. When Crystal McDaniels found out she was pregnant, in 2017, she had to come to terms with this feeling and said, "as soon as I learned that I was pregnant back in September, it was like a switch turned on and I started seeing

[207] "Proceedings of the 2018 New York Maternal Mortality Summit." *2018 New York Maternal Mortality Summit | New York Academy of Medicine*, 2018, www.nyam.org/summit-resources/.

story after story about the risk associated with childbirth and motherhood for Black women. It felt like a cruel joke".[208]

Even though it is heartbreaking to hear the fear in Crystal's testimony, there is also a glimmer of hope in it. The fact that Crystal was able to look to other stories to prepare for her pregnancy and dismantle the unrealistic expectations for happiness and safety, helped her to actively prepare for the realities of her pregnancy. Women coming forward to tell these stories, and those stories being published to see, allows Black women to directly combat the blame that had historically been put on them. Moreover, because of these stories women, like Crystal, can go into their pregnancies with knowledge about what to expect and learn how they can prepare to be their own effective advocates during pre-natal and post-natal care.[209]

After 2015, the importance of having an advocate during pregnancy for Black women has increasingly become more recognized. There is a common understanding amongst Black mothers, that they cannot solely rely on the support of the traditional healthcare teams. Many Black women have been urged to have advocates with them throughout their pregnancies so that if they are ignored, their advocates can speak up for them. Similarly, to how Deidre Johnson's father was an advocate for her when her concerns were ignored during her pregnancies. Additionally, many women are turning to doulas to advocate for them throughout their pregnancies. But, there is a preconceived notion that doulas are a luxury form of care, but in a

[208] Magazine, The New York Times. "Black Mothers Respond to Our Cover Story on Maternal Mortality." *The New York Times*, The New York Times, 19 Apr. 2018, www.nytimes.com/2018/04/19/magazine/black-mothers-respond-to-our-cover-story-on-maternal-mortality.html?action=click&contentCollection=Magazine&module=RelatedCoverage®ion=Marginalia&pgtype=article

[209] Taylor, Morgan. "What Information on Black Female Mortality Rates in the 1950s/60s and Present Day Tells Us About Maternal Mortality". 2018

reality, there are many organizations targeted at offering this form of care to women of all socio-economic backgrounds, like the Birthmark Doula Collective in Louisiana.[210]

The pronounced changes listed above, can be linked to the drastic uptick of Black voices being involved in the conversation surrounding their health. Having increased amounts of news coverage has changed the climate around Black female maternal mortality. Before 2015, Black women were aware that there were issues in the healthcare system related to their race, but many did know to what extent or what ways they could combat it. Now, Black women can learn first-hand from other Black women's experiences with the healthcare system while pregnant.

A lot of the increased publications around Black female maternal mortality have been spurred by other Black scholars, and particularly other Black female scholars who are eager to share their experiences with the medical system while pregnant, and other Black women who are sharing their personal experiences with the broader public. In 2017, Dani McClain, a Black journalist, wrote an article for *Nation*[211] titled, "In Fighting for Healthy Black Pregnancies". McClain, opens up about her experience with the medical system while pregnant, in another effort to rewrite the commonly accepted narrative around Black female maternal mortality. McClain stresses how her knowledge about the dangers of being Black and pregnant has been helpful and hurtful for her. Because they have led her to overthink many of her actions throughout her pregnancy, like when she questioned how she would be treated in her physician's office if she had worn her hair naturally or in braids instead of straightened. But, because of her existing knowledge, she is aware that she could be treated poorly due to her appearance and can

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[210] Linda Villarosa, "Why America's Black Mothers and Babies Are in a Life-or-Death Crisis." *The New York Times*, The New York Times, 11 Apr. 2018, www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.
An example of how a lower-socio economic woman was helped by a Doula organization can be found in the article *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis.*

[211] The Nation is a progressive newspaper originally founded by abolitionists.

try to take steps to mitigate it, and not all Black mothers have this knowledge. She goes onto address a 2016 study from UVA that showed that half of white medical students and residents held at least one out of the four, chosen, false biological differences between white and Black people and how the co-author of the study Dr. Norman Oliver identified that social determinants of health played a large role in biases in clinical treatment.[212]

Moreover, stories, like McClain's, highlight the history of mistrust between physicians and Black women and how that, on top of the historical blame narrative, has led to tension and less than ideal experiences while pregnant for Black women. During her pregnancy, she found herself questioning the necessity of certain questions and treatments, that she believed her white counterparts would not have been asked. Like, asking her extensively about her marital status, drug use, and alcohol use. All of which ties back to discussions that took place in the 1970s and 1980s, around how Black women's marital status was the reason for their poor health. Not only, does she identify the issues in the medical system for Black women, but she also identifies the spaces where she sees improvement, one of them being the expansion of the conversation around Black mothers' experiences while pregnant. And, expanding the usage of medical professions, like doulas and midwives. McClain's decision to bring up these two suggestions as ways to address the Black female maternal mortality crisis is a part of the rise of the advocate.[213]

The rise in these exposé pieces removes the veil and thereby, almost, forces Black women to come to the reality that societal structures put them at an increased risk, during

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[212] McClain, Dani. 2017. "FIGHTING FOR A HEALTHY BLACK PREGNANCY." *The Nation*, Mar 06, 17. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1876427564?accountid=14707.

[213] McClain, Dani. 2017. "FIGHTING FOR A HEALTHY BLACK PREGNANCY." *The Nation*, Mar 06, 17. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/1876427564?accountid=14707.

pregnancy. Journalist, Fleda Jackson does this by addressing the stress that Black women endure from the moment they realize they are pregnant, regardless of their background, because they know what it means to be Black in the United States and are beginning to understand the dangers of being Black and pregnant. Black women have to fear for their lives and the lives of their unborn babies, throughout their pregnancies, because of their race.[214]

Preeclampsia 2010-2020

In 2013, Kyle Moore became pregnant with twins. Since she was carrying twins and had polycystic ovary syndrome she knew that her pregnancy was not going to be, necessarily, easy, but she was in no way prepared for what laid ahead. Going into her pregnancy, Moore relied on friends in the area who had already gone through pregnancies to recommend physicians to her. She ended up deciding on a practice in Greenwich, CT, but the only OB who was available to take her case was a white female who was known to practice good medicine but greatly lack in bedside manner. Up until 33 weeks, Moore had a positive experience with her physician and with her pregnancy, but at about 33 weeks she started to experience several symptoms that concerned her.[215]

Against her physician's advice, she continuously went to the ER based on her gut feeling that something was wrong. For those next five weeks, she was in and out of the hospital being monitored and receiving a variety of treatments. At 38 weeks, things drastically turned for the worst. Her blood pressure shot up drastically and she began to retain water and swell. Within 24

[214] Fleda, Mask Jackson. 2020. "Floyd's Plea Felt by Black Mothers: Even before Children are Born, Black Mothers Worry about Racism." *The Atlanta Journal - Constitution*, Jun 26. https://proxy.library.upenn.edu/login?url=https://search-proquest-com.proxy.library.upenn.edu/docview/2417236233?accountid=14707.

[215] Kyle Moore, [Oral History Interview with Author], June 8th, 2020

hours she was diagnosed with preeclampsia. From that point on everything became life or death. When Moore would express hesitation or fear about certain procedures or next steps, she was not comforted she was just told that if she did not go forward that she would die.[216]

After giving birth, via C-section, to two healthy twins and returning home, issues began to rise again. She noticed that she was developing a fever and was in pain. When she called her physician, her symptoms were brushed off until she went to the hospital herself to be examined and found out that her C-section incision had been infected. Moore was able to make a full recovery, to her knowledge, but still feels like something was off about the, at times, robotic care that she received and that she missed out on certain key moments of early motherhood. [217]

Moore's story points to the dangers surrounding preeclampsia. Even though she had been going in and out of the hospital consistently for the five weeks before her delivery, physicians were unable to diagnose her with preeclampsia. One assumption that can be made around the delay in diagnosis, can be related to the classification of preeclampsia at the time. Up until 2016, to be diagnosed with preeclampsia you had to demonstrate high blood pressure and/or the presence of proteins in urine. Moore did not experience high blood pressure until 5 weeks after she started experiencing other symptoms. As a Black woman, Moore often wonders how her race impacted the care she received. Even though she was aware that the OB she had chosen was known for being somewhat robotic, she wondered if those robotic traits heightened, because of Moore's race. A prime example that Moore questioned was when her physician brushed off the severe pain Moore was in. These are considerations all Black mothers have to think about while pregnant, especially when they are in dire circumstances. These considerations point to why it is

[216] Kyle Moore, [Oral History Interview with Author], June 8th, 2020
[217] Kyle Moore, [Oral History Interview with Author], June 8th, 2020

so important for Black women, especially, to understand their conditions and have a team of advocates with them, which Moore had in the form of her, white, husband. [218]

As the recognition of the dangers of practicing racialized medicine increased and preeclampsia was increasingly being seen as something detrimental to mothers, the conversation around race and preeclampsia became even more prominent. The 2018 New York Maternal Mortality Summit also served as a milestone in the recognition of preeclampsia. When Eleni Tsigas, the CEO of the Preeclampsia Foundation[219] addressed that once again the etiology around the disease was still unknown, but he also addressed the importance of patients' education. Since the diagnosis of preeclampsia relies so heavily on the patient identifying their symptoms they must be aware of what to look for and the severity of the disease.[220] As previously noted, in 2016 the classification around preeclampsia changed again. Instead of relying on the hallmark symptoms of high blood pressure and protein in the urine to make the diagnosis, the symptoms that could lead to diagnosis were expanded to include severe headaches, changes in liver and kidney function, etc. [221] The change in classification makes Eleni Tsigas's point, around increasing education for preeclampsia, even more important, because there are now so many symptoms that can, officially, be used to assign a diagnosis.

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[218] Kyle Moore, [Oral History Interview with Author], June 8th, 2020

[219] was founded in 2000, which correlates to the change in preeclampsia classification and the rise of maternal mortality being recognized as a serious condition in the United States. The Preeclampsia Foundation's mission is to reduce maternal and infant illness and death as a result of preeclampsia. The Preeclampsia Foundation is advised by a medical board that is made up of top medical and scientific experts on preeclampsia. They also partner with other non-profit organizations, government agencies, academic institutions, and corporations. The Preeclampsia Foundation is an advocacy group, that falls in parallel with the rise of advocacy in the 2000s.

[220] "Proceedings of the 2018 New York Maternal Mortality Summit." *2018 New York Maternal Mortality Summit | New York Academy of Medicine*, 2018, www.nyam.org/summit-resources/.

[221] Website. "Home - Preeclampsia Foundation." *Preeclampsia Foundation - Helping Save Mothers and Babies from Illness and Death Due to Preeclampsia*, 2020, www.preeclampsia.org/.

The topic of race and preeclampsia continues to be widely disputed, due to the long-held beliefs and disputing studies surround the relationship between race and hypertension. Several studies have been done over the last decade to try to determine why Black women are more likely to develop preeclampsia, and the results remain, relatively, inconclusive. In a 2015 study titled, *The Relationship among Psychosocial Factors, Biomarkers, Pre-eclampsia, and Preterm Birth in African American Women*, scientists make the argument that women with preeclampsia have higher levels of psychological stress compared to low-risk pregnant women. [222] This conclusion is in line with a lot of discussions right now about the conversation of how stress caused by racism throughout the mothers' lives negatively impacting their health while pregnant.

In 2017, Danicka Russo became pregnant with her first child. At her first appointment, to confirm pregnancy, her physician noticed that her platelet count had dropped drastically. She was automatically sent to a hematologist, but physicians were unsure of what was going on due to the unusual and early onset symptoms. As her pregnancy progressed she continued to be monitored regularly, but her symptoms only continued to get worse, migraines, extreme nausea, getting sick 8-10 times a day, and more. By her second trimester, she was beginning to lose weight and was diagnosed with extreme morning sickness.[223]

Over a month before her due date, she went in to see her physician and hematologist to get her levels checked and was called the next day and told that she would need to check into the hospital, because her platelet count had gotten dangerously low. But, by Saturday morning her symptoms had gotten drastically worse and things were becoming dire. She was beginning to show signs of hemolysis, her platelet count was continuing to drop, her liver enzyme levels were

[222] Giurgescu, Carmen et al. "Relationships among psychosocial factors, biomarkers, preeclampsia, and preterm birth in African American women: a pilot." *Applied nursing research : ANR* vol. 28,1 (2015): e1-6. doi:10.1016/j.apnr.2014.09.002

[223] Danicka Russo, [Oral History Interview with Author], July 1st, 2020

shooting up, her red blood cells were breaking down, and her migraines were only getting worse. It was clear at that point that her body was beginning to fail her and that something was seriously wrong.[224]

At that point, she was diagnosed with HELLP syndrome, the most severe derivative of preeclampsia, and told that she had to have an emergency C-section to save her and the baby's life. She and the baby made it through safely, and she made a full recovery but was told that if she had children again there was no guarantee that she would not get HELLP syndrome again. So, going into her second and third pregnancies, where again she developed HELLP syndrome, she took her medical care into her own hands. Even though she had, had a positive experience with her physicians before she wanted to make sure she did not end up in the same dire place. So, she took the time to deeply research her condition so she could accurately tell her physicians what treatments she wanted, for example, steroid intervention or bed rest, and better understand her body, so she could be aware when things were getting dangerous and she needed to be admitted.[225]

Even though Danicka had a positive experience with her physicians during all of her pregnancies, her testimony highlights the vast unknown that surrounds preeclampsia. When reflecting, Russo highlighted that she believed that things turned out so well for her at the end of her first pregnancy because she had started to show concerning symptoms at the start of her pregnancy, which gave physicians time to monitor her and determine the severity of her condition. But, most women, do not show symptoms of preeclampsia before 20 weeks and by that point, symptoms may have reached a detrimental point. [226]

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[224]Danicka Russo, [Oral History Interview with Author], July 1st, 2020
[225] Ibid
[226] Danicka Russo, [Oral History Interview with Author], July 1st, 2020

The importance of the re-classification of the disease in 2016, is highlighted in Russo's story. She got every symptom of HELLP syndrome besides high blood pressure, the key landmark symptom. Without this symptom and constant monitoring, it took the entirety of her pregnancy for her diagnosis to take place, but going forward as soon as she showed any of the other symptoms she was automatically diagnosed. Russo was able to educate herself so well because of the increased presence of Black mothers' voices in public spaces and the general role of the advocate. As preeclampsia is one of the most severe issues for maternal mortality, many of these stories shared critical information about preeclampsia and the way it impacted Black mothers, specifically. The importance of awareness can only be highlighted in these testimonies where you see the impact of them. [227]

The Rise of Advocates

But, what spurred this rather sudden and drastic change?

The Black Lives Matter (BLM) is one reason for the change. The purpose of the BLM movement is to bring attention to the unique qualities of Black lives in the U.S. and to help Black people achieve equal rights.[228] This broad mission allows all Black people to implement it into their own specific scenarios, like Black female maternal mortality. This differs from the Civil Rights Movement which was centered around eliminating segregation in the United States. The BLM movement is focusing on achieving equal rights beyond segregation.

The BLM movement has had a direct effect on Black female maternal mortality in the United States. Over the last ten years, Black women have taken it into their own hands to

[227] Danicka Russo, [Oral History Interview with Author], July 1st, 2020
[228] Lopez Bunyasi, Tehama, and Candis Watts Smith. 2019. *Stay woke: a people's guide to making all Black lives matter*, 1.

develop systems to protect their own. Organizations like the Black Mammas Matter Alliance and SisterSong have come together to form the Trust Black Women partnership, to advocate for Black mothers. But, after the founding of the BLM movement, these organizations have been able to further amplify their voices, by partnering with BLM.[229]

BLM has been able to help Black women and their families learn more about the underlying causes of Black female maternal mortality and give them the knowledge needed to effectively advocate for themselves. The vast attention that the BLM movement has gotten has made it possible for the spread of various principles like Black Girl Magic, color-blind racism[230] and racial gas lighting[231]. The broader recognition of Black Girl Magic has helped to make room in popular culture for Black women's voices, which has been instrumental in getting more Black women's stories heard. And, having terms like, color-blind racism and racial gas lighting more frequently talked about in the media has helped Black women and their physicians be more aware of the subtler racist practices that could be affecting their care.

In conjunction with the rise of the BLM movement, other advocacy groups like the Preeclampsia Foundation and Black female-centric advocate organizations, like Black Mammas Matter Alliance and SisterSong, all provide a space through their discussion boards for Black mothers' voices to be heard. Along with promoting Black mothers' voices, these organizations serve as entities that could advocate on the behalf of these mothers. And, ergo Black mothers and other individual advocates have further able to share their experiences on platforms, like the *New*

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[229] "Centering Black Women's Issues & Leadership." *Sister Song*, www.sistersong.net/centering-black-womens-issues-leadership.

[230] Colorblind Racism is the worldview that suggests that since race should not matter, it does not matter

[231] Racial gas lighting is a systematic effort to discredit claims of racism, typically by means of contradiction, outright denial, misdirection and lying

York Times, and thereby further inform other Black females of the issue and white people in the U.S. about an issue they have never had to be concerned about.

As the Black female mortality crisis continues to gain more attention, from the increasing advocacy, aspects around Black female maternal care are beginning to change. One of those aspects is preparedness. After Alia McCant, a Black mother, gave birth to twins and suffered from a life-threatening hemorrhage, she was able to learn through news outlets that many Black women had similar stories. This led to her reflecting on her care. When she did this she realized that she had experienced more covert acts of racism from her medical team than she had previously noticed, like overhearing the physician talking while she was coming out of anesthesia say, "another Black woman having babies".

The increased understanding of how implicit bias infects the healthcare system allows women, like Alia, to understand how pervasive implicit bias, along with other forms of racism, are negatively impacting the care that they receive. This increased awareness helps Black mothers to better prepare for their first or next pregnancy. Not only does this increased awareness help Black mothers and their families prepare for the implicit bias they may face, but it also draws attention to medical professionals about how pervasive implicit biases are.[232]

Conclusion

Black women in the U.S., occupy a particular spot in the U.S. and because of this, they are face increasing amounts of danger when they are pregnant. Black women are at particularly

[232] Chuck, Elizabeth. "How Training Doctors in Implicit Bias Could Save the Lives of Black Mothers." *NBCNews.com*, NBCUniversal News Group, 14 May 2018, www.nbcnews.com/news/us-news/how-training-doctors-implicit-bias-could-save-lives-black-mothers-n873036.

high risk, because of systematic racism within the healthcare system, a fact that has led many medical professionals to underestimate or distrust Black women who report symptoms of preeclampsia/ Even though there have been little to no changes in the treatment of the Black pregnant women, there has been a positive change in the way the Black female maternal mortality crisis has been portrayed in the public eye.

Over the past two decades, physicians, public health officials, and the general public have been eager to learn more about preeclampsia, as the problem around it only continues to get worse. Due to this motivation to learn more about preeclampsia, two critical changes have taken place. The first being the two re-classifications of the disease. In 2000, preeclampsia was reclassified as a hypertension disease and given a set description that included symptoms to look out for. One of those being high blood pressure. Then in 2016, edits were made to the classification again. Preeclampsia is still considered a hypertension disease, but now the hallmark symptoms have expanded to not just include high blood pressure and proteins in urine. Now they also include symptoms like severe headaches and evidence of liver and kidney failure, amongst others. The second critical shift that took place over the last two decades was around education. Between 2010 and 2020, there has been a greater push to expand education around preeclampsia to the mothers themselves. Since the diagnosis and ability to successfully treat preeclampsia relies so much on patients identifying their symptoms early and bringing them to their doctors' attention. They must be educated well enough to understand how they can monitor their bodies.

The association between preeclampsia and race has evolved and remained stagnant in some ways. Due to long-standing beliefs around high blood pressure and race, many physicians and public health officials still argue that there is a biological component as to why Black

women develop preeclampsia and develop more severe complications. But there has also been increasing scholarship and discussion around the falsehood of these claims and additional studies that are pointing towards the important role that implicit biases, social determinants of health, and generational stress plays in Black female maternal mortality, especially when it is related to preeclampsia. Additionally, Black women have increasingly taken a role in educating the broader public and the Black community about Black female maternal mortality and their own experiences with the medical system. Which has led to many Black women using other Black mother's experiences to educate themselves and motivate themselves to go out and learn about the variety of conditions, like preeclampsia.

The increased attention in the news on the Black female maternal mortality crisis establishes that the Black female body is gaining value in the public eye and the medical space. Being able to relate the Black Lives Matter movement to the Black female maternal mortality crisis allows Black women and their families to further educate themselves and have room in the media to share their stories.

Advocates have led to increased awareness of the Black female mortality crisis. This awareness benefits Black women who have heard about the issue but do not fully understand the impact, because they have not gone through it yet, and white women, physicians, and public health officials who have never had to think about the issue in the same way that Black women have. The increasing prominence of awareness and Black mothers' voices, has allowed other Black women to know that they are not alone in their experiences and educates them in ways to better protect themselves. And, helps healthcare teams who are blind to their own implicit bias to think retrospectively in ways that they can improve the care they provide Black women, and informs the public that Black female maternal mortality is a more complex issue than just a

medical one. And has played an instrumental role in the growing attention to preeclampsia in the Black community, and to Black women taking the initiative to act preventatively around the complication.

Conclusion

"Could America tell itself the truth about how it arrived at this moment?"[233]

This is not a story of immense medical change, instead, this is a story of the rise of activism. In the U.S., there has been a long-standing precedent of demeaning women, especially Black women. Since the creation of maternal mortality committees in the U.S., physicians and public health officials have worked to craft a narrative that portrays them in the most favorable light and places increased responsibility on women.

But even before the creation of the maternal mortality committees, there have been key moments in the past that have contributed to the present-day Black female maternal mortality crisis. During slavery, the principles of racialized medicine were solidified, which allowed physicians, like Marion Sims, to see Black women as lesser than white women. In addition, to being dehumanized, because of their race, Black women also had to navigate the changes that were taking place in, general, maternal care. During the 1950s, maternal care was becoming increasingly hospitalized, which consequently shifted it from being a predominantly female practice into a male-dominated one, where the females' perspective was considered less. The historical stigmatization of minorities and females, made crafting a narrative that placed increasing blame on Black women easier.

Going forward from the 1950s, the blame narrative continued to permeate the discussion around maternal mortality and preeclampsia. Starting in the 1960s, physicians and public health officials began pushing the prenatal care initiative, which focused on putting the responsibility on mothers and promoting the triumphalist physician narrative. By pushing the idea that prenatal care, a service initially developed because of preeclampsia, was the "magic bullet" for maternal

[233] Glaude, Eddie S. 2020. *Begin again: James Baldwin's America and its urgent lessons for our own,*67.

mortality, physicians crafted the narrative that if women did not want to get prenatal care, that it was their fault for their poor outcomes.

The prenatal care initiative remained prominent through the remaining decades, but over time it ran parallel to various other conversations. One of the prominent ones was the villainization of Black women. Starting in the 1960s, Black women began to be continuously framed as being responsible for putting their families in poor environments, and by 1980, were being portrayed as being responsible for the stagnation and downfall of the Black race. In tandem, with the Black villainization conversation, physicians and public health officials started shifting the conversation away from maternal mortality and towards infant mortality, in the 1980s. The move towards infant mortality was another attempt to divert the attention away from maternal health and put additional responsibility on mothers, as they were framed as also being responsible for poor infant outcomes.

The narrative surrounding preeclampsia and its direct impact on mothers also struggled to gain significant recognition. Throughout history, preeclampsia has been a condition that has plagued maternal health and was, primarily, able to do so because of the lack of understanding surrounding the etiology of the disease, which negatively impacted the development of treatments.

The narrative surrounding preeclampsia cycled similarly to the narrative around maternal health. The preeclampsia narrative was severely impacted by the focus on prenatal care and infant mortality. Due to this, the dangers of preeclampsia were frequently downplayed by physicians and public health officials in medical journals, as well as general media sources, like local newspapers. And, as the focus on infant mortality progressed, the narrative around preeclampsia shifted towards focusing on the impact it had on infants over mothers. This moved

the focus away from maternal care and put increased responsibility on mothers to manage the complication and the effect it had on infants.

In tandem, with the increased responsibility being put on mothers, because of the conversation happening around preeclampsia, Black mothers faced even more scrutiny, because of the ways they had been, historically, villainized. Over the past decades, it was evident to physicians and public health officials that there was a massive disparity between Black and white rates of preeclampsia. But, the problem was individualized and therefore, seen as a problem that only Black women could solve. Initially, saying that it was caused by a racial genetic component, then shifting to saying that it was due to Black women's inability to properly take care of themselves, and eventually a combination of the two. Historically, physicians, public health officials, and even the general public have pushed that prenatal care and extensive knowledge are the “cures” to the problem but simultaneously have ignored structural inequities that frequently prevent Black mothers from accessing these resources, while nonetheless continuing to push the idea that it is their responsibility to fix it.

The precedence of the blame narrative surrounding Black female maternal mortality and implicit bias has drastically impacted the maternal care of Black women. For over fifty years, this narrative has been relatively unchallenged in public forums. Even Black journalists, historically, have played into the larger blame conversation, because it so widely permeated the general space.

But by the late 2000s, advocates were making an effort to break down the existing paradigm. As the domestic maternal mortality crisis, in general, got progressively worse and the classification of preeclampsia changed. It forced physicians to alter their treatment and advocates were given the "perfect storm" to protrude through the status quo.

As the counter conversation to the status quo opened up, Black female advocates were able to make their voices heard. Over the past ten years, Black women have increasingly been able to share their concerns in widely read publications, like the *New York Times*, and their ability to do this has served to educate and open the eyes of Black women who have not gone through pregnancy yet or even those who have and white physicians, public health officials and people who have never been through the tribulations that Black women have or had to think about it. Furthermore, Black advocating groups like SisterSong and Black Mammas Matter Alliance and preeclampsia advocating groups, like the Preeclampsia Foundation, have worked to advocate for Black women and the severity of preeclampsia for Black mothers. And, instead of working in a bubble, they have involved several other actors like physicians, public health officials, and other advocates who are interested in the issue.

Going forward, advocates, specifically Black mothers, will have to continue to work to dismantle the individualized blame narrative that has been in place for over 70 years. And, as more Black mothers and families share their stories and perspectives on maternal treatment, we will all be privy to an experience that we may have not had or given the insight to retrospectively understand our own experiences. As advocating continues, it forces us to realize that we cannot just *say* that healthcare is equitable and that a problem does not exist to make it disappear. But, the underlying issues, which include racial and gender discrimination, have to be tackled, to see any substantial change. And, the first step is pulling back the curtain, by having Black women and families share their stories. But, where we still struggle is broadening that scope and including Black women who are not just higher income and well educated.

This paper helps to illuminate the complex issues that make up the historical and current, Black female maternal mortality crisis and the ways that it continues to evolve, specifically

highlighting that it is not an individual issue, but a societal one. But, it also brings to light the history, which is necessary for us to understand our current predicament. As James Baldwin said,

> In the end, we cannot escape our beginnings: the scars on our backs and the white-knuckled grip of the lash that put them there remain in dim outline across generations, and in the way, we cautiously or not so cautiously move around one another. This legacy of trauma is an inheritance of sorts, an inheritance of sin that undergirds much of what we do in this country. It has never been America's way to confront the trauma directly, largely because the lie does not allow for it. At nearly every turn, the country minimizes the trauma, either by shifting blame for it onto fringe actors of the present…or, worst, back onto the traumatized.[234]

Reminding us of Black women, like Whitney Polk, who have, historically, had the blame for their trauma placed on themselves, but they are now taking their care into their own hands and are sharing their stories in an effort to highlight the systemic nature of the Black female maternal mortality crisis. We cannot change our history or create false paradigms around it if we want to fix our present-day and future. Advocates in the Black maternal mortality crisis, are forcing us to confront the false paradigms around Black female maternal mortality and preeclampsia in an effort to change the current situation for the better.

[234] Glaude, Eddie S. 2020. *Begin again: James Baldwin's America and its urgent lessons for our own,*46.

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