Discrimination Against Black Women in Reproductive Healthcare

by
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I would like to dedicate this thesis to all the Black women, past and present, who helped it come to fruition. The knowledge, experiences, and perspectives you have courageously shared will stay with me for the rest of my life. Thank you.

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Lastly, I would like to thank my family and friends for their support throughout my thesis journey. Their love and kindness provided stability when I felt overwhelmed. They were there for me through every step, and I am forever grateful.

Abstract

Centuries of racial and gender oppression have coalesced into the discrimination against Black women in reproductive healthcare. Since its founding on the plantations of the Antebellum South, American gynecology has viewed Black women as less than human. Despite achievements in the Civil Rights and women's rights movements, Black women continue to face high rates of maternal morbidity, mortality, and mistreatment in reproductive healthcare settings. The purpose of this study was to determine how discrimination against Black women manifests in reproductive healthcare, to create practical solutions for decreasing this discrimination based on knowledge obtained from Black women, and to potentially inform Black women of the current resources they can utilize to ensure they are receiving non discriminative, quality reproductive healthcare. Qualitative interviews were conducted with six Black women between the ages of twenty-seven and fifty-three who reside in Tennessee. The interviews were conducted to understand their lived experiences as patients and to ascertain ways their experiences in reproductive healthcare can be improved. The data indicate that participants of various backgrounds and socioeconomic statuses experienced discrimination. The participants offered several solutions for improving the quality of care Black women receive as reproductive health patients: training practitioners to be empathetic and culturally conscious toward Black female patients, increasing the numbers of female doctors and doctors of color, and creating a welcoming environment through active listening and engagement with patients. The centering of Black women's voices in the discussion of improving reproductive healthcare is essential for service improvement.

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OB-GYN: Obstetrician Gynecologist; a doctor who specializes in pregnancy, labor and delivery, and general female reproductive healthcare.

Pap smear (Papanicolaou test): a test for cervical cancer that is performed during annual gynecological examinations.

C-section (Caesarean section): surgical procedure to deliver children through the stomach instead of the vagina.

Intersectionality: the intersection of multiple forms of oppression, such as discrimination on the grounds of race and gender, that an individual can experience; the connection between several forms of oppression results in a unique experience of discrimination (Crenshaw, 1989).

Transnational Black feminism: a version of feminism that centers Black women and their lived experiences to understand how intersecting oppressions contribute to the discrimination against and the subordination of Black women globally (Collins, 2009; Crenshaw, 1989).

Bracketing: a qualitative research method utilized by researchers who are conducting research with participants of a different cultural background to ensure the research is free from bias (Tufford & Newman, 2010, pp. 87-92).

Snowball sampling: a recruitment method used in qualitative research to recruit participants from historically marginalized communities who are otherwise inaccessible (Woodley & Lockard, 2016, pp. 321-24).

Member checking: technique utilized by qualitative researchers to ensure their data and data analysis aligns with the information provided by the participants (Birt et al., 2016. pp. 1803-6).

Chapter I
Introduction

Black women are subject to discrimination based on their unique experiences as those identifying with minoritized identities, including but not limited to race and gender. The United States' reproductive healthcare system is one arena in which discrimination occurs. Due to their knowledge and experiences, Black women offer an interesting perspective into determinants of discrimination in the field of obstetrics and gynecology and how these problems can be amended to ensure all women receive quality reproductive healthcare.

The foundation of gynecology in America is built upon exploitation of and experimentation on enslaved Black women (Hill, 2020, pp. 3-6; Owens, 2017, p. 17). Enslaved Black women in the United States represented a vulnerable population who had no freedom to decide what was done to their bodies. The United States Congress passed a law banning the importation of enslaved Africans in 1808, creating an issue for slave masters who desired slaves to exploit as a labor source and to sell for a profit; as such, slave masters began to "breed" their slaves to maintain a steady population of a slave labor force (Dudley, 2021, p. 11; Owens, 2017, p. 15; Taylor, 2020, pp. 507-8). At the same time, white American men began to enter the field of gynecology where they medicalized the bodies of women and positioned themselves as experts able to "fix" the problems ailing women (Owens, 2017, p. 19). Like any other science, medicine requires experimentation. However, medical experimentation is not usually something a person would willingly submit to, especially during a time when that branch of medicine was new. White male doctors in America had access to a class of individuals who had no option but to submit. The "Father of American Gynecology," Dr. James Marion Sims, was a slave owner who experimented on enslaved Black women to advance the field of gynecology and create a name for himself (Owens, 2017, p. 80; Taylor, 2020, pp. 508-09). The women who were exploited by Sims and other American doctors were forced to endure pain, maltreatment, and embarrassment, all while being unnamed and uncredited in the medical research they helped to advance (Dudley, 2021, pp. 5-6; Owens, 2017, p. 20, 25, 27).

The abolition of slavery did not end the medical exploitation of Black women. In the first half of the twentieth century, the eugenics movement, a social movement characterized by the practice of forcibly sterilizing those within society deemed “unfit,” began in the U.S. (Roberts, 1997, pp. 60-2, 69; Washington, 2006, p. 191). African Americans were one of the groups deemed “unfit” based upon stereotypes of Black inferiority and hyperfertility (Davis, 1981, pp. 213-14; Taylor, 2020, p. 509; Washington, 2006, p. 191). The methods used by eugenicists to prevent the birth of Black children mimicked the ways in which early American gynecologists exploited enslaved Black women. Birth control clinics were strategically placed in Black communities to encourage Black women to undergo abortions or to use dangerous birth control methods such as the pill or intrauterine devices that were previously untested (Jackson, 2011, pp. 27-28; Prather et al., 2018, pp. 251-52; Washington, 2006, pp. 200-1). Another more insidious method of Black population control was the forced sterilization of thousands of Black women, many of whom were not informed they were undergoing a sterilization procedure or were not informed of medical options that avoided sterilization (Davis, 1981, pp. 215-17; Roberts, 1997, pp. 90-91; Washington, 2006, pp. 202-5).

Continued discrimination against Black women is now manifested in higher maternal mortality rates. In a study conducted by the Centers for Disease Control and Prevention (CDC) between 2007 and 2016, the rate of maternal mortality among Black women in the U.S. was 40.8 deaths per 100,000 live births compared to 12.7 deaths per 100,000 live births for White women (Petersen et al., 2019, p. 763). The Giving Voice to Mothers Study, conducted in the U.S. in 2016, surveyed women who had given birth between 2010 and 2016. The study found that 22.5% of the Black women surveyed experienced mistreatment by a healthcare provider compared to 14.1% of the white women surveyed (Vedam et al., 2019, p. 8). While no person should experience mistreatment by her provider, it is important to recognize the racial disparities in the treatment of Black women and white women (Lister et al., 2019, pp. 2-3). The mistreatment of Black women in reproductive healthcare occurs via stereotyping, ignoring or dismissing pain, opting for surgical procedures with a greater number of potential complications, and preventing access to quality healthcare in situations when the woman is low income or lacks health insurance (Taylor, 2020, pp. 510-14). Assumptions that Black men and women have a higher threshold for pain stems from the beliefs maintained by slave owners and doctors that justified their poor treatment of enslaved peoples; more contemporary beliefs in Black peoples' high pain tolerance partially come from the notion that their experiences of hardship and discrimination have "made them strong" (Trawalter & Hoffman, 2015, pp. 147-52). A qualitative research study assessing the experiences of young Black women in Family Planning Care found that many of the participants experienced care that lacked empathy and investment in the women's lives and reproductive health, and some of the participants attributed this inadequate and discriminatory care to stereotypes providers held about Black women and motherhood (Logan et al., 2021, pp. 1177-78). Racial discrimination against Black women in reproductive healthcare settings also impacts the children of those women. A review of fifteen different studies found that discrimination against Black women was significantly tied to the low birth weight, preterm birth, and small size of Black infants (Alhusen et al., 2016, pp. 711-17).

Despite the exhaustive efforts of women's rights and civil rights groups, Black women continue to face the dangers of discriminative healthcare. This discrimination may continue to happen due to biases that exist among medical practitioners and/or ineffective or nonexistent empathic training in medical schools. Both factors can contribute to communication failures between Black female patients and their care teams. Systemic racism in the institutions of healthcare and education are also barriers to the equitable treatment of Black women in reproductive healthcare. As such, it is imperative that measures of intervention be put in place to guarantee Black women receive quality healthcare that considers their experiences and wishes. One such method of intervention is empathic listening on the part of the practitioner. Intervention methods that focus on practitioner empathy and building a positive practitioner-patient relationship indicate that such interventions result in more quality healthcare and decrease the patient's experience of anxiety and/or pain (Howick & Rees, 2017, pp. 352-53; Kelley et al., 2014, pp. 5-6). To decrease discrimination against Black women, it is necessary to determine how discrimination and bias affect the type of healthcare Black women are likely to receive and to ask Black women about the ways in which they want healthcare to change to better suit their needs.

Chapter II
Methods

A qualitative study design was employed to answer the following questions:

Q1: How does discrimination against Black women manifest in reproductive healthcare?

Q2: What practical solutions will reduce Black women's experience of discrimination?

Q3: What current resources can Black women utilize to ensure they are receiving non-discriminative, quality reproductive healthcare?

Using transnational Black feminism as the framework for this study, a series of interview questions was created to capture the lived experiences of Black women pertaining to reproductive care. A transnational Black feminist approach involves centering Black women throughout the African diaspora to understand how multiple avenues of oppression, such as discrimination based on one's racial or gender identity, coalesce into the subordination of Black women across the world (Collins, 2009, pp. 251-57). This version of feminism focuses on the lives and experiences of Black women and rejects ways of thinking that denigrate the history of people and people of color themselves as may be the case with mainstream White feminism. Intersectionality, a cornerstone in Black feminist theory, recognizes that people can experience more than one form of oppression simultaneously and captures the unique experience of Black women as minoritized both in race and gender (Crenshaw, 1989, p. 149). The approach of this research was phenomenological in nature, meaning that the phenomenon of discrimination in reproductive healthcare was examined and described from the viewpoint of the Black women who may experience it (Neubauer et al., 2019, pp. 91-2). The current study was designed to incorporate intersectionality and the centering of Black women's experiences into its methodology. As such, the interview questions were crafted to obtain an understanding of the participants' experiences throughout her reproductive lifetime while considering the various facets of her identity. For example, one interview question asked, "Have you ever experienced discrimination in a reproductive healthcare setting?" (Appendix A). The participants were asked to describe the discriminatory, or non-discriminatory in some cases, experience, including how they felt during or after the experience and how that experience altered their view of reproductive health practitioners or reproductive healthcare in general. Along with a transnational Black feminist approach, an emancipatory design was used. The emancipatory design generates research that benefits the historically marginalized group to which the study's participants belong by privileging the knowledge and experiences they share (Noel, 2016, p. 457). Their knowledge and experiences were privileged by focusing the data collection and analyses on their responses to interview questions, by centering their solutions for improving Black women's experiences in this discussion, and by sending to the participants the summaries of their interviews for their review and correction if needed. The study was approved by the Middle Tennessee State University Institutional Review Board (IRB) on October 21st, 2022.

Bracketing was included within the methodology, as common to qualitative research. Bracketing refers to the continuing responsibility on the part of the researcher to ensure an unbiased interview and analysis process that allows for the emergence of new perspectives (Tufford & Newman, 2010, pp. 87-92). This research tool is used when the researcher comes from a different background, whether cultural or socioeconomic, than that of the participants; this difference can result in the introduction of bias in the reporting and interpretation of data from a study. The primary researcher in this study was a White woman. As a White woman, the researcher has a different cultural perspective from the Black women who served as participants in this study. Bracketing was practiced by the researcher through the suspension of personal biases and the continued presence of a cultural liaison throughout the study. The cultural liaison served as the faculty advisor for this research, meaning that the advisor was were involved in the creation of the study and its questions, the recruitment of the participants, the analysis of the data, and the review of the final product.

Recruitment

The priority population for recruitment was English-speaking Black women who presently resided in Tennessee. The minimum age for participation in this study was twenty-one years old, which corresponds to the American College of Obstetricians and Gynecologists' (2021) recommended age for women to begin cervical cancer screenings through annual Pap smear examinations by their doctors. The maximum age for participation was fifty-five years old, or roughly the time when women begin to enter menopause (Mayo Clinic, 2022). Participants were recruited from various organizations and community spaces for Black women across all three regions of Tennessee. These groups received information regarding the study in the form of a recruitment email, flyer, or a direct message on their social media page. This form of recruitment proved to be difficult due to the hesitance to participate in a study concerning discriminatory experiences in reproductive healthcare. To counteract the lull in interest, the method of snowball sampling was utilized. Snowball sampling is a method used to meet and recruit participants who are part of "hidden populations" for qualitative research (Woodley &

Lockard, 2016, pp. 321-24). The term “hidden population” refers to a historically marginalized group of people who are difficult to contact for research purposes. Snowball sampling has been utilized by researchers who wish to be as inclusive as possible in their studies or wish to understand the experiences of those who have been previously excluded from studies by Eurocentric academics (Woodley & Lockard, 2016, p. 323). This type of sampling was particularly useful for this study as it sought to acknowledge, understand, and share the experiences of Black women through a Black feminist framework. Using this research tool involved asking confirmed participants to share the study’s information with Black women they knew who may be interested in sharing their experiences. Unlike the traditional recruitment method first employed, snowball sampling was more effective. In total, six participants were interviewed. This number is consistent with the existing literature within qualitative research that states a series of six to twelve interviews are sufficient to achieve data saturation (Guest, Bunce, & Johnson, 2006, p. 78; Saunders et al., 2018, pp. 1899-1901).

Interviews

The six participant interviews were conducted individually via Zoom for the participants’ convenience. The participants were given information regarding the scope of the study and were read the informed consent. Verbal consent was obtained prior to conducting the interview. The interview questions were structured to obtain demographic information, information regarding the participants’ experiences as patients within reproductive healthcare settings, and opinions concerning ways to improve the experiences of Black women in reproductive healthcare (Table 1). The questions were designed to give the participants ample time and opportunities to share their unique experiences throughout their entire reproductive lifetime. The interviews were recorded and transcribed with the permission of the participants. The names and identifying information of the participants were kept confidential. Following the interview, the participants were given mental health resources, resources for reporting discrimination, healthcare resources for Black women, and a copy of their interview transcript. These resources were provided to ensure the women had information regarding their options if they felt triggered by the interview questions, if they wanted to report an experience of discrimination, or if they wanted to find healthcare geared toward Black women specifically.

Table 1. Interview questions.

How would you define empathy in healthcare?
Describe your first reproductive health visit.
In your reproductive lifetime, have you had both male and female medical practitioners? - Did you notice a difference in the level of empathy expressed by male vs. female practitioners? - Did you feel more comfortable with a practitioner of a certain gender? - Explain why you felt more comfortable with that practitioner.
In your reproductive lifetime, have you had only White or only people of color as your medical practitioners? Both? - Did you notice a difference in the level of empathy expressed by White practitioners vs. practitioners of color? - Did you feel more comfortable with a practitioner of a certain race? - Explain why you felt more comfortable with that practitioner.

Have you ever experienced discrimination in a reproductive healthcare setting? - Describe the experience. - How did the experience make you feel? - Did this experience change the way you interacted with medical practitioners or make you seek out a different practitioner?
In what ways do you think medical practitioners can change how they approach Black women's healthcare to provide a better experience for Black women?
Are you aware of any healthcare programs in your area that are geared toward Black women's healthcare?
If resources were to be made available to Black women in your community through state or federal healthcare programs, would you trust these resources? - Why or why not?
Is there anything else you would like to add, or are there any resources you are aware of that you would like to share?

Data Analysis

The data from the participant interviews were reviewed individually for general understanding. Then, interview data were coded individually. Initial codes were representations of each participant's responses to the interview questions. Repeated code words were organized into subcategories based on commonalities in the responses. Not all the code words, however, could be represented by a subcategory. Those words that did not fit within a subcategory were still included in the codebook but fell under the overarching interview themes. From the subcategories emerged larger categories or themes that showed similarities in the experiences and knowledge provided by the participants. The themes/categories, subcategories, and codes were organized into a codebook with corresponding evidence from the interviews. This type of classification is a common tool used by those conducting qualitative research (Braun & Clarke, 2006, pp. 86-93). During each step of the analysis, multiple researchers reviewed the data to ensure the information shared by the participants was represented appropriately and correctly. The themes generated from the data were further analyzed using Black feminist theory to understand the unique experiences of the participants and to explain the data.

Member Checking

Following the data analyses, individual summaries of the interview transcripts with their corresponding analyses were created. Summaries included direct quotations and analysis of quotes in relation to the overarching themes produced from all of the interviews. The summaries were sent to the participants to confirm that their experiences were being represented correctly. Participants were able to give their feedback and provide corrections if necessary. Member checking is often utilized by qualitative researchers to ensure the collected data and/or the data analysis aligns with the information provided to researchers (Birt et al., 2016. pp. 1803-6). It was important for study participants to have the opportunity to review the analysis, since the study was phenomenological in nature.

Limitations

This study does not seek to generalize the experiences of Black women in reproductive healthcare settings to all Black women in the state of Tennessee nor in the United States. As a historically marginalized population, Black women experience oppression in various ways dependent on the many facets of their identity. As such, discriminatory experiences impact each woman uniquely (Collins, 2009, p. 32). The current study was designed to identify similarities in experiences among the participants and to generate solutions to discrimination with the participants.

Chapter III
Results

At the beginning of each interview, demographic information was collected to better understand the background of the participant. Table 2 summarizes this demographic information. Most participants were in their forties with the minimum participant age and the maximum participant age being twenty-seven and fifty-three, respectively. All the participants identified as Black or African American, female, and heterosexual. The highest level of education obtained by the participants ranged from some college education to Doctorate or PhD level education. All participants reported having health insurance at the time of their interview. Three out of the six participants had been pregnant and had given birth to a single child, one participant had been pregnant but did not give birth, and two participants had never been pregnant, nor did they have children. The women who had experienced a pregnancy and birthed a child did so in a hospital setting.

Data analysis of the interview transcripts yielded six main themes: empathy, discrimination, communication, reasons for seeking gynecological care, attitudes toward gynecological care, and solutions for improvement. The themes were defined based on the information provided by the participants’ answers to the interview questions. Each theme contained at least one subcategory that further explained the participants' responses.

Table 2. Demographic Information.

Category	Participant Responses to Demographic Questions					
Age	43	27	53	44	46	45
Ethnicity	Black	African American	African American	Black/ African American	Black/ African American	Black/ African American
Gender Identity	Female	Female	Female	Female	Female	Female
Sexual Orientation	Heterosexual	Heterosexual	Heterosexual	Heterosexual	Heterosexual	Heterosexual
Region of State		Middle Tennessee	Middle Tennessee	Middle Tennessee	Middle Tennessee	Middle Tennessee
Income Level	More than $50,000	More than $50,000	At $50,000	More than $50,000	More than $50,000	Less than $50,000
Highest Level of Education	Doctorate/PhD	Masters	Some College	Masters	PhD	Masters
Occupation	Professor	Employee of Tennessee Department of Health	Technical Support	Educator	Director of Retention	Teacher
Marital Status	Widow	Single	Single	Divorced	Single	Single
Health Insurance	Yes	Yes	Yes	Yes	Yes	Yes
Pregnancy	No	Yes	Yes	Yes	No	Yes
Location of Delivery	N/A	Did not give birth	Hospital	Hospital	N/A	Hospital
Children	None	None	One	One	None	One

Empathy

Empathy, as defined by the participants, is practicing care, comfort, and concern for patients on the part of the medical practitioner. It should involve understanding, listening, and communicating in a culturally appropriate manner. The subcategories for this theme are gendered and racial empathy, or the differences and similarities in the type of empathy expressed by practitioners of different races and genders.

Gendered Empathy

Gendered empathy consisted of the differences and similarities in the empathetic practices of male practitioners versus female practitioners. It is important to preface that the information obtained in the interviews was only for practitioners who the participants identified as men and women. While there are certainly more than two forms of gender expression, the results of this study focus only on the differences in male and female doctors as described by the participants. Participant D reported experiences of male and female doctors who were empathetic as well as male and female doctors who lacked empathy. She described the empathetic doctors of both genders as being "very concerned." Participants B and E both felt their female doctors were more empathetic:

> I feel as though I get a little bit more empathy on the female side, of course, than the male side. I think that female practitioners are, and doctors are a lot more they have more of a connection with their patient because they have the same biological makeup versus the male.
> – Participant B

> And so, with the women that I've experienced they were more talkative letting you know what's going on. They'll say, oh, my hands are cold. Let me warm my hands up. Or just kind of walking you through.
> – Participant E

Unlike Participants B and E, Participant F experienced more empathy from her current male doctor compared to female doctors she had in the past.

> My doctor is a male now he is more detailed oriented; I like details and he made sure that I was breathing. I was comfortable, even though it's still uncomfortable as just a whole. He educated me on everything before he

> starts. Even though I knew what was happening, he still wanted to make sure that this was going forth. – Participant F

The female doctors she has seen neglected to ensure her comfort because they assumed she knew what to expect due to her previous pregnancy. When discussing empathy differences, participants continuously mentioned the doctors' abilities to create a comfortable and caring experience as an indicator of empathic expression.

Racial Empathy

Racial empathy consisted of the differences and similarities in the empathetic practices of White practitioners versus practitioners of color. When one participant was asked about the empathy White practitioners expressed, she said:

> Zero. They don't have empathy. – Participant A

Another participant described her Black doctors as being more understanding and expressing more empathy:

> What I started learning, what mattered more to me honestly, was if they looked like me. If I felt, if they looked like me, they were more understanding, there was more empathy, they understood more, and they were willing to help more. – Participant D

The negative experiences Participant D described were with White doctors:

> The bad experience came from both a White male and a White female doctor that were very, there was no empathy, very abrasive, very harsh, just very, this is what needs to be done.

Other participants, however, felt their White practitioners were more empathetic or noticed no differences in the empathy expressed by practitioners of different races. Participant B reported seeing no differences in empathy but did describe feeling "a little bit more heard" with a White practitioner; she was unable to explain why she felt this way. Similarly, Participant C did not recognize a difference in empathy, although she felt she “had a better way of communicating with them [doctors of color].” Participant F felt her current White doctor was more patient with her than a Black doctor she previously saw. This participant indicated that she did not believe this difference was due to race but was instead due to regional differences in the approach to gynecological care.

Discrimination

According to the participants, discrimination involved prejudiced actions, assumptions, or language about the patient that stems from marginalization of the patient’s identity. In this case, the marginalization of the patient's identity pertains to her race, gender, socioeconomic status, or a combination of any of these three. Two subcategories emerged from the theme of discrimination: overt discrimination and covert discrimination.

Overt Discrimination

Overt discrimination was the obvious usage of discriminatory language and/or practices by a medical practitioner or by other medical staff. This type of discrimination took the form of negligence, disrespect, and stereotyping in the description of the participants’ experiences.

Negligence included errors made by physicians or other medical staff that threatened or harmed the emotional, psychological, or physical well-being of the patient. Two participants shared experiences of medical negligence. Participant A once visited a

Planned Parenthood clinic when she was in college. When describing that experience, she said,

> I was trying to access birth control and, some kind of way, they mix urine samples with someone else's, and they said I was pregnant, which was not true. And you can imagine how devastating that would be cause I was not in there for a pregnancy test. But anyway, so it was not handled well.

The other participant who described negligence, Participant F, did so in the context of her labor and delivery experience. She said,

> So, my daughter has autism and I experienced it because I think it happened when I went to the hospital, and they waited 12 hours before they gave me an emergency c-section. So, I think that the time on how they treat their patients, and I was just left in the room and needed to push. I remember it, my baby's 21, almost 22, so I just remember that it took forever for them to give me the emergency C-section. And now my daughter has autism. She had a bowel movement while she was still inside.

This participant attributed her daughter's autism to negligence on the part of the hospital staff. To further understand her experience, she was asked if the doctor who performed her emergency C-section spoke with her or explained what was going on prior to the procedure. Her answer to both questions was no. In explaining how she felt, she said,

> I was tired. I remember my back was hurting. I am a single mom, so depression was there and being in the hospital by yourself is a horrible feeling. And for you to sit and wait and don't know. So, this is my first and my only pregnancy. And not knowing what's going on, what to expect, why are you waiting, why your contractions are going and nobody's saying anything. So that was hard.

Disrespect was defined as not treating the patient as a person deserving of quality care. Three participants described disrespectful experiences. Participant A spoke about several instances when her time was disrespected:

> And typically, in those types of visits, at least for me, I wait on average of an hour to an hour and a half for most of my annual appointments. And

> that's just unacceptable to me, especially when you're in the examination room for 10 minutes.

She also explained several instances in which she was the only Black patient left in the waiting room while the White patients, who had spent less time waiting, had already been called back to the examination rooms. She was unsure if this was due to discriminatory practices, but those situations did cause her to wonder. When asked how she felt during these situations, she said,

> I mean, it's our day to day. We experience this over all the time. You're always overlooked. You can be in line at a grocery store, and they will address a White person before they address you. Hands down. Restaurants. Hell, in the classroom. I'm a professor. You're not ever seen as the authority no matter what. It's always other people.

When Participant B was describing her first reproductive health visit, she said,

> And I will never forget, the doctor said to me, why can't everyone who comes in here be as easy as you? Your, I can feel your cervix immediately. It's tight and you are clean, and you smell great. And it was just so uncomfortable <laugh> and she was a woman.

At the time of her visit, the participant was somewhere between the ages of thirteen and fifteen. The visit took place at her local health department due to the low-income status of the participant and her family. She explained that the comments made by the doctor caused her to become more self-aware and insecure about her hygiene. This same participant described a recent experience where she was discriminated against based on her insurance status. During the check-in process for a scheduled gynecological appointment, there was an issue with Participant B’s insurance. Despite having active health insurance, the system incorrectly displayed her insurance status as inactive. Prior to the issue, the receptionist was behaving kindly toward the participant. After the issue was discovered, the receptionist acted annoyed. Participant B still decided she wanted to be seen by her doctor. After waiting for an unnaturally long time, she was informed that she would not be able to see her doctor and that someone else would have to perform her examination.

> Yeah, it was very frustrating. It was very frustrating because I'm sitting here and I wanna see the person who I am used to. ‘Think I have rapport with my doctor about my medical diagnosis and about my comfortability in the office in general. And so, I'm having to see a stranger on top of an hour and 40 minutes to even be seen. So, it was very frustrating, and definitely that was one of my more dreadful visits.

Another uncomfortable experience that was shared was by Participant F, and it occurred during an annual gynecological examination. At the time, this was the participant’s first visit to a gynecologist at eighteen years old. The doctor performing her examination asked if it would be all right for some medical students to sit in on her Pap smear. Because she did not know what the procedure entailed, she allowed the medical students to watch the examination. When she was asked if she had a problem with the students being present after she realized how a Pap smear was conducted, she said, “Yes, yes, yes.”

Stereotyping was the assumptions made by a practitioner about the lifestyle, conduct, feelings, or the experiences of pain of Black female patients. Three participants experienced stereotyping by a practitioner or multiple practitioners. When discussing her labor experience, Participant D said,

> I had to go through the emergency room and the doctor, he was very abrasive, very rough. He was doing the check and he instantly ask me, because my baby was small, I mean, I was small. He asked me, was I on drugs?

At the time, the participant was young and going through her first labor experience. The emergency situation she was in caused her not to recognize the discriminatory language, but she described it as “very offensive” at the time of her interview. Not only did his discriminatory comment make her uncomfortable, but so did his abrasiveness while conducting her examinations:

> So, then it became what, I don't want him to touch me. I don't want him to touch me. I'll let me sit here until my doctor get here.

Covert Discrimination

Covert discrimination involved hidden or subtle usage of discriminatory language and/or practices that may be unconscious. This subcategory largely included the experiences of being dismissed by a practitioner. Every participant recounted at least one experience in which she was dismissed by a practitioner. Often, the dismissal occurred when the participant brought up a concern or mentioned being in pain:

> They're not listening. They're focused on taking their notes and prescribing medication and getting you out the door. – Participant A
>
> The male doctor that did not have empathy, it was like he just didn't care. He didn't. You say, ‘Hey, that hurts.’ And it was, ‘Well, I have to do this.’ – Participant D
>
> I felt like I was being dismissed that it was, it's maybe like, oh, oh, that's just in your head. And for me I don't let people think that for me because I'm like, okay, well you may not think it, but I need this. I knew something was going on when I had the heavy bleeding first of all, and I felt like a Pap smear or something should have occurred then, just go in there and see what's going on. – Participant E

Communication

The category of communication related to conversations between the patient and practitioner or the patient and other clinical staff about questions, concerns, and experiences of pain. The subcategories within this theme were practitioner responsibilities, lack of follow-up, and self-advocacy.

Practitioner Responsibilities

Practitioner responsibilities were expectations participants had for how practitioners should conduct themselves when caring for a patient. The most important aspects described by the participants within expectations were time and space, listening and believing, and cultural competency. Time and space as a category refers to the physical or conversational areas and times the practitioner provided for the patient to voice concerns, ask questions, and discuss her health freely. The participants noted that time and space also applied to the practitioner's responses to questions and concerns. Participant A's description of responsibility in healthcare is as follows:

> Well, one would be providing space for the patient, which would be me to talk about my health and concerns and just be able to ask questions and providers allowing me the time to do that. But instead, it's typically a very rushed experience.

Whenever time was mentioned elsewhere in the interviews, it related to participants' experiences of long wait times whether in the waiting room or the examination room.

Listening and believing were mentioned by four of the six participants. They described listening as actively absorbing information, concerns, and questions the patient may bring up during her healthcare visits and believing as recognizing that a patient is telling the truth when describing her concerns or feelings and acting on those concerns and feelings to improve the patient's health. These terms were mentioned in the context of participant experiences in which the participant felt her doctor was dismissive of pain or concerns. In Participant D's response to the question about how practitioners can change their approach to Black women's healthcare, she stated,

> I believe they can change by listening. Listening to us and believing that we hurt the same way. And that we know our bodies just as our White counterparts know their bodies.

Cultural competency was discussed by two participants, specifically concerning their experiences with practitioners who lacked cultural knowledge on African Americans. Participant E believed her frustrating experience with uterine fibroids partially stemmed from her doctor's lack of knowledge about the prevalence of uterine fibroids in African American women. She also mentioned the importance of practitioners knowing about African American health to build patient-practitioner trust:

> So, if I say, oh, well do a lot of African Americans do get this or have this, and to me they should know that information. So being knowledgeable and then talking about the experiences that they probably have had with other African American patients, like, oh, I have. And I think that helps too, because if my doctor says, oh, I have several African American patients and here are things that we've talked about, and it's like, oh, okay.

Lack of Follow-up

Two of the participants described feelings of frustration over a lack of follow-up from their physicians. Participant A said,

> The other thing that I don't appreciate is that there's never a follow-up when you try to call and make you leave messages with the nurse's voicemail it, it's not a level of, I guess it feels like there's not a level of care or concern for patients.

For this participant, lack of communication by the practitioner came across as uncaring and unempathetic. During a particular experience with her gynecologist, Participant F explained how she never received an answer as to why she was experiencing an abnormally long menstrual period despite bringing up the concern to her doctor. When asked how she felt about the lack of response, Participant F stated,

> Oh, I didn't like that. I didn't like that at all because even though with the test results saying that[‘s] normal, I still didn't get to this day the answer to why I was having my cycle for too much.

These participants characterized lack of follow-up as not communicating with the patients after their visit to a practitioner's office despite their desire and attempts at communicating.

Self-Advocacy

Self-advocacy was defined as acting as an advocate for one's own health to ensure practitioners are providing you with the care you deserve. Participant F explained how she utilizes self-advocacy to promote her healthcare needs and avoid being dismissed by doctors:

> I'm such an advocate for me and my healthcare, and I, it all stems from just the bad experiences that I had with that one doctor.

She also stressed the importance of all women practicing self-advocacy in healthcare:

> So anyway, it's just knowing your body, not giving up on when you feel a certain way.

Reasons for Seeking Gynecological Care

This category represents the specific visits to gynecological facilities shared by the participants and the reasons why the visits occurred. The two main reasons the participants saw a gynecologist were to obtain birth control and to receive labor and delivery care.

Birth Control

Four of the six participants' first visits to a gynecologist were to acquire birth control. The women were in their teens or possibly their early twenties when these visits occurred. For two of the patients, they chose to go to a Planned Parenthood clinic. One of them explained that she chose Planned Parenthood for its confidentiality:

> I liked that they didn't tell anyone because [my friend and I] we were both 16 and that was probably my major fear is it. So, I probably wasn't paying attention to if they were caring or empathetic. I was like, I just don't want my mama to know. – Participant E

Two of the participants also described being unaware that the practitioners were going to perform a Pap smear in order to prescribe the birth control. They both expressed feeling a general level of discomfort or awkwardness when undergoing this procedure.

Labor and Delivery

Labor and delivery as a subcategory refers to the instance when a participant's pregnancy culminated in the birth of a child in a hospital setting. This subcategory included the thoughts and feelings described by the participants. For each participant, the labor and delivery ach described was her first and only pregnancy. All three participants underwent emergency C-sections. Out of the three participants who described a labor and delivery experience, only one of them was positive:

> And I always seemed to be taken care of. I always got explained what was going on. It wasn't something that I was not told what was going on.
> – Participant C

The labor and delivery experiences shared by Participant D and Participant F which were previously outlined, involved stereotyping and negligence, respectively.

> It made me wanna seek out a different medical practitioner because he was the emergency room doctor, and so I had to wait for my primary care doctor to come in and I told him I don't want, and by that, because he even in, he gave that comment, but he was also very rough in doing his checks and everything. – Participant D

> It was labor and delivery because I came in and they admitted me, but I wasn't dilated, but her [daughter's] heart rate was low and so I don't know why they made me wait. – Participant F

Attitudes Toward Gynecological Care

This theme concerned sentiments shared by the participants about gynecological care and gynecologists. The subcategories that emerged were fear, trust, and comfort.

Fear

The fear mentioned by the participants included feelings of scaredness or unease that Black women have pertaining to the possibility of experiencing culturally incompetent healthcare. Two participants explained that many Black women are afraid of seeing a doctor due to the multitude of negative and dangerous experiences Black women have historically had.

> But I do know there is, I know women are Black, some women are scared to go to the doctor. – Participant E

Participant B's fear concerned childbirth specifically:

> While we're not having babies, especially Black women, there are so many Black women who are dying in childbirth. And that scares a lot of people. I can personally say that scares me. That is the reason why I do not desire to have children, because I cannot imagine having to deal with the incompetent medical team during childbirth, or a medical team who just isn't aware of the discrepancies against Black women.

Trust

This subcategory encompasses how the patient felt about the practitioner during or after the appointment; these feelings were either expressed as trust or mistrust of the practitioner. Participant D explained how she had a high level of trust and rapport with her OB-GYN during her pregnancy:

> She just made me feel very comfortable enough to the point that when I was informed that I would have to have a Caesarean, I was like, nope, no one's cutting me but her. So, because I was like, no, she's the only one that I trust to do this for me.

The trust Participant D had in her OB-GYN stood in opposition to the mistrust she had with the abrasive emergency room doctor who initially performed her examination when she was brought into the hospital after going into labor. Two participants shared instances when they were mistrustful of doctors. Participant C said,

> I had some people that were, like I said, I really don't think that they're telling me the truth or their intentions of what they were doing with me or about me was correct there.

At one point during her interview, Participant E described reluctance among some in the Black community to see a doctor. When asked what the cause of this reluctance could be, she said,

> I think it's two things. I think it's the lack of trust and got to pay for it.

Participant E posited that the mistrust could stem from a bad experience with a practitioner in the past.

Comfort

Several participants discussed specific aspects they look for when selecting a gynecologist. Comfort, or feeling at ease with practitioners or medical staff because of their display of empathy, was a key factor in the selection process. Two participants expressed a preference for Black practitioners because they felt Black doctors would have a better understanding of their needs and concerns as Black women.

> I think that I would feel more comfortable with a Black practitioner. So, because Black women are at higher rates of death and disease than their white counterparts, and I feel as though having a Black practitioner, I'm able to connect with them on that level just that level of understanding. – Participant B

Two different participants expressed a preference for female practitioners. The reasons given for this preference were commonalities in experiences and the ability of female doctors to connect with and understand female patients in a way that male doctors cannot.

> I always felt that they would be more concerned or more able to understand what we was going through rather than a male, male doctor. I just always felt comfortable with it. – Participant C

> But when it comes to my women parts, I think women can identify what we go through because they get Pap smears and those types of things. And so, I think because of that, they are more in tuned and they understand the process more. – Participant E

Participant E also shared that she chooses a gynecologist based on recommendations from other Black women:

> What I tend to do when I go to new areas, because I move a lot, is I ask around, I ask people, who's your gynecologist? Do you mind me? Do you have a recommendation? What are your thoughts? So, I do a lot of, I ask questions before I actually go to the different, to the gynecologist.

Solutions for Improvement

The information within this category comprises the ways to improve Black women's experiences in various reproductive healthcare settings according to the participants. The subcategories within this theme include resources for Black women and practical solutions.

Resources for Black Women

Resources for Black women refers to healthcare resources geared toward the betterment of Black women's health. During each interview, the participants were asked about the viability of potential resources. Four of the participants said they would trust resources specifically geared toward Black women but with a bit of hesitancy. These participants stated that they would need to do research on their own to determine the trustworthiness of said resources.

> I would take a look at 'em and initially look at 'em and see. So, I will always give them the benefit of the doubt. I am a strategic scientific, more type of person anyway, so I can always see where is it coming from and what resources that is coming from and if it's connected to the right people and right organizations, then yes, I would trust it. – Participant C

> Yes, and I would research them out myself and further and yes, I will look into it. – Participant D

A few participants mentioned that the resources would need to be connected to the "right" people. The "right" people included Black female leadership and credible medical professionals.

> I think that leadership would have to be black women or it wouldn't have to be all Black women, but the leadership of these programs would have to be a woman who has lived experiences, or someone who can advocate for the Black women population. – Participant B

> I probably have to hear word of mouth from someone and say, oh no, there are some good doctors. And I don't know how that could get out unless maybe there's some African American women that are at maybe there to tell about the services. – Participant E

Participant C noted that potential resources must be reputable. Her determination of the reputability of resources was informed by questionable medical treatment African Americans have historically faced:

> But I myself have, don't feel like I've experienced that. A doctor is saying they're treating me for one thing, but they're actually doing something else or not giving the treatment. But that has been the case in the past, especially when it comes to African Americans in general at all. But I don't feel like I've experienced any of that personally.

Practical Solutions

This subcategory encompasses the suggested solutions to improve Black women's experiences in reproductive healthcare proposed by the participants. The solutions offered by the participants involved systemic changes, equal access to education, and holistic care. When the participants described system-level changes, it was with the ultimate goal of increasing the number of practitioners of color and/or female practitioners:

> So that's important because about 10 years ago, there were very few midwives in the area when my friend was having her first child. And I think that's something that many Black women could probably benefit from. And just having also support from Black doulas with the birthing process. – Participant A
>
> And as much as we try to have an all-black advocate team for birth, or just anyone who advocates for Black women's reproductive experiences, it's hard because everybody's also trying to do that as well. So, it's very limited in the space of people who are advocating for Black women, and they're either overworked or they're just overbooked, and it's hard sometimes. – Participant B
>
> Yeah, I do think we need more Black professionals in the field though. I think that would help with the healthcare system for African American women if we have more female doctors. – Participant E

Participant A discussed the need to generate pathways and training programs to increase the number of people of color in medicine. One key pathway she identified was education:

> All schools are not equal in terms of what resources are being provided. And so that ultimately impacts what happens at the medical school

> training programs and the number of people of color that are physicians and things of that nature.

Holistic care was described by two participants as viewing the patient as an individual person with a unique life experience. They both noted the importance of not defining the patient based on their appearance, socioeconomic status, or diagnosis:

> I think that our healthcare professionals should look at the patient as a whole patient and not just a diagnosis or someone who is coming through the office for a routine checkup. I think that considering environmental factors as well as predisposing factors of their health as alongside family history is very important. – Participant B
>
> For each individual person they should really take in account of what's going on them in particular and not group them in a yes, I know certain women of your type, your size is going to experience this. We're just going to automatically put you on this type of medicine because I can tell by looking at you that you're going to need this and instead of actually taken any test or anything like that. – Participant C

Chapter IV
Discussion

Six themes arose during the analysis of the interviews: empathy, discrimination, communication, reasons for seeking gynecological care, attitudes toward gynecological care, and solutions for improvement. The theme of empathy included two subcategories, gendered and racial empathy. The participants defined practitioner empathy in similar ways. They expected providers to care for them, listen to them, and treat them as individuals deserving of time and respect. In addition to this, they expected practitioners to have a cultural understanding of Black women as patients and people. The participants gave comparable descriptions of unempathetic practitioners. The second theme and the way it manifests in overt and covert ways generates an understanding of how discrimination manifests against Black women as reproductive healthcare patients. Participants described instances of dismissal, negligence, stereotyping, and disrespect. Discrimination on the grounds of health insurance status was also mentioned. Communication was a consistent theme when discussing previous experiences and communication. The participants prioritized communication between the patient and the provider and conveyed feelings of disappointment when they discussed instances in which providers did not reciprocate this prioritization. Practitioner responsibilities were outlined by the participants and included time, space, cultural competency, and following up with patients.

Although all participants shared unique experiences from their lives, there were some commonalities encapsulated under the theme of reasons for seeking gynecological care. For one, four of the six participants first visited a reproductive health office or clinic to obtain some form of birth control. Three participants also described labor and delivery experiences. Two of those experiences were negative while the other was positive. The attitudes toward gynecological care expressed by the participants included feelings of fear, trust, mistrust, comfort, and discomfort. These feelings often dictated the type of gynecologist a participant would select. Participants indicated an interest in potential healthcare resources that are geared toward Black women's reproductive health. The solutions they suggested for improving Black women's experiences in reproductive healthcare were creating equal access to education, providing avenues for people of color and women to become medical practitioners, and training doctors to provide holistic care that is empathetic and culturally competent toward Black women.

The inclusion of cultural competency in the participants' ideas about empathetic healthcare practices likely stems from previous experiences where doctors lacked an understanding of them as Black patients. A level of understanding seemed to be a key component in the participants' perceptions of gendered and racial empathy. Participants tied this understanding to the similarities between themselves and their practitioner.

There was not a general consensus, however, about the empathy that practitioners of different races and genders typically showed to their patients. This is to be expected because each participant had unique experiences in different locations with different doctors. While it is important for practitioners in all specialties to be empathetic toward patients, it may be even more important for practitioners in reproductive health to do so. This is because of the delicate nature of women's reproductive health, particularly among Black women in the United States. As mentioned earlier in this thesis, gynecology in the United States is plagued with a difficult history that rests on the backs of the exploited Black female slaves who were crucial in its founding (Taylor, 2020, pp. 507-10). A participant in this study mentioned the exploitation of Black men and women at one point during her interview when discussing her own experiences. This knowledge likely stays with the participant during her various visits to medical practitioners, making visits to doctors more stressful than they may already be (Shen et al., 2018, p. 129). Some of the participants even mentioned the stress and fear that exist among many in the Black community concerning seeing a doctor. It seems that practitioner empathy plays an important role in creating a positive experience for Black patients, especially Black female patients. The position of care in the participants' definitions of empathy and descriptions of positive healthcare experiences reveals a culturally specific version of provider empathy that was significant for the participants.

For many within the African diaspora, motherhood is a critical role for women that often involves self-sacrifice and stands as a pillar within Black communities (Collins, 2009, pp. 188-90; Rosenthal & Lobel, 2016, pp. 415-17; Dow, 2016, pp. 183-84, 192-94). Due to the necessity for communal child-rearing as a result of slavery, minimal labor opportunities, and the mass incarceration of Black men, many Black women find themselves becoming caretakers for those in their community whether they are biological mothers or not (Collins, 2009, pp. 190-215). For this reason, Black women may find themselves seeking reciprocal care from their medical practitioners, hence the presence of care in the definition of empathy in healthcare presented by the participants. Reciprocal care can be understood as the kind, empathetic, and trustworthy care that Black women offer to others in their lives as a result of their position as caretakers. This understanding of empathy may be specific to Black women in the United States due to their unique history and experiences.

An important part of the findings was that every participant had been dismissed by a medical practitioner in at least one point in her life. Experiences of dismissal are likely the reason that the participants defined listening and understanding as part of practitioner empathy. Most often, the participants' concerns and pain were dismissed. The dismissal of pain is not a revolutionary experience for Black women. During the creation of American gynecology, Black women were used as experimental subjects due to their supposed "high tolerance" for pain (Owens, 2017, pp. 23, 44). Of course, Black women's inferior status as slaves also contributed to the ease with which White male doctors exploited their bodies. Brutal treatment toward Black women was justified through their delegation to the status of subordinate in both sex and race (Owens, 2017, p. 46). It is not surprising that the myths about Black women's pain tolerance have persisted in the field of gynecology since their inability to feel pain was foundational in its construction.

The instances of negligence, disrespect, and stereotyping described by the participants also has roots in the exploitation of and experimentation on Black women. All three manifestations of discrimination reflect a disregard for Black women's emotional and physical well-being. In the experiences described by the participants, practitioners treated them more like medical subjects rather than like people. This was distressing to the participants, especially when this treatment was consistent or when this treatment occurred during an emergency medical situation. The denial of Black women's personhood was common in medical and scientific literature during the enslavement of Black men and women in America (Owens, 2017, pp. 19-21). Like the myths surrounding pain, it seems treatment of Black women as less than human has persisted.

The discrimination, subpar treatment, and discomfort described by a few of the participants in regard to the healthcare they received at their local health departments when they lacked insurance demonstrates the intersectionality of race, gender, and class. The suggestion that one reason some within the Black community do not go to the doctor is the cost of healthcare is a good representation of this intersectionality. Slavery, Jim Crow Era segregation, and persistent racial discrimination have contributed to the lack of generational wealth and access to quality healthcare affecting many African Americans (Gaskin, Headen, & White-Means, 2005, pp. 97-101; Pfeffer & Killewald, 2018, pp. 1430-3; Yearby, 2018, pp. 1133-8). For one participant, obtaining health insurance allowed for the ability to select a practitioner and resulted in the improvement of experiences in reproductive healthcare. Perhaps the most telling piece of information shared by a participant concerned the everyday experience of discrimination people of color face in the United States. When she made this comment, it was a matter-of-fact statement said with frustration and anger. Her tone reflected the experiences she has had living as a Black woman in the U.S. The experiences shared demonstrate that Black women are the subject of discrimination regardless of socioeconomic status (Taylor, 2020, p. 512).

Several aspects of communication tie into expectations of empathy and practitioner responsibilities. The participants expected practitioners to behave in certain ways to ensure a quality visit (Shen et al., 2018, pp. 129-30). Like the participants' definitions of empathy, many of these expectations were formed from past experiences. The most significant expectations included allotting the patient time and space and listening actively. Some of the participants expressed frustration at the long wait times they experienced at doctors' offices or local health departments and made correlations between these long wait times and a lack of care by the practitioner and other medical staff. They felt they were not being treated as a priority. This directly conflicted with their definition of empathy in healthcare, indicating the importance of past experiences in the formation of the participants' opinions about practitioner responsibilities. The conversational space desired by some of the participants may be linked to previous instances of dismissal by medical practitioners. This space would require practitioners to create opportunities for patients to discuss their health concerns free of judgment. When the participants discussed positive experiences they had with practitioners, communication was always mentioned as one of the reasons they enjoyed seeing a particular practitioner. This may be why communication connected to the other four themes.

Communication, whether good or bad, had a significant impact on the experiences of the participants. It served as an indicator of whether an experience was discriminatory or nondiscriminatory. In reproductive healthcare, improper communication can result in the death of the patient and, in labor and delivery situations, the death of a child (Byrd, Ingram, & Okpara, 2022, pp. 6-8; Ravi, Iacob, & Profit, 2021, p. 2). Cultural and medical knowledge specific to Black women was an aspect of communication mentioned by a couple of the participants. One participant specifically wanted her doctors to know about the medical conditions that affect African Americans more greatly than European Americans. She also wanted her doctors to be able to effectively communicate with their African American patients. By having the knowledge and ability to communicate effectively with Black patients, practitioners can help build rapport and trust that may contribute to a better experience for Black patients.

When the participants discussed their first reproductive health visits, they described feelings of being uncomfortable or awkward during their appointments. These feelings were attributed to seeing a gynecologist for the first time and undergoing an invasive pelvic examination or being unaware about what to expect from a gynecological appointment. A lack of knowledge about gynecological healthcare and expectations of discomfort may set the stage for a girl or woman's first reproductive health visit to be dreadful or traumatizing. If the gynecologist is unempathetic or discriminatory toward the patient on top of these feelings, the patient may come to expect bad experiences or avoid seeing a gynecologist all together. Comprehensive sex education in secondary schools along with sensitivity training for those working in gynecology could help improve the first-time gynecological experiences of Black women and girls.

The labor experiences that involved emergency C-sections described by the three participants may be connected to higher maternal mortality rates among Black women. Saluja & Bryant (2021) noted that Black and Latina women are more likely to undergo C-sections than White women despite the leading causes of maternal mortality being associated with this procedure. With Black women possibly experiencing discrimination on top of complicating procedures such as C-sections, it is no wonder that their maternal mortality rates are higher. It is interesting that only one participant had a positive labor experience. The mention of the multitude of complaints made against the emergency room doctor who stereotyped one participant indicates a possible failure on the part of the hospital to protect female patients from a rough, abrasive doctor. If similar complaints had been previously reported but the behavior had not changed, it may mean that the specific hospital the participant visited lacked an appropriate response or intervention strategy to correct harmful practitioner behaviors. It is also interesting that another participant attributed her daughter's autism to her negative labor experience. While there is likely no way to confirm that that experience was the cause of her daughter's diagnosis, it is important to recognize the participant's belief. It is confusing as to why the participant was left in the dark concerning the progression of her labor and her daughter's condition prior to her C-section. Even the participant expressed feeling confusion, both then and now.

Attitudes toward gynecological care revealed what the participants looked for in a gynecological experience and in a gynecologist and what they did not want to see. A significant piece of knowledge offered by participants was how some Black women fear negative experiences and sometimes death at the hands of negligent and culturally incompetent practitioners. This knowledge is particularly significant when discussing reluctance to visit physicians among some within the Black community as mentioned by a participant toward the end of her interview. It is not enough to encourage people to go to the doctor. It is crucial to understand why they do not go to the doctor. For Black women, past experiences, practitioner incompetency, and lack of access to culturally competent doctors can all play a part in discouraging them to seek medical care.

Incompetent medical practices may also be a determinant in Black women's decisions whether or not to have biological children. It is certainly understandable that Black women may experience fear when considering pregnancy and childbirth given the high instances of maternal morbidity and mortality among Black women in the United

States (Petersen et al., 2019, pp. 762-5; Howell et al., 2016, pp. 122.e3-5). This awareness may be a reason why the participants sought trustworthy doctors with whom they felt comfortable. The participants' past experiences, both negative and positive, contributed to who they thought could be an appropriate gynecologist. For some of them, gender and race were indicators of the baseline level of comfort they could have with a practitioner, meaning they would not feel comfortable if the gender and/or race preference of doctor was not already met. Having the ability to choose a male, female, White, or Black doctor gives the patient more agency in her own healthcare. This can be incredibly important for those in historically marginalized communities. Unfortunately, the availability to choose does not exist for all people in the United States, especially those who do not have health insurance or lack the financial means to pay for healthcare. Black Americans, due to centuries of discrimination, may likely experience these issues (Fiscella & Sanders, 2016, pp. 382-5; Gaskin, Headen, & White-Means, 2005, pp. 97-101; Yearby, 2018, pp. 1133-8).

Arguably the most important part of this study are the solutions for improvement suggested by the participants. There was a general lack of knowledge about the availability of current resources geared toward Black women's healthcare. This might be due to the unpopularity of resources that do exist. The participants might have been unaware because they all had health insurance and could have their healthcare needs met at a primary care facility or hospital. The fact that the participants all expressed interest in potential resources for Black women and their healthcare was an encouraging discovery that indicates that at least some Black women would find these resources helpful. The participants did have stipulations about the viability of said resources. First, Black women must be involved, preferably in leadership and community involvement positions. Second, the resources must be attached to reputable organizations and practitioners who are promoting Black women's reproductive health. Third, the resources must be accessible to all Black women regardless of socioeconomic and insurance status. Lastly, the resources should be available to research through various outlets (e.g., webpages, pamphlets, etc.). If these conditions are met, the resources could be a great success.

The practical solutions offered by the participants focused on centering Black people and on centering patients throughout all avenues of healthcare. System-level changes involve addressing inequities that exist that prevent people of color and people of low income from entering medicine and other fields that require higher education. These system-level changes need to occur at various stages of life to ensure equitable access to opportunities and the greatest efficacy. The participants specifically wanted systemic changes to increase the number of Black women in medicine. It was suggested that equal access to quality education and pathways into the medical field are crucial components for increasing the number of Black doctors both male and female. Because the criteria required to become a Doctor of Medicine (M.D.) includes obtainment of a post-secondary college degree, it makes sense that quality education was something the participants saw as important. Pathways, as discussed by Participant A, need to be created to train people of color to enter the medical field. These pathways need not lead to medical school. Medicine could be just as impacted by increasing the numbers of people of color in nursing, administrative, and midwifery positions.

Some of the participants emphasized the need for Black midwives and doulas in improving Black women's birthing experiences. A study assessing the use of doulas and midwives among U.S. Black and White women found that both groups of women were equally interested in doula and midwifery care (61.5% and 61.6% expressed interest, respectively), but Black women, especially those with a public form of health insurance, are less likely to be able to afford such services (Sperlich, Gabriel, & St. Vil, 2019, pp. 995-7). Considering the high maternal morbidity and mortality among Black women as discussed earlier, increasing the number of healthcare professionals who understand and care about Black women is vital. A proposed solution that applies to healthcare in general is that practitioners should use a holistic care approach to treating patients. Holistic care that prioritizes the individual, empathy, and the impact of the environment on one's health could be especially beneficial for Black women. Discrimination generalizes people into groups based on a facet of their identity. In healthcare, this means that patients who experience discrimination are being generalized in a way that lessens the quality of their care. A holistic care approach would also require the patient to be the central focus of the provider, something that could greatly benefit the Black women who often experience dismissal and poor treatment. Currently, the United States Department of Health and Human Services (HHS) Office of Minority Health maintains standards of care known as Culturally and Linguistically Appropriate Services (CLAS) that are designed to reduce health disparities. The fifteen standards under CLAS direct health services on how to properly recruit and lead diverse care teams, to offer communication assistance options for patients, to improve the standards, and to maintain accountability for ensuring the standards are continuously met (U.S. HHS, 2023). To ensure practitioners utilize a holistic care approach, it could be beneficial to include standards for holistic care in CLAS standards. Including such standards would promote more individualized care that

Black women believe would improve their healthcare experiences. Altogether, the solutions discussed by the participants have the ability to revolutionize the treatment of Black women in reproductive healthcare for the better.

Chapter V
Conclusions

Black women's experiences with discrimination and their viewpoints on how to end this discrimination should be made central in the discussion of improving the reproductive healthcare system. The stories shared by the participants in this study demonstrate how discrimination in reproductive healthcare continues to manifest and impact Black women of all socioeconomic backgrounds in the state of Tennessee. Their positive and negative experiences can be used to create a more ideal reproductive healthcare system that focuses on the needs and concerns of female patients. Healthcare professionals, state healthcare agencies, and advocates for Black women's health should work in tandem to implement the solutions offered by the participants and other Black women who have shared their experiences. Implementation of these solutions should involve collaborative efforts to change policy, revolutionize the reproductive healthcare system, and educate healthcare professionals and White Americans on their role in perpetuating racism in the United States. Empathy, effective communication, and cultural competency can be incorporated into the everyday practice of medical professionals to increase Black women's quality of care, ultimately improving the quality of care for all women. The information offered by the participants indicates a need for conversations between Black women and reproductive health providers and administrators to determine the best course of action to decrease discrimination in reproductive healthcare settings. It is essential that Black women lead these discussions and that practitioners and healthcare officials give them the space to do so. The guarantee of equitable access to education, the creation of pathways for people of color to enter medicine, and the adoption of a holistic care approach to healthcare are potential solutions that must be utilized to ensure Black women receive quality, non discriminative reproductive healthcare.

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Appendix A
Interview Questions

1. How would you define empathy in healthcare?
2. Describe your first reproductive health visit.
3. In your reproductive lifetime, have you had both male and female medical practitioners?
    a. Did you notice a difference in the level of empathy expressed by male vs. female practitioners?
    b. Did you feel more comfortable with a practitioner of a certain gender?
    c. Explain why you felt more comfortable with that practitioner.
4. In your reproductive lifetime, have you had only white or only people of color as your medical practitioners? Both?
    a. Did you notice a difference in the level of empathy expressed by white practitioners vs. practitioners of color?
    b. Did you feel more comfortable with a practitioner of a certain race?
    c. Explain why you felt more comfortable with that practitioner.
5. Have you ever experienced discrimination in a reproductive healthcare setting?
    a. Describe the experience.
    b. How did the experience make you feel?
    c. Did this experience change the way you interacted with medical practitioners or make you seek out a different practitioner?
6. In what ways do you think medical practitioners can change how they approach Black women's healthcare to provide a better experience for Black women?

7. Are you aware of any healthcare programs in your area that are geared toward Black women's healthcare?
8. If resources were to be made available to Black women in your community through state or federal healthcare programs, would you trust these resources?
    a. Why or why not?
9. Is there anything else you would like to add, or are there any resources you are aware of that you would like to share?

Appendix B
IRB Approval Letter

10.21.22
Investigator: Brooklyn Pickle
Investigator(s) Email: bp4v@mtmail.mtsu.edu

Protocol Title: Discrimination Against Black Women in Reproductive Health
Protocol Number: 23-2032

Dear Investigator,

The MTSU Institutional Review Board or its representative has reviewed the research proposal identified above and has determined that the study poses minimal risk to participants or that you have satisfactorily worked to minimize risks, and you have satisfactorily addressed all of the points brought up during the review.

Approval is granted for one (1) year from the date of this letter for 10 participants.

Please note that any unanticipated harms to participants or adverse events must be reported to the Office of Compliance. Any change to the protocol must be submitted to the IRB before implementing this change.

You will need to submit an end-of-project form to the Office of Compliance upon completion of your research. Complete research means that you have finished collecting data. **Should you not finish your research within the one (1) year period, you must submit a Progress Report and request a continuation prior to the expiration date.** Please allow time for review and requested revisions. Failure to submit a Progress Report and request for continuation will automatically result in cancellation of your research study. Therefore, you will not be able to use any data and/or collect any data. Your study expires **11/21/23**.

According to MTSU Policy, a researcher is defined as anyone who works with data or has contact with participants. Anyone meeting this definition needs to be listed on the protocol and needs to complete the required training. **If you add researchers to an approved project, please forward an updated list of researchers to the Office of Compliance before they begin to work on the project.**

All research materials must be retained by the PI or faculty advisor (if the PI is a student) for at least three (3) years after study completion and then destroyed in a manner that maintains confidentiality and anonymity.

Sincerely,
Aleka Blackwell and William Langston
Chairs, Institutional Review Board
Middle Tennessee State University

Appendix C
Code Definitions

Emotional and/or biological connection with practitioner: the ability of participants to connect with their practitioner based on an observed understanding and connection through emotions and/or similar biology.

Practitioner race and level of connection: the impact of the practitioner's race on the ability to connect with the patient. Includes inability to connect.

Lack of empathy: lack of understanding, concern, and care expressed by a practitioner.

Caring empathy: empathy practiced in a caring/nurturing way that is centered around the patient's comfort.

Regional differences in empathy: differences in provider empathy based on the location of the practice/doctor's office/hospital.

Negligence: errors made by physicians or other medical staff that threatened or harmed the emotional, psychological, or physical well-being of the patient.

Disrespect: not treating the patient as a person deserving of quality care or empathy.

Stereotyping: assumptions made about the lifestyle, conduct, feelings, or experiences of pain of Black/African American female patients expressed by a practitioner.

Dismissive: ignoring a patient’s concerns, questions, or pain.

Underlying racism: a type of prejudice that is unconscious or unrecognizable due to its consistent appearance throughout society (normalized behavior that still affects the well-being of the person being discriminated against).

Discrimination based on insurance status: discriminatory treatment against a patient by administrative and medical staff based on their lack of insurance or utilization of state/federal insurance for medical visits.

Everyday discrimination: the everyday experience of prejudice against people of color in the United States based on their racial or ethnic identity.

Time and space: the amount of time a practitioner allots the patient to ask questions and allots themselves to thoroughly assess the patient’s needs. Space refers to the physical or conversational area the practitioner provides for the patient to voice concerns and discuss their health freely.

Acknowledgment: recognition by the practitioner concerning factors that impact the patient’s life such as their socioeconomic status or experiences as a person from a historically marginalized community.

Listening: actively absorbing information, concerns, and questions the patient may bring up during their healthcare visits and responding appropriately for the overall improvement of the patient’s emotional and physical well-being.

Promptness: communicating with a patient regarding their health and concerns in a timely fashion.

Pain investigation: investigating a patient’s experiences of pain beyond the day of their visit to the medical office.

Bedside manners: treating patients with kindness, respect, compassion, and concern while they are under your care.

Believing: recognizing that a patient is telling the truth when describing their concerns or feelings and acting on those concerns and feelings to improve the patient’s health.

Cultural competency: understanding the history and experiences of Black Americans/African Americans in the United States (e.g., history of slavery and segregation, systemic racism, etc.).

Patronizing: condescending communication from the practitioner that may seem positive on the surface.

Invalidating patient communication: a practitioner’s disregard for the patient’s desire to communicate concerning their health.

Prioritizing oneself and one’s healthcare: practicing self-care by ensuring the practitioner is centering the patient and their health. Not allowing the practitioner to dismiss concerns.

Uncomfortable: a patient’s feelings of unease in a reproductive healthcare setting that may be the result of the practitioner's conduct.

Unpleasant: feelings of dread associated with a gynecological health visit that causes the patient discomfort.

First reproductive health visit: what occurred during the participant’s first visit to a gynecologist and how they felt during this visit.

Experiences with pregnancy and birth in a hospital setting: the positive or negative experiences participants who had had a child shared concerning the birth of that child.

Cultural incompetency: fear associated with reproductive healthcare due to statistically high mortality rates among Black women and systemic racism/discrimination.

Surgical intervention: the necessity for a patient to undergo a Caesarean section to aid in the birth of the child.

Mistrust: disbelief that a practitioner's intentions are for the benefit of the patient's mental and physical well-being.

Research and recommendations: researching potential gynecological providers by examining online information or by asking other women for recommendations.

Choosing a practitioner: selecting a gynecologist and the reasons for that selection.

Current initiatives: resources and programs that currently exist to better Black women's experiences in reproductive healthcare.

Viability of potential resources: the likelihood that resources developed for Black women will be trusted, helpful (attends to their needs), and successful.

Lack of options: being unable to choose a specific practitioner because of the low presence of women and people of color in the field of medicine.

Change system: institutional change that gives historically marginalized communities equitable access to resources and opportunities that they have previously been barred from

Pathways: creating ways for historically marginalized groups of individuals, specifically people of color, to access institutions that could lead to their entrance into the medical field and to the advancement of their socioeconomic status.

Education: equal access to quality schooling for all children regardless of their race or socioeconomic status.

Holistic care: viewing the patient as an individual person with a unique life experience. Not defining the patient based on their appearance, socioeconomic status, or diagnosis.