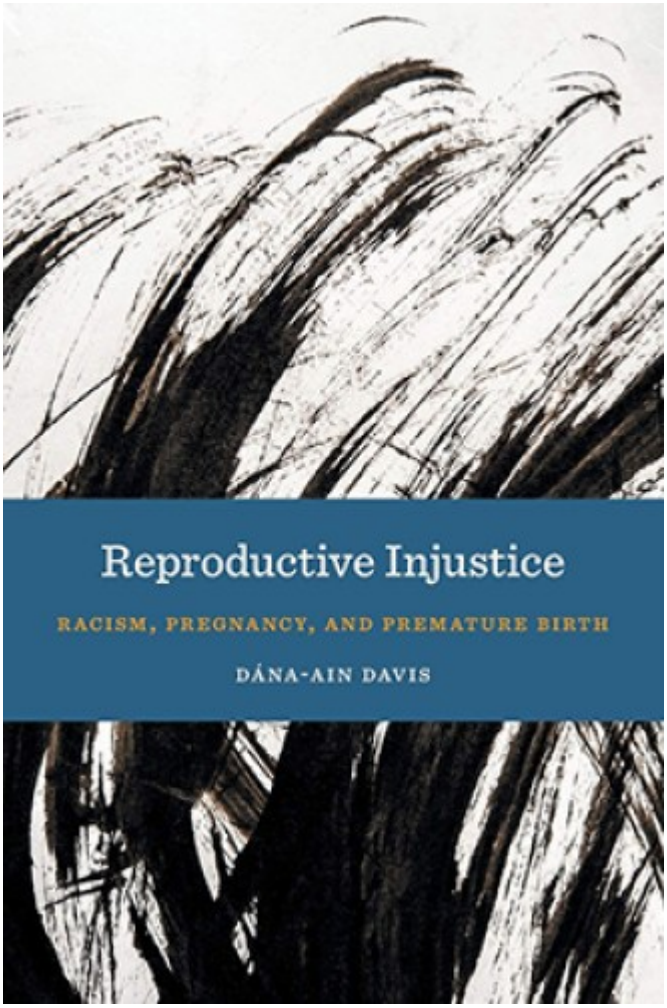
An anthropologist explores the dangers of being pregnant while black

Using case studies, Dána-Ain Davis shows how medical racism hurts black women.

by Justin List in the March 25, 2020 issue

In Review



Reproductive Injustice

Racism, Pregnancy, and Premature Birth

By Dána-Ain Davis
NYU Press

A young woman of color recently came into my clinic for medical care during her work break. A few months before, she'd borne a premature infant. When I asked her an open-ended question about her experience in the neonatal intensive care unit, she told me I wouldn't be able to understand how much of a nightmare the NICU experience had been for her. She said she'd spent at least 12 hours a day in the NICU for weeks, and she insinuated that this was only the tip of the iceberg. As I read *Reproductive Injustice*, I regretted not having probed further into her story.

Dána-Ain Davis, an anthropologist who serves on a maternal mortality task force for the state of New York, paints an alarming picture of how medical racism affects black women's health and black infant prematurity. Her own medical encounters as an expectant black mother inform the book, but it's rooted primarily in the stories of other black women who were mistreated during their prenatal period and as parents of premature infants in the NICU.

Davis defines medical racism as "the ideas and practices that perpetuate racial hierarchies and compromise one's health or facilitate vulnerability to premature illness or death." She conducted nearly 50 ethnographic interviews with black women and men, health-care professionals, birth justice advocates, and administrators at the March of Dimes (an organization that works on reducing prematurity and supporting pregnant women). She uses her interviewees' experiences to demonstrate the pervasiveness of medical racism that black families experience around childbirth.

Davis contextualizes her interviewees' stories by examining them through an anthropological lens called "the afterlife of slavery framework." This framework examines the continuous recalibration of racism over time that leads to premature death, poverty, incarceration, and other injustices that fall disproportionately on black people.

In medicine, the afterlife of slavery often takes the form of tropes, presuppositions, or insinuations about pregnant black women. Davis incorporates a range of historical examples that delineate the evolution of the afterlife of slavery in eye-opening ways. Assumptions that black women are "more hardy" in childbirth, that premature black babies are "more fit," and that black women can tolerate more pain than white

women stretch across America's colonized history.

Even today, the trope about black people having a higher pain tolerance represents a living vestige of racial science. A recent *New York Times* article (November 25, 2019) showcases how black people are often undertreated for pain and may have avoided part of the opioid crisis as a result.

In one of Davis's most vivid examples, a young pregnant woman named Ashley is diagnosed late with a threatening condition called preeclampsia. She asks questions and expresses her health concerns over a period of time, but she is repeatedly talked down to and dismissed by various health-care team members. When she finally goes to the hospital with severe symptoms, she needs an emergency cesarean section. Readers are left to wonder: If health-care providers had listened to Ashley sooner, could the emergency have been prevented?

As I read the first part of the book, I found myself wishing that Davis had offered more population-level public health data. Black women, even when controlling for income and education, have higher rates of severe maternal morbidity than women of other races and ethnicities. A discussion of this data could widen the scope of Davis's argument beyond her small set of ethnographic case studies.

Later in the book, however, Davis incisively describes the purpose of her ethnographic approach. She uses narrative discourse to bring context to the large-scale statistics and inferences that are built of individuals' stories. Part of the afterlife of slavery has been the tendency to explain away statistics by singling out black women and blaming their individual behaviors, treating each woman in isolation rather than pointing to systemic inequities and toxic stress and their effects on health. Telling multiple individuals' stories in aggregate works against this tendency; it creates a picture of structural racism.

Davis reiterates frequently that racism in medical encounters varies in intensity. It can be as subtle as a slight by a nurse or physician, or as frightening as a diagnostic lapse or delay. Furthermore, "racist intention is not necessary in the creation of racist outcomes." Some of her interviewees illustrate this point more convincingly than others, but her point is made by the existence in the stories she tells of a spectrum between intent and implicit bias.

Where do we go from here? Davis argues that de-medicalizing the pregnancy and birthing process is one place to start. She interviews several radical birth

workers—doulas, midwives, and advocates—who are trained to help black pregnant women give birth at home or in birthing centers whenever possible. They also provide mentorship, help with birth planning, and promote dignity in medical settings, serving as a liaison between a patient and a medical team. Radical birth workers aim to reduce infant prematurity and maternal and infant mortality. Limited evidence has been collected at this point on outcomes, but there is high satisfaction among clients.

Health-care professionals also need to work harder at dismantling racism. Davis provides examples of physicians and nurses anchoring themselves in social determinants (factors such as poverty, education, neighborhood) when explaining pregnancy disparities—at the expense of calling out the impact racism has on black pregnant women. Davis writes, “the repertoires of racism exist in the crevices and creases of a conversation, in the space between a comment and a pause. If doctors and nurses give dismissive looks or make a woman feel unworthy, that also constitutes a repertoire of racism.” When health-care workers avoid race and racism in conversations about determinants of health, we pass up opportunities to identify and dismantle structural inequities at the bedside and in society.

The American health-care system must reckon with its place in the afterlife of slavery. This includes training in implicit bias, hiring more health-care professionals of color in senior clinical roles, and better understanding how racism has historically impacted social determinants of health. Davis concludes the book with a challenge for health-care professionals to “look racism in the face and question the ways that the system within which they work might contribute to racist outcomes, draw from racist discourse, or perpetuate racist ideas.”

A version of this article appears in the print edition under the title “Birthing while black.”