More Than a Statistic: How Black Women's Birth Stories Can Reshape Maternal Healthcare in the U.S.

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Abstract

Black women are nearly three times more likely to die from pregnancy-related complications than white women, regardless of income or education (Fields par. 38). This paper examines oral histories from Black women in the CDC's *Hear Her* campaign to uncover the root causes of these inequities and suggest improvements for maternal healthcare. Through analysis of these narratives, alongside blog posts, journalistic accounts, and testimonies from the book *Pregnant While Black* (Rainford, 2023), recurring themes of neglect, bias, and emotional harm are identified. The dismissal of patient concerns breeds mistrust in the medical system, revealing that racism permeates maternal care. Systemic racism fosters a culture of neglect towards Black and marginalized women. These narratives also highlight paths for improvement, including enhanced cultural competency training, patient-centered communication, and advocacy programs. Centering Black women's lived experiences in healthcare is crucial to addressing disparities and improving maternal outcomes.

Introduction

> The new mother in Nebraska with a history of hypertension who couldn't get her doctors to believe she was having a heart attack until she had another one. The young Florida mother-to-be whose breathing problems were blamed on obesity when in fact, her lungs were filled with fluid, and her heart was failing. The Chicago-area businesswoman with a high-risk pregnancy who was so upset at her doctor's attitude that she changed OB/GYNs in her seventh month, only to suffer a fatal postpartum stroke (Martin and Montagne par. 20).

These birth experiences are not uncommon amongst Black women in the United States. According to the *Black Maternal Health Caucus,* "700 to 900 women die every year because of pregnancy-related complications. However, women of color have the highest rate of maternal death, with Black mothers among the most at risk, no matter their socioeconomic/educational status" (Andrews-Dyer par. 10). This is an unacceptable statistic to have in such a wealthy and medically advanced country. In fact, according to the *Commonwealth Fund,* a private foundation that aims to support independent research that promotes an equitable healthcare system, the U.S.'s maternal mortality rate for Black women is alarmingly high compared to most other wealthy nations. It has been reported to be "more than double, sometimes triple, the rate for most other high-income countries" such as Australia, Canada, France, and Germany (Gunja et al., par. 5).

This paper analyzes the reasons behind this statistic. It uses personalized autobiographical and biographical articles and oral accounts of Black women's experiences in pregnancy as a means to highlight the racial disparities in maternal health outcomes. After listening to these narratives, many recurring themes of medical neglect/dismissal in the hospital were found, as well as examples of positive experiences with culturally sensitive providers. This paper also explores these experiences thematically to reveal how patient-physician interactions

can be improved to reduce maternal mortality rates in the United States. For example, one approach to enhancing these interactions could be to conduct more research based on interactions, rather than relying solely on statistics, and further evaluate provider training programs for their effectiveness in eliminating bias. It is crucial that future healthcare providers understand the importance of providing equitable and compassionate care to all their patients, regardless of race or other identifying factors. It is also essential to hear directly from women and providers to add a layer of understanding that data alone cannot capture. Listening and hearing Black women's testimonies of their real experiences not only highlights problems, but also shows what good care can look like, offering real examples of how providers can improve their approach.

Context

The issue of systemic racism is deeply rooted in the United States. Even many sources, such as Daná-Ain Davis's paper links this deeply traumatic past to the unfortunate prevalence of obstetric racism, and overall, the disparities that exist in sexual and reproductive health (Davis par. 1). There are a multitude of different historical periods in which African American women have experienced these traumatic events, leading to inequities in maternal healthcare and a mistrust of the medical system. For example, in the period of slavery, from 1619 to 1865, which spanned around 246 years, many enslaved women were treated as medical specimens, instead of humans. They were forced to undergo "nonconsensual gynecological and reproductive surgeries" (Prather et al., table 1) repetitively without the use of anesthesia, including painful procedures such as cesarean sections and ovariotomy as a means to advance the medical field at the time. The Jim Crow era, which lasted about 100 years (1865 to 1965), forcibly sterilized Black women, and nonconsensual experimentation continued with the addition of either poor healthcare to impoverished Blacks or a lack thereof. Because of the incredibly oppressive nature of the Jim Crow era, there was a significant difference in the quality of the healthcare services that Black people received compared to other demographics (Prather et al., table 1). Overall, there was a very persistent and repetitive form of lynching, rape, hypersexualized stereotypes, and negative portrayals of Black women during these three oppressive periods as a result of the sexual abuse and nonconsensual reproductive medical experiments they were forced to go through.

Even in contemporary times, there is a very similar portrayal of Black women in society, contributing to their current negative experiences with healthcare. This Post-Civil Rights era, as described by Prather and colleagues's article lasting about 43 years from 1975 to 2018, highlights the same hypersexual images from the media, leading to a continuation of unequal healthcare, consisting of "targeted sterilizations, hysterectomies, abortions, and birth control" (Prather et al., table 1). Not only have Black women gone through oppressive periods in the past, but they continue to live through the remains of these periods when they are disregarded and treated as less worthy of quality care in the healthcare system. The repetitive nature of these negative experiences has fostered a pervasive sense of mistrust in the healthcare field, an alarming issue that warrants immediate attention.

Literature Review

The issue of inequalities in maternal healthcare in the United States, especially regarding Black women, is not new and is one that has been thoroughly researched and explored by many

researchers. Such sources include the perspectives of researchers, physicians, and government officials (Rainford; “This isn’t another horror story about Black motherhood; Mollard et al.). This research paper will draw on the perspectives of multiple reputable sources such as the well-accomplished Dr. Monique Rainford, MD’s book *Pregnant While Black: Advancing Justice for Maternal Health in America,* the *Black Maternal Health Caucus,* which is run by U.S. elected government officials such as Representative Lauren Underwood and Alma Adams, and Mollard and colleagues’s research paper, “Reclaiming narratives of empowerment around Black maternal health: a strengths-based, community-informed focus study.” These sources and their various perspectives have provided valuable background and context on the ongoing and relevant issue of racial disparities in maternal healthcare.

In her book, Rainford offers readers a unique perspective from a physician on the maternal health crisis. Rainford generally focuses on how Black women are disadvantaged when it comes to quality healthcare during pregnancy. She provides the disconcerting data that Black women in the United States are “three times more likely to die from pregnancy than if they are described as White” and that “her [a Black woman’s] risk of dying from a pregnancy-related complication during pregnancy or in the first 42 days after pregnancy was more than 40 in 100,000” (Rainford 1). These statistics are likely because of prominent structural racism in the United States, as much smaller, less funded areas such as the small Caribbean Island of Grenada have a much lower complication risk/maternal mortality rate: “the risk [is] ... 25 in 100,000 for a Grenadian woman having her baby in the small Caribbean Island of Grenada” (Rainford 1). The author also mentions situations that were proven credible, as they were firsthand experiences that Rainford encountered as a physician, which led her to realize the racial bias in the healthcare field. For example, one Black pregnant patient, Jessie, who died from cervical cancer, a cancer that is known to be highly preventable if a Pap screening is done early on. However, her doctors neglected her care and did not do a Pap screening, a mistake that cost Jessie her life. This story is one of many common occurrences in the American healthcare system, an issue that needs immediate rectification. Dr. Rainford explains that she, like many other physicians, has been taught to view these unfortunate medical issues as consequences of socioeconomic disparities. However, even when socioeconomic factors are accounted for, there is still a disparity in health between Black women and their White counterparts. This point is illustrated with another personal account in which one of Rainford’s Black patients, young, healthy, and economically advantaged, had a risky, premature delivery. Rainford accounts that she didn’t “realize that being Black in America was a risk factor that had nothing to do with…economic status or genetic background” (Rainford 11).

Another valuable source, the *Black Maternal Health Caucus*, gives further insight into the issue of racial disparities in maternal healthcare, but includes birth stories of high-profile Black women to do so. Founded by Representatives Lauren Underwood and Alma Adams in 2019, this bipartisan caucus in Congress aims to reduce the alarmingly high maternal mortality rates for Black women in the United States. In her article “This isn’t another horror story about Black motherhood”, Helena Andrews-Dyer talks explicitly about the racial bias against Black women using Black celebrity pregnancies as significant examples, proving that socioeconomic factors are not alone responsible for the divergent care between Black women and their white counterparts. For instance, Andrews-Dyer talks about how world-renowned Black singer and actress Beyoncé had an “extremely difficult” second pregnancy with twins (Andrews-Dyer par. 6). Beyoncé said, “I had high blood pressure. I developed toxemia, preeclampsia” (Andrews-Dyer par. 6). Preeclampsia is a severe pregnancy complication that can be fatal if not

treated properly. Beyoncé's lack of early diagnosis and improper prenatal care is what ultimately led to her uncomfortable and terrifying pregnancy experience. Another example was of famous tennis player Serena Williams whose birth story included an emergency C-section and "doctors that ignored her as she pressed to get the CT scan that ultimately saved her life" (Andrews-Dyer par. 6). Again, this highlights how neglected and "brushed off" Black pregnant women's concerns are to physicians who are supposed to be taking the best care of them in their vulnerable state.

The author goes on to state a devastating statistic that the author for the case of reparations at a congressional hearing, Ta-Nehisi Coates, repeated at a congressional hearing: "black women die in childbirth at four times the rate of white women" (Andrews-Dyer par. 6). This devastating statistic shows how racial bias plays into the quality of care pregnant women receive in the United States. Interestingly, the article also states that pregnancy is a much more anxious and stressful experience for Black women who are afraid they won't receive the best care early on in their pregnancy because of racial bias. This is because of the horrifying stories and statistics that they have read and heard about. Stress is also known to be a complicating factor in pregnancy. This idea is illustrated when the author claims that "as a Black woman, it's not enough to 'stay hydrated' and curate the perfect nursery on Pinterest. There are studies to digest, articles forwarded by your best friend on C-section rates to read, summits to attend on combating implicit bias, and doctors to screen for implicit bias. It is exhausting work" (Andrews-Dyer par. 8). These "statistics" that the author is talking about are ones such as these: "Women of color have the highest rate of maternal death. Black mothers are among the most at risk, no matter their socioeconomic or educational status" (Andrews-Dyer par. 10).

However, this article also portrays a positive coping mechanism that Black pregnant women have established to feel less apprehensive about their future birth: they have created their own "origami-tight safe spaces" (Andrews-Dyer par. 14). Andrews-Dyer defines this term as "community, sister circles, and tight bonds ... responsible for knitting wounds." (Andrews-Dyer par. 14). It is essentially an analogy in which Black women have "folded in on themselves, forming an origami-tight safe space" (Andrews-Dyer par. 14). Black pregnant women need to have a community where they feel heard and appreciated, something they unfortunately do not always get in a hospital-setting, with the implicit bias of nurses and doctors around them. There is still hope in resolving the alarming maternal mortality crisis that disproportionately affects Black women in the United States. Andrews-Dyer goes on to say that the country needs more brave and inspiring women such as Representative Lauren Underwood and Alma Adams (the co-founders of the *Black Maternal Health Caucus*). Andrews-Dyer reiterates that leaders who are willing to empower Black pregnant women are necessary to help them speak up against the obstetric racism and maternal healthcare crisis and, most importantly, be heard. This research paper drew inspiration from this argument and aimed to identify potential improvements for the future of maternal healthcare for Black patients.

Mollard and colleagues are scholars who also emphasize the need to adopt a more positive or strengths-based approach. Drawing on Mollard and colleagues' paper, "Reclaiming narratives of empowerment around Black maternal health: a strengths-based, community-informed focus group study," can also provide an essential research perspective on the issue of racism in maternal healthcare. In this paper, there is an explanation of the "looping effect", a term coined by philosopher Ian Hacking and can be defined as "the self-reinforcing

cycle of defining the problem, asking limited questions, and arriving at negative conclusions" (Mollard et al., par. 8). For instance, some limited questions that researchers studying Black maternal mortality could be asking "what are the genetic or physiological causes of preeclampsia in Black women" rather than the more helpful, broader question "how do accounts of Black women highlight harmful healthcare provider attitudes that affect preeclampsia outcomes in Black communities". In the context of the racially motivated maternal health crisis, the looping effect is when there is a reinforcement of racial stereotypes, constantly causing Black pregnant women to be oppressed in a healthcare setting, resulting in a lack of quality care in the United States, one of the most medically advanced countries in the world. Unfortunately, researchers can often contribute to the worsening of the maternal mortality crisis, shaped by racial bias. This article offers a practical solution to this problem by proposing the "strengths-based approach", which acknowledges the positive aspects of Black pregnant women rather than the negative ones, reducing stereotypes around them. Mollard and colleagues propose this approach — one that highlights the positive factors, knowledge, and resilience within Black women and communities. This includes: listening to their lived experiences and making sure the research is culturally relevant (Mollard et al., par. 9). Moreover, Mollard and colleagues go on to say that "to counter the effects of a deficit focus, it is essential to ... acknowledge Black individuals as primary sources of knowledge in research" (Mollard et al., par. 9). This leads to a more accurate and respectful understanding and better solutions to this overarching crisis in the United States.

This review found that all sources concur on the severity of this issue in the United States and the urgent need for action. All sources agree that essential steps must be taken to rectify the problem, but they have different proposals to do so. More specifically, there is an understanding that Black women's lived experiences need to be the center of maternal mortality research, that more "origami-tight safe spaces" need to be a resource to the often secluded Black pregnant women, and that physicians need to begin hearing all patients as a means to end the pattern of neglect towards Black pregnant women. This paper will present a mix of solutions by including first-hand accounts from interviews with Black women who experienced complicated pregnancies due to neglect or delays in care by physicians. It will also highlight the positive experiences that helped these women overcome their almost-fatal situations.

Methods

This paper is based on an original qualitative analysis of personal narratives and oral histories directly related to Black women's experiences of pregnancy and childbirth. The goal was to identify patterns and themes that reveal systematic issues in maternal healthcare and patient-physician interactions. This gives insight into potential solutions to eliminate these recurring problems in maternal healthcare, providing a more comfortable and positive experience for Black pregnant women in the United States.

The primary source used includes the autobiographical oral account of the CDC's *Hear Her* campaign. This public health campaign features video and oral testimonies from women who experienced pregnancy-related complications as a result of insufficient care. Launched in 2020, this campaign sought to "prevent pregnancy-related deaths by sharing potentially life-saving messages about urgent maternal warning signs" (CDC's *Hear Her* par. 2). Overall, this campaign has helped empower women to speak up and raise concerns during uncomfortable pregnancy situations. *Hear Her* has done this by picking interviewees who had

gone through dismissal or marginalization in the hospital while pregnant. I analyzed this source to gain a broader understanding of the issue of inequities in maternal healthcare and to provide a more comprehensive and nuanced analysis of the problem. This qualitative analysis highlights the recurrent negative experiences of Black women and pregnant women overall in the healthcare setting. Specifically, this campaign utilized interviews with Black women to analyze and highlight racial disparities in care and communication, drawing from their personal experiences.

This source was selected because it included detailed individual reflections on medical care during pregnancy (in autobiographical text) and an overview of the maternal health crisis and the effect racial bias has on the quality of care a pregnant woman will receive through the story of specific Black women's experiences. Additionally, this source prioritized first-person accounts from Black women (in the form of oral histories). By doing so, this source also ensured diversity, since the *Hear Her* campaign included oral interviews that were more personal and emotional. However, there was a limitation to this source—namely, variety. For example, there were no additional stories where women had taken incredible caution and advocated for themselves early on in their pregnancy to avoid complications. This would've made *Hear Her's* message a lot clearer to viewers who are only seeing patients who had been dismissed from the hospital and were discouraged from speaking up. Despite this limitation, the source still proved to be a handy tool in instilling how physicians' medical neglect/dismissal and lack of communication with the patient can lead to undesirable maternal outcomes.

Using thematic analysis, the recurring themes in the oral histories were examined. Specifically, the method of qualitative coding was used to identify these themes with more ease. First, a transcript of the testimonies was examined and assigned descriptive "codes" or "labels", each about a paragraph long, to specific sections that would help pinpoint repetitive instances where the Black mother's concerns were dismissed or left unheard. Then, these elaborate codes were condensed to identify the more repetitive themes throughout each testimony given on the *Hear Her* campaign website. By examining and incorporating these diverse sources (both primary and, later, secondary sources) in such an organized way, this study provides a comprehensive perspective on the issue of racial disparities in the maternal healthcare field.

The more personal and visual form of the *Hear Her* primary source contrasts with that of articles, blog posts, and other more common, well-known pieces of literary work that present the issue in a more second-hand perspective. These are secondary sources that include the New York Times' article *Unwanted Epidurals, Unwanted Pain: Black Women Tell Their Birth Stories,* which features this second-hand perspective, giving one Black pregnant woman's negative experience as a cause of racial bias in the hospital, illustrating how this encapsulates the unfortunate reality of many Black women going through pregnancy in the United States.

To better understand how cultural incompetence affects patient outcomes in maternal healthcare, four interviews from the CDC's *Hear Her* campaign website were examined, which amplify the voices of women who experienced serious maternal health challenges in the past. These stories were a firsthand insight into how trust and communication between the patient and physician are essential to ensure a safe and comfortable pregnancy for the future mother.

Results: Voices of Resilience - Personal Narratives Shaping Black Maternal Experiences

Black women's pregnancy experiences reveal a troubling pattern: the physician's negative mindset, inadequate resources, and the repeated dismissal of patient concerns. These characteristics of modern-day healthcare intersect to create patient care environments where fear and mistrust in the healthcare system thrive. These factors do not operate in isolation, however, and are often coupled together, showing how racial bias in maternal care is not just an individual issue, but a systematic one.

An example of one or more of these healthcare traits is highlighted in Allyson Felix's interview from the CDC's *Hear Her* campaign, where Allyson Felix, the now-retired Olympic track and field athlete, shared her complicated pregnancy story, in which she experienced severe preeclampsia at 32 weeks pregnant. It was an unexpected occurrence for Allyson as she "...studied and read and went to classes, and [she] felt prepared to have this natural birth" (Felix, Allyson. Interviewed by CDC). However, even with extensive research and preparation, complications can occur. When Allyson's doctor noted concerns from her monitoring, Allyson immediately thought of "...the statistics of…Black women being more at risk for complications" (Felix, Allyson. Interviewed by CDC). Despite being a high-profile athlete, Allyson's story emphasizes that even when disregarding socioeconomic factors, Black patients often have a significant mistrust in the maternal healthcare field as a result of recurring racial bias.

At 32 weeks, Allyson was officially diagnosed with severe preeclampsia, a condition that, if left untreated, can rapidly lead to organ damage, seizures, or death for both mother and child. While waiting with her husband at the hospital, she was suddenly told by a doctor that she "...cannot wait any longer. We are going to have to rush you in for an emergency C-section." The abrupt urgency, coupled with the lack of emotional guidance or explanation, left Allyson "scared" and "terrified" in a situation she was already unfamiliar with. Although her care team ultimately acted in time, the absence of clear communication heightened her fear of what could have happened. She later reflected: "There are so many women who do not walk out of the hospital. They are not there to raise their children" (Felix, Allyson. Interviewed by CDC).

Her words underscore the life-or-death stakes of conditions like preeclampsia, which disproportionately affect Black women. For many patients, not recognizing symptoms early (or not feeling empowered to push their concerns) can mean the difference between survival and mortality. Allyson, unlike many others, was able to persist and advocate for herself when something felt wrong, and that persistence was crucial in ensuring the survival of her and her daughter.

Although the specific hospital where Allyson Felix received her care is not disclosed, Joanna's interview from the CDC's *Hear Her* campaign shows that similar patterns of pregnancy complications and patient vulnerability occur across different healthcare settings, emphasizing that these are not isolated incidents. Joanna, a Black woman, was diagnosed with postpartum preeclampsia after her first pregnancy and experienced an unexpected recurrence after her second pregnancy. She recalled spikes in her blood pressure and swelling in her legs and hands, symptoms that could have been dismissed as "normal" postpartum discomfort. In fact, Joanna reflected that had she not been admitted to the hospital when she was, she "could have

had a stroke, or…possibly even had a seizure" (Joanna. Interviewed by CDC). What makes Joanna's case significant is not only the medical danger she faced, but also the weight she placed on having to advocate for herself. Her insistence that "You know your body. If something doesn't feel right, speak up and get the care that you need" underscores how Black women often feel responsible for pushing past potential dismissal to obtain appropriate care. While the campaign does not provide a comparison to white women in the same hospital, national data show that Black women are more likely to experience preeclampsia and more likely to die from it, even when controlling for income, education, and access to care. (Petersen et al., par. 4). Joanna's story illustrates how racial disparities in maternal health are perpetuated and not necessarily by a single physician's bias, but through a broader system where Black women's concerns are too often questioned or minimized until the situation becomes critical.

Even so, Joanna's second post-pregnancy experience proved even more difficult—physically and emotionally. Although her doctors had assured her that her blood pressure was back to normal after her second pregnancy, her home health nurse noticed an abnormally high spike in blood pressure. She prompted her to go back to the hospital to get checked for any serious complications before it was too late. This had occurred three times, and the third time she visited the hospital to get checked, doctors were insensitive and often said things like "Oh, you're here again," or some even went as far as to say that she should just stop checking her blood pressure at home. The lack of compassion and sympathy made Joanna's visits to the hospital emotionally troublesome. Joanna recalls feeling like she "was dismissed" and "not taken seriously" during that time.

Along with the physical pain Joanna experienced, she also experienced heavy emotional pain. She felt hurt and alone to be viewed as a burden by doctors who she thought were supposed to give her care and emotional support. Joanna even tells the audience that "if someone had heard [her], it would've made such a big difference." She reflects on her experience, saying, "I wish there was more compassion from the providers that I felt like I needed, that I was looking for. I didn't receive that." Medical neglect and dismissal should not be standard practices in the hospital. It is essential that physicians fulfill their duty of care to every patient, and Joanna's story highlights how a lack of compassion can often leave a patient feeling isolated in an already unfamiliar situation. However, there are solutions to improving maternal healthcare. As a patient who experienced medical neglect in a hospital setting and a lack of sympathy from healthcare providers, Joanna concludes with a patient perspective on how to improve the experience of all pregnant women in the hospital. She believes that "...doctors should listen to their patients, should also not only just hear what their patients are saying or asking, but also body language plays a whole role in it because sometimes, people can be…intimidated by doctors…and might not always feel comfortable asking questions" (Joanna. Interviewed by CDC). With increasing mistrust in maternal healthcare, it might not come as a surprise that Joanan is one of many patients who have felt isolated and frustrated by the behavior of physicians around them.

Building on Allyson and Joanna's experiences, Valencia's story offers yet another perspective on how a lack of emotional understanding from physicians and medical neglect continue to shape Black women's pregnancy journeys. Valencia, now a proud Black mother of her six-year-old daughter, shares her difficult pregnancy story on the CDC's *Hear Her* website to

"help other women speak up and be heard" (Valencia. Interviewed by CDC). She starts off describing her pregnancy experience as "one of the worst pregnancies ever" and that "[she] had a long time to have a very tough pregnancy" as her painful symptoms started around two months in (fairly early in her pregnancy). Unfortunately, Valencia is another woman who had trouble speaking up due to the often intimidating environment of a hospital. She was unaware of the available resources because no doctor took the time to communicate with her and explain which tools she could use effectively. Valencia remembers feeling that she "didn't have what [she] needed, the tools. [She] didn't know who to talk to or how to talk or how to speak up for [herself]. [She] would have a lot of pain that [she] just couldn't explain" (Valencia. Interviewed by CDC). Valencia also seemed to feel secluded in her unusual pain so early in her pregnancy because no one seemed to hear her concerns. However, as her pain started becoming more unbearable, she began advocating for herself. She recalls, "I talked to a lot of different people. I tried to talk to my doctor. I even talked to my primary care physician, who's not even my OB, just to get information." A patient should never have to go through this much just to get checked or get answers to their pain. Valencia even notes feeling "scared all the time" because she "felt like no one heard [her]." All these patients (Allyson, Joanna, and Valencia) note down everyday experiences where they "didn't feel heard" or "felt neglected and dismissed" by their healthcare providers, instances that warrant immediate attention.

Specifically, Valencia's story highlights the fear and pain of navigating pregnancy alone. However, her story also offers recommendations for the future of healthcare on how to address this issue. In the broader context, recognizing how commonplace fear and anxiety seem to be in hospitals because of a lack of sympathy and compassion from providers proves that there needs to be more advocacy programs, more support groups for pregnant women, and more healthcare training for providers. There needs to be more doctors who care about the well-being of their patients and are sensitive to their emotional state during complications. Pregnancy is a scary and often unfamiliar experience for many, so having to navigate it and its pain alone is horrible.

Physicians need to hear their patients' concerns and address them. Strong communication between the physician and patient is necessary in maternal healthcare. Unfortunately, Valencia's case lacked that, and instead, she faced medical neglect/dismissal. However, Valencia does incorporate a positive experience she had with a healthcare professional as a means to emphasize good practices in maternal healthcare. She stresses how her primary care physician saved her life by advocating for her and finding a doctor who cares and addresses her concerns. She even mentions how much it meant to her during this tough time when she felt isolated by elaborating that had it not been for her primary care physician, she would probably not have surpassed the pain she experienced. Her primary care physician saved her life by advocating for her when no one else did. It is so important that doctors listen to their patients for them to have the safe pregnancy they deserve. Had her previous OB done what her primary care physician did, she might have been able to have a less painful pregnancy in the long run. Valencia's story highlights the crucial role of the physician in this significant milestone in a future mother's life. Pregnancies can become complicated and painful, and the OBGYN, doctors, and nurses must keep an eye out for their patients during this vulnerable time.

Another interviewee, Sanari, had an experience that further illustrates the importance of listening to patients when they're experiencing discomfort or pain, which undoubtedly takes into account the physician's mindset. Sanari's story also tells women all over how important it is to speak up so as not to jeopardize their physical and mental health during their pregnancy. Sanari's goal for her second pregnancy was to have a vaginal birth after a Cesarean (VBAC). She had a very unusual case in which her water broke two days before she finally gave birth to her son. After she delivered her son, that's when her complications started happening. Just two days after delivery, she began to feel the soreness and the piercing pain kicking in, and by the end of day two into day three, the pain got worse and worse until it felt as though the pain wasn't just coming from her recent birth. Sanari thought that it "just didn't feel right." Sanari trusted her gut and asked nurses and doctors about the severe pain she was experiencing, but they often disregarded her and told her she was just experiencing pain from gas buildup in her body. Sanari said, "I asked the nurses, explained my symptoms and that I was having crazy pains, and they assured me that it was just gas." There is a strong theme of medical neglect here. Without doing any tests and assuring Sanari that "it was just gas," the nurses are wrongfully dismissing her. There wasn't a powerful sense of communication, either. It seemed as though they weren't hearing Sanari's concerns. It's almost as if they neglected her pain because it would make their job easier. Although one might argue that this is Sanari's perception of what happened, this perception matters. Feeling as if one is dismissed is just as problematic as being dismissed. Even after the medications Sanari took for this "gas," such as "Gas-X, suppositories, pain medicine, morphine," Sanari still felt the unusual piercing pain.

Sanari did, however, state a positive experience in which she finally received help. After noticing a dangerous amount of odorous discharge, Sanari finally went to the emergency room in a different hospital, one that cared for her and heard her. Here, doctors had found an eleven-centimeter abscess on Sanari's uterus, an almost-fatal situation. One where "had it gone into [her] bloodstream... it could've been uncontainable" (Sanari. Interviewed by CDC). Being able to finally go to a hospital that listened to her concerns and addressed her pain was the only way Sanari was able to be treated. If her doctors had listened to her previously, she wouldn't have been in this situation. It's essential that she advocated for herself and realized that the pain she was feeling was not normal, despite what other physicians had told her. Sanari was only able to avoid this dangerous situation because she realized that her pain was real and wasn't normal. She continued to advocate for herself by reaching out and asking for help constantly. Sanari tells viewers, "even if those around you aren't listening or they're trying to pacify what you're feeling..., trust your gut and know that it's not normal if you don't feel it's normal" (Sanari. Interviewed by CDC). Sanari advises women that if they feel the pain they are experiencing is "just not right," they too need to advocate for themselves, just as Sanari once did.

Allyson, Joanna, Valencia, and Sanari's stories all convey the same message: healthcare professionals who consistently refuse to listen to their patients create an uncomfortable environment, and in some cases, this can be fatal. It is not just enough to know their stories; it's also important to know what the future of maternal healthcare should look like for pregnant women seeking the care and comfort they deserve. This begins with the recommendation of next steps that physicians can take to enhance the pregnancy experience, thereby fostering a relationship of trust and dignity within the hospital.

Recommendations

In the case of many Black pregnant patients, poor patient-physician communication or a lack thereof leaves them terrified and confused. It adds unnecessary stress to an already scary situation. A way to rectify this could be to implement more provider training programs in the United States and then evaluate the programs to ensure they are more culturally appropriate and reduce racial bias, one of the biggest reasons why there is a mistrust of the healthcare system. A reduction in racial bias will not only mitigate Black maternal mortality rates but will also make future Black mothers more confident in the healthcare system and comfortable with the care they are receiving. Provider training programs are given by hospitals to specifically educate doctors, nurses, midwives, and other healthcare professionals on how to care for pregnant patients, communicate effectively, and avoid bias of all kinds. Through program evaluations, hospitals can thoroughly assess whether current providers are more effective at recognizing symptoms in Black women after completing the training, exhibit less racial bias in their behavior when interacting with patients, and whether Black maternal health outcomes are improving following the implementation of these programs. Some examples of "evaluating" these training programs could be implicit bias training in which the hospital gives providers the required training on racial bias, and researchers analyze the effectiveness of the training by surveying patients (especially Black women) on how respected and comfortable they felt.

Another example could be a more simulation-based training in which providers are trained using simulated emergency births with racially diverse manikins and patient backgrounds. By doing this, evaluators/researchers can see if there are changes in clinical decisions based on race and aim to solve the issue. This might prove to be a helpful tool, as it was even used by Patel and colleagues in their paper, "Potential Racial Bias During Pediatric Emergency Care: A Simulation Study." In the study, they found that "...there were some significant differences noted. All of the dark-skinned infants received oxygen, while only 55.5% (5/9) of the light-skinned infants received oxygen ($p = 0.03$). Additionally, 89% (8/9) of the light-skinned infants received compressions after asystole occurred while only 40% (4/10) of the darkskinned infants received compressions ($p = 0.05$)" (Patel et al., par. 3). By being able to identify the significant disparity in care received through an evaluation of a provider training program, Patel and colleagues have shown that it is vital to not only make sure there are such programs, but to make sure that the programs are doing what they are supposed to do. This helps doctors recognize the severe consequences of their bias on more marginalized groups, such as Black women, and aims to mitigate these effects.

Another recommendation that could hopefully raise awareness about the ongoing Black maternal health crisis could be listening to more stories from Black women themselves or even partnering with more advocacy organizations. Such organizations could include ones such as the CDC's *Hear Her* campaign and the U.S. government-run *Black Maternal Health Caucus.* The public must be aware of these significant healthcare issues to facilitate reform successfully.

Conclusion

The troubling narratives shared by Black women regarding their pregnancy and childbirth experiences highlight the urgent need to address systemic disparities in maternal health care in the United States. These stories, as discussed by the CDC's *Hear Her* campaign, reveal high

levels of medical neglect and dismissal in the hospital setting of these women, but also reveal ways to improve upon such experiences.

These disparities can be addressed by making it a practice to shift the healthcare focus towards improving patient-physician interactions and evaluating provider training programs aimed at eliminating bias. By prioritizing the amplification of Black women's voices, the healthcare community can foster a more equitable and compassionate approach to care. It is essential to listen to the real-life experiences of Black women to highlight the challenges they face and showcase examples of adequate care, providing valuable insights into how healthcare professionals can enhance their practices. Overall, ensuring that all future mothers receive the respect and quality of care they deserve is crucial for creating a maternal healthcare environment that supports the well-being of all women, regardless of their background.

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