AMERICAN REPRODUCTIVE INJUSTICE AND ITS IMPACT ON THE CONTEMPORARY PATIENT-PROVIDER RELATIONSHIP

Alyssa Tigner
McGovern Medical School
University of Texas Health Science Center

December 31, 2020
The field of obstetrics and gynecology has not only habitually failed to encourage minority trust in providers, but also to provide quality, unprejudiced, and equal care amongst patients. Such transgressions have created barriers to care by abolishing patient trust. It is the provider’s responsibility to meet these patients’ needs.
INTRODUCTION

From the dawn of gynecology in the 1840s, at which time unanesthetized operations on enslaved black women without consent were not only pursued but encouraged by the so-called “father of gynecology,” Dr. J. Marion Sims, to the 20th century, which brought eugenics and scientific racism, Tuskegee, an experiment that highlighted a gross abuse of power and racial prejudices, and sterilization without consent of numerous minority groups, women’s health has not only failed again and again to encourage trust in obstetrics and gynecology providers, but also ultimately to provide quality, unprejudiced, and equal care amongst patients. To discuss reproductive rights without acknowledging race or our history is to not discuss reproductive rights at all.


Reproductive injustices and systematic health inequities, particularly targeted at black women and other minorities, have shaped and defined the field of obstetrics and gynecology from its inception, deservedly garnering minority mistrust of providers and negatively impacting care. It is the obligation of providers to make efforts to meet the needs of minorities, analyze biases impacting healthcare management, and work towards rebuilding trust.
Racism and discrimination were built into American politics from the very beginning (Roberts, 2017). Thus, the United States became a complicated paradox: ensuring liberty to all, while denying it to many.

To reconcile this discrepancy, scientific racism was used as justification, its principles grounded in the innate and heritable inferiority of all minorities, and more specifically black persons (Kuhl, 2002). As Dorothy Roberts (2017) suggests in her book “Killing the Black Body: Race, Reproduction, and the Meaning of Liberty,” the belief of inheritable traits as innate to specific races coupled with the acceptance of white superiority married reproductive rights to policy; their vows only promising the perpetuation of injustice, racism, and brutality.
• White slaveowners were financially invested in the fertility of enslaved black women; it ensured their workforce (Roberts, 2017).

• This incentive fielded the propagation of stereotypes of hyperfertility and hypersexuality of black people, which used scientific racism as a crutch for an explanation (Kuhl, 2002).

• If a black woman was able to escape the stigma of this stereotype, she was resigned to the role of a “Mammy” (Roberts, 2017). This woman loved white people and raised their children, instead of her own (Roberts, 2017). These images were not only demeaning to black women but were starkly contrasted to the image society created of the idyllic woman (Roberts, 2017).

• Historically, the idyllic woman, although viewed as inferior to men in intelligence and physical ability, prevailed as a model of morality (Roberts, 2017). They were the perfect mothers and the perfect homemaker (Roberts, 2017). Still to this day much of a woman’s identity is tied to this socialization.
DISCUSSION & EVIDENCE

- When the affects of this socialization is acknowledged at all it is done so in the context of the most privileged of woman. This disparages minorities and others at the intersections of different groups, who also lay claim to the victimization by this standard but are often denied claim to it due to who they are and the societal biases that are attached to such an identity (Mason, 2013).

- Their claims of injustices or attempts to advocate for themselves are inundated because their identity does not reflect the privilege (Mason, 2013). To acknowledge the experiences of minorities as valid and different from that of the white woman, was seen to invalidate the progress of the group (Iyioha, 2019).

- Such a mentality fails to acknowledge the struggles of other groups and defines only one narrow lens to identify the “struggle of womanhood” and related injustices. This inherently perpetuates the injustices of those not privileged.
• American eugenicists pushed for sterilization legislation in the early 20th century (Kuhl, 2002). There was a focus on the “unfit,” the “morally ill,” the “feeble-minded,” the “degenerate,” and the “inferior” - all adjectives often imposed on racial minorities at the time (Iyioha, 2019).

• California was the first state to allow the forced sterilization of the mentally handicapped, and by 1913, nine other states had followed suit (Kuhl, 2002).

• Essentially, white agenda promoted black fertility when it served an economic benefit to white interests. When black fertility no longer served this purpose and the white majority no longer had direct control on black reproduction given the elimination of slavery, the white agenda shifted to attacking black fertility. The benefit of black fertility was gone, and racially fueled hatred persisted.

• Driven by unfounded stereotypes and anti-black rhetoric, the mentality was to limit reproduction in lieu of creating systemic structural support.
Up until the 1970s, women like Fannie Lou Hamer were sterilized without their consent and often without their knowledge. These transgressions on humanity and autonomy were rather lazily reasoned as “life-saving” measures by the surgeons, and retribution was rare.

Sterilization further distanced black women from their womanhood by stripping them involuntarily of their reproductive ability. This is torture, both of a physical, psychological, and perhaps spiritual nature (Sifris, 2013). Sterilization creates a deep grief, often precipitating depression, anxiety, and hostility (Sifris, 2013). Their quality of life suffers, as well as their relationships (Sifris, 2013).

Although consents for sterilization are now mandatory, issues of prejudicial sterilization still exist. Presently, coercion for consent to sterilization is not illegal in the United States and there are programs that pay women addicted to crack cocaine to consent to sterilization. These women are disproportionately minorities.
DISCUSSION & EVIDENCE

• Furthermore, racial disparities are known to still exist in obstetrics and gynecology. There is an increase in morbidity and mortality for black neonates and pregnant black women as compared to white patients (Davis, 2020).

• Delivery is more likely to be premature in black women and black babies are more likely to be admitted to the NICU, be underweight, and die than their white counterparts (Davis, 2020). These likely reflects a deeper problem within our society and profession. Whether we directly recognize it or not, bias still exists and influences patient care.

• Black women are less likely to utilize health care than other groups of women, rather relying on their support system (Copeland, 2003).

• Studies show that black women prefer providers who do not rush them, who respect them and their autonomy, who provide holistic care and explain to them what is happening (Copeland, 2003).

• These are not unique wants, nor unsurmountable requests, but effort is needed on behalf of providers to meet these needs. It is our obligation and our responsibility to do so.
SIGNIFICANCE

- These injustices have shaped and are shaping the practice of modern obstetrics and gynecology. Facilitated by and often promoted by obstetricians and gynecologists, reproductive injustices have alienated minorities, invalidated their concerns, transgressed their trust, and violated their bodies without their consent, their input, and sometimes without their knowledge. This mistrust, readily earned and well-deserved by the field of medicine, becomes just another barrier to care among the numerous other obstacles already systemically in place. Not only is trust touted as a cornerstone to an effective patient-provider relationship, but primary prevention and early detection are known to improve morbidity and mortality. Yet abuse of power and negligence of autonomy created a system that deters patients from seeking healthcare until they are well-beyond these stages of illness. The perpetuation of abuse continues.
CONCLUSION

How do we, as providers, address this; how do we amend ruined trust? First, we acknowledge this history and our role as a provider to minority women. We advocate for diversity within the field, so that providers better reflect the populations they treat. We listen to our patients’ needs and work to improve relationships with our minority patients (Dale). We reflect on how we practice and identify any biases that may influence our care; then we actively address them. We hold each other accountable.