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## **“It’s A Broken System That’s Designed to Destroy”: A Critical Narrative Analysis of Healthcare Providers’ Stories About Race, Reproductive Health, and Policy**

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“It’s A Broken System That’s Designed to Destroy”:

A Critical Narrative Analysis of Healthcare Providers’ Stories About Race, Reproductive Health,  
and Policy

by

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A thesis submitted in partial fulfillment  
of the requirements for the degree of  
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## DEDICATION

To all those the system sets out to break.

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## ABSTRACT

Constructions of race, reproductive health, and gender have been inextricably linked in the United States since the beginning of the nation. Today, these linkages remain evident in the marked racial and gender inequities in reproductive health outcomes that persist in the U.S. To better understand how these meanings and material outcomes are negotiated and produced by actors on the ground, this study asked: “How do reproductive healthcare providers (RHPs) communicate about the intersections of race, reproductive health, and policy?” I conducted semi-structures interviews with 24 RHPs, resulting in over 35 hours of recorded interviews. Drawing on critical-cultural communication, Reproductive Justice, Narrative Medicine, and Postcolonial theories, I developed a novel approach to narrative inquiry—Critical Narrative Analysis—to explore my data. Here, I present an in-depth analysis of 8 narratives shared by my participants. I conclude that participants communicated about race, reproductive health, and policy by engaging with dominant cultural narratives around these topics. While some participants contested dominant narratives, most upheld the foundational logics of oppressive systems in the stories they shared. To advance reproductive justice, I argue that new approaches to teaching clinicians, which engage with both narratives and sociopolitical structures affecting these narratives, are needed. By sharing my participants’ stories and contextualizing them within dominant narratives and social institutions, I aim to identify future research and practice opportunities for creating new stories about reproductive health and physician identity, stories which could suggest more equitable and just ways of doing reproductive health care.

## CHAPTER ONE

### INTRODUCTION

- Bria: How do you like manage all that frustration that you, like, face?
- Dr. Three: Oh we have—we have a rather dark comedy at the clinic
- Bria: ((laughs))
- Dr. Three: If somebody heard us
- Bria: ((laughs))
- Dr. Three: Yeah, we—we're pretty good at bouncing things off each other when we get frustrated. Y'know when the—we have to have a TV on because the—it's a department of health place—
- Bria: Right
- Dr. Three: So they have to have a way—it, it's some kind of rule that all D-O-H facilities have to have a TV on at all times so in case there's a public service—y'know, like a, an emergency message?
- Bria: Uh-huh. Huh.
- Dr. Three: Um, so whenever—we just turn it on cartoons whenever Trump is on.
- Bria: ((laughs))
- Dr. Three: So we don't have to listen to the idiot who makes—who, who doesn't care about women and who,
- Bria: Right
- Dr. Three: You know, supports all these horrible policies.
- Bria: Right. Do you—are you seeing any of those policies start to like—
- Dr. Three: —Oh yeah
- Bria: Can you talk about that?
- Dr. Three: Umm. Uh, for one thing, uh, last er—in 2016, um for a long time, I still hear it, um when I would have girls who were raped and I'd talk to them about reporting it, they'd say,  
        'Nobody cares that I was raped. The president is a rapist.'
- Bria: Are you serious?!
- Dr. Three: I am utterly serious.
- Bria: Oh my god. How do you have that conversation with them? Like, what do you say in response to that?
- Dr. Three: I say,

‘You’re right. But I do.’

Bria: Oh my god.

Dr. Three: ‘And there’s a lot of people who do. And I think you’re right, I think the president is, you know, a total misogynist. But, y’know—’

And now, with Me Too, I say,

‘Yeah, but there are other people who are being held accountable for their actions.’ Hopefully Trump, someday will be held accountable for his actions, but there’s lots of other people who have been held accountable.’

Bria: Mhm. What did they say—did they—does that usually help them? Or, how do they feel about it?

Dr. Three: There’s no ticker tape parade when you say that you’ve been raped.

Bria: Yeah.

Dr. Three: When you report that you’ve been raped, I mean, your life generally gets worse. It’s not like, y’know, people are super helpful. It’s not like the rate of conviction is high. I mean. So most of them still don’t. And there’s nothing I can do about it.

The interaction portrayed above, between myself and a participant in this thesis study, illustrates a central theme of my project: narratives about reproductive health have real, material consequences. In this exchange, Dr. Three (a pediatrician) describes two cultural narratives which influence her interactions with teenage patients. The first narrative is about Donald Trump (and other men like him) who are able to assault women with impunity. Dr. Three’s patients use this narrative to make sense of their own rapes; this narrative suggests that they should not press charges against their rapists, since powerful Men are unlikely to be punished for hurting Women. The second narrative is the story told by the #MeToo Movement. This narrative, constructed through organized resistance and political action, insists that powerful Men will be held accountable for their violence; #MeToo serves as a counter-story which challenges oppression and offers a vision for a more socially just future (Delgado, 1989). Within our exchange, then, Dr. Three depicts a contest of narratives, each story suggesting a different course of action (to report or not report a rape to police). **The goal of my thesis is to understand how reproductive healthcare providers (RHPs) communicate about the intersections of reproductive health,**

**race, and policy.** Through my exploration of this issue, I show that RHPs make sense of these intersections (as Dr. Three does above) using dominant narratives and counter-stories.

Throughout this effort, I aim to show how these narratives contest, (re)produce and/or disrupt institutional structures and materially influence human health.

The relationships between race, policy, and reproductive health are particularly vital given the significant racial inequities in reproductive health outcomes in the contemporary U.S. (American College of Obstetricians and Gynecologists, 2015; Dehlendorf, Rodriguez, Levy, Borrero, & Steinauer, 2010). For example, the fetal mortality rate for non-Hispanic black women in the U.S. is more than twice the rate for non-Hispanic white women (MacDorman & Gregory, 2015) and the prevalence of vaginal and cervical cancers (illnesses associated with HPV) is significantly higher among black patients than whites (CDC, 2019). These inequities are tied to the nation's long history of racial oppression, structural injustices, and the devaluation of the bodies and reproduction of people of color (Gomez, Mann, & Torres, 2018). In other words, women of color today are becoming sick and dying at disproportionately high rates because women of color (particularly black women) have been subjected to hundreds of years of reproductive oppression—a complex web of abusive and coercive policies and medical practices developed to control their reproductive lives (Bridgewater, 2005; Harris & Wolfe, 2014). Such policies and practices have included forced sterilization, tethering social service benefits to contraception usage, and implementing contraception counseling strategies which prioritize increasing the uptake of certain methods over the needs of individual patients (Gomez, Fuentes, & Allina, 2014; Harris & Wolfe, 2014; Yee & Simon, 2011). These histories and conditions demonstrate that “conflicts over reproduction are, at their essence, political. Reproductive bodies

become ideological battlegrounds to delineate the appropriate relationships between gender, sexuality, population, and family” (Stevens, 2015, p. 50).

Reproductive healthcare providers (including family physicians, obstetricians and gynecologists, nurses, and counselors) contribute significantly to discourses about the meaning of reproductive health and related policies (Joffe, 1987; Stevens, 2015). Within clinical encounters, reproductive healthcare providers (RHPs) exercise the power to support patients in making their own decisions about reproduction or constrain patients by selectively sharing information or refusing patients’ requests (Henderson, Raine, Schalet, Blum, & Harper, 2011; Kelly et al., 2017). Importantly, policy is not made solely by legislators and c-suite executives, but also by those who work on the ground with patients. Frontline workers (such as healthcare providers and staff) make important decisions about how to interpret and enact government and organizational policies in their everyday activities and give life to policy through these decisions (Joffe, 1987, p. 5). However, despite the central role RHPs play in constituting reproductive health meanings and politics, few studies on contraception counseling and reproductive health have focused on the perspectives of healthcare providers and staff (Williams, Gavin, Carter, & Glass, 2015).

My thesis combines insights from Reproductive Justice and Postcolonial Theories with the methodology of Critical Narrative Analysis to understand how RHPs recycle, revitalize, and disrupt dominant narratives about race, reproductive health, and politics. Reproductive Justice Theory (RJT) drew my attention to narratives because RJT identifies the importance of understanding both how discursive practices can reproduce oppression and how narratives can be vital tools of resistance (Ross, 2017, p. 178). A Postcolonial lens has allowed me to foreground processes of discursive and narrative imperialism in my analysis (Shome, 1996), while

simultaneously recognizing how these processes operate in relation to material, structural violence (Césaire, 1955).

Dr. Three's narrative demonstrates how these theories play out on the ground in reproductive healthcare settings. One narrative says that Men can rape with impunity and, by discouraging survivors from sharing their stories, helps men to continue raping with impunity. By offering an alternative story, #MeToo has provided Dr. Three with a discursive resource for contesting patriarchal dominance. To explore how RHPs like Dr. Three use master narratives and counter-stories as they communicate issues of race, reproductive health, and policy, I begin by outlining the dominant narratives/structures of White supremacy, colonialism, neoliberalism, and biomedicine. I next examine how these narratives/structures have evolved over time and provide an example of these processes by exploring the character of the Good Mother. I then discuss how activists have resisted reproductive oppression throughout the history of the U.S. before turning to my study methods and processes.

### **A Note on “Woman”**

The large majority of research on reproductive health has focused on cisgender women, erasing many people who experience reproductive oppression. While I am concerned about perpetuating this pattern, as I've read more about the history of reproductive oppression, I've come to view reproductive oppression in the U.S. as a project to define and demarcate womanhood, and to specifically control those gendered as women (Ross & Solinger, 2017). This is not to say that women are the only people who have experienced reproductive oppression; many transgender, non-binary, and queer people have been assaulted by stratified reproduction. Furthermore, as Dr. Durham (personal communication, September 7, 2018) has shown, even “the ‘choice’ of woman does not make the person woman, it could mean that the person does not have

the cultural, political, or institution power to ‘choose’ another category and does not ‘choose’ man or male. It might also mean no other gender options are available...” However, reproductive oppression continues to target women (and, simultaneously, demarcates womanhood and assigns people into this gendered category). I feel it is important to use language which reflects this dynamic.

Mohanty (1988) speaks to these tensions when she distinguishes between “Woman—a cultural and ideological composite Other constructed through diverse representational discourse... and women—real, material subjects of their collective histories” (62). Following Mohanty, I have decided to distinguish between “Women” and “women” and “Mothers” and “mothers.” When discussing the representational Other targeted by reproductive policies, I use the words “Women” and “Mothers.” Otherwise, I use “women,” “mothers,” or avoid gendered language. While this is not an ideal solution, I hope that my use of these terms can be seen as politically strategic, in that I chose them as a way to point to historical patterns of power and control of gendered and racialized bodies.

CHAPTER TWO  
LITERATURE REVIEW

**Theorizing Race**

Race is not a fact; it is not static, inherent, or singular. Race has been understood in a variety of ways by a variety of groups. For example, Marxists have argued that race is essentially a manifestation of class conflict (Omi & Winant, 2015, p. 65) whereas discourse analysts view race as a signifier, “an utterance, sound, or image whose meanings are made possible only by the application of rules or codes” (Cashmore, 2004c, p. 334). I draw on Omi & Winant’s (2015) theory of racial formation, which posits race as “a flexible, fluid, and socially constructed way of ‘making up people’ and othering” (12). Race, from this perspective, is formed through racial projects, “efforts to shape the ways in which human identities and social structures are racially signified, and the reciprocal ways that racial meaning becomes embedded in social structures” (Omi & Winant, 2015, p. 13). The meanings of race change across social, political, economic, and historical contexts as dominant and non-dominant groups engage in conflicts over interests and values. The theory of racial formation is well-suited for Communication research because it assumes that race is constituted through communication and interaction within the context of broader social structures (Allen, 2009).

Applying the theory of racial formation, I come to see this thesis itself as a racial project. There is no single, static, or authentic group of people that constitutes “people of color” or “patients of color.” I am concerned that, in asking RHPs to single out their “patients of color,” I may have contributed to processes which other and essentialize non-White people (Alexander et



al., 2014). I focused on their perceptions of “patients of color” because I hoped this project might elucidate the ways in which RHPs sense-making processes can contribute to (and/or interrupt) racist reproductive oppression. I aimed to utilize strategic essentialism, using “patients of color” not as a description of an authentic, discrete group of people, but as a discursive tool which allows me to develop critiques of hegemonic relations (Shome, 1996, p. 47). Nonetheless, the danger remains that, particularly in my interactions with healthcare providers wherein “patients of color” was sometimes used as a taken-for-granted category, I may have reproduced that which I aimed to critique.

### **Foundations: Coloniality, White Supremacy, and Capitalism**

To understand the significance of reproductive oppression in the U.S., I argue that there are (at least) three foundational conditions which must be understood. First, “coloniality” refers to the assemblage of strategies developed by one group to control the sovereignty (e.g., colonize) another (Misoczky, 2011). Generally, these strategies include the classification and ranking of peoples; the creation of institutions which define and maintain these classifications; and the promotion of an epistemological perspective to naturalize these definitions and institutions (Misoczky, 2011). In European colonization, Western Modernity became the dominant epistemology of coloniality (Dussel & Ibarra-Colado, 2006). Western Modernity valorizes scientific knowledge produced by those who claim objectivity and neutrality (Hedge, 1998, p. 277), and works to delegitimize forms of knowing which recognize emotionality, subjectivity, and fragmentation (Broadfoot & Munshi, 2007). At the global level, Western Modernity defines and ranks peoples through the ideology of Orientalism (Chavez, 2009), which separates the West (the Occident) and the non-West (the Orient) “in binary, asymmetrical terms; the former considered superior, civilized, developed, moral, scientific; the latter inferior, uncivilized,

backward, immoral and superstitious” (Jack, Westwood, Srinivas, & Sardar, 2011, p. 277; Said, 1978).

Within the U.S. context, the ideology of White supremacy functions to separate Western Modern subjects from the Other (Cashmore, 2004b). White supremacy began with the invention of the White race as a category to which only Europeans could belong (Bonds & Inwood, 2016). White supremacy constructs attributes associated with Whiteness as superior, natural, and normal while also positioning non-White others as inferior and, therefore, expendable (Bonds & Inwood, 2016). In keeping with Western valorization of science, White supremacy initially regarded racial variation as a product of biology which could be indisputably “proven” through scientific study (D. E. Roberts, 2017). By positioning Native peoples and enslaved Africans as biologically non-White and therefore non-human, White supremacy enabled colonists to re-imagine their thefts, assaults, and massacres as the morally legitimate tactics of a just civilizing project (Munshi, Broadfoot, & Smith, 2011). Thus, White supremacy was “the foundational logic of the modern capitalist system” (Bonds & Inwood, 2015, p. 6), as it authorized the violent strategies of capital accumulation employed by colonizers.

Global capitalism is the economic system which is “the present dominant form of organizing much provisioning activity [wherein] ownership and control of most production is highly centralized and highly undemocratic ”(Acker, 2006, p. 105). Capitalism and colonialism (and therefore, modern racial formations) are deeply interlinked because capitalism cannot exist without the “raw material, labor, and market[s]” it extracts from colonies (Dutta, 2012, p. 46). Capitalism is organized around the principle that individuals and (increasingly) corporations work to accumulate private property through competition in marketplaces of goods and consumers (Mathison, 2005). As global capitalism was made possible and is governed by

Western patriarchal colonization, the inequalities created by global capitalism are distributed by race, geography, and gender (Acker, 2006; Jaggar, 2008; Koepke, 2007).

### **Contemporary Formations: Neoliberalism, Colorblind Racism, and Neocolonialism**

In the decades following World War II, several historical developments challenged the dominance of White supremacy, European colonialism, and capitalism. First, scientific theories of race fell into disfavor due to their association with Nazism (Gordon, 2007; Omi & Winant, 2015). Second, the Civil Rights and other social movements in the U.S. demanded that wealth and other resources be redistributed to reduce racial and gender inequalities (Harvey, 2007; Omi & Winant, 2015). Finally, Europeans were forced to cede governance of colonial territories back to native peoples in many areas because of global decolonization movements (Omi & Winant, 2015; Worden, 2012). To maintain dominance, then, White supremacy, coloniality, and capitalism needed to evolve.

The ideology of neoliberalism has been an indispensable discursive resource in this project. Neoliberalism “advocates the dominance of a competition-driven market model. Within this doctrine, individuals in a society are viewed, if viewed at all, as autonomous, rational producers and consumers whose decisions are motivated primarily by economic or material concerns” (Farmer, 2004, p. 5). Neoliberalism suggests that individual liberty and freedom are the cornerstones of democracy and civilized society (Harvey, 2007) and that the fairest way to distribute resources is to protect individual property and maximize competition in the market so that those who work hard and contribute the most can be successful (ten Have, 2016). Thus, business regulations, taxes, and funding for public services should all be reduced so as to encourage free market competition and personal responsibility (ten Have, 2016)

The ascendancy of neoliberalism effectively blocked progressive efforts to redistribute (White male) wealth by popularizing the character of the “undeserving poor,” a class of lazy, irresponsible, and unintelligent people who prefer to live off the taxpayers rather than working to earn an income (Omi & Winant, 2015, p. 215). Through this discursive move, neoliberalism recycles racist, anti-Black tropes long deployed by White supremacists, but appears to apply them in a way that is “race neutral” (Omi & Winant, 2015). By drawing on neoliberal discourses, then, whites were able to perpetuate the same old anti-Black stereotypes while distancing themselves from the (now taboo) philosophy of scientific racism (Omi & Winant, 2015).

These discourses solidified into the ideology of “colorblind racism,” which argues that good people don’t “see” race and that racial inequalities stem from “market dynamics, naturally occurring phenomena, and presumed cultural deficiencies” rather than structural discrimination (Bonilla-Silva, 2007, p. 132). Colorblind racism relies on four central frames: abstract liberalism (e.g., “everyone has the opportunity to succeed,”); naturalization (e.g., “I don’t have any black friends because that’s just how things naturally worked out”); biologization of culture (e.g., “black people are not as wealthy as whites, on average, because their culture doesn’t value education and they have kids too young”); and minimization of racism (e.g., “racism was an issue in the past, but that was taken care of with the Civil Rights movement) (Bonilla-Silva, 2007). By making it “common sense” that everyone can succeed in the free market and by suggesting that racial inequalities are the result of degenerate cultures and individual lifestyle choices, colorblind racism supports the dominance of neoliberal thinking and White hegemony (Roberts & Mahtani, 2010).

Globally, neoliberalism has maintained coloniality by claiming that previously colonized peoples can only achieve wealth and success if they create and open economic markets to

transnational capital (Dutta, 2015a). Although territorial imperialism by the West has been reduced, neocolonial practices persist in the forms of corporate outsourcing, economic “development” projects which disproportionately benefit transnational corporations, structural adjustment programs (Chavez, 2009; Dutta, 2012). Neocolonialism also operates at the discursive level, where Western Modernity is spread through transnational media conglomerates. Evidence of discursive imperialism can be seen in “the universality of English and the ways in which Orientalism operates as Western scholars treat non-Western peoples and contexts as objects of study” (Broadfoot & Munshi, 2007, p. 258).

### **Reproductive Oppression at the Nexus**

The control of Women’s reproduction has been essential for maintaining coloniality, White supremacy, and capitalism. For example, for European colonizers to settle, Indigenous people needed to disappear and so their reproduction (as well as their lives and cultures) needed to be eliminated (Smith, 2006; Wolfe, 2006). Consequently, as Cherokee people were murdered and forced from the homes, traditional childbearing and rearing practices were violently interrupted, and pregnant women and women with young children were at heightened risk of illness and death as they traveled the Trail of Tears (Solinger, 2005, p. 45). In contrast, because colonizers depended on enslaved labor to build the empire, white slave holders engaged in “slave breeding,” the systematic sexual and reproductive exploitation of enslaved women “made possible by force, coercion and oppression... [and] done for the socio-economic uplift of slave owners” (Bridgewater, 2001, p. 15). Slave “breeding schemes” became especially profitable for slave “owners” following the close of the international slave trade, particularly Mid-Atlantic states where agricultural labor yielded lower returns (Bridgewater, 2001). A full recognition of the scope of this history necessitates understanding the practice of slave breeding—and,

particularly, control over Black Women's reproduction—as “essential to the systematic functioning and character of American slavery” (Bridgewater, 2001, p. 19).

Following the formal end of slavery, white elites continued to advocate for and implement policies which controlled and racialized reproduction. The Comstock Laws—passed in the 1870s to forbid the provision of information about contraceptives and abortion—were intended to enforce gendered norms which equated White Womanhood with Motherhood and chastity (Solinger, 2005). In the 1900s, when debates about legalizing contraception began in earnest, this charge was led by eugenicists who hoped to use contraception to limit the reproduction of Women viewed as “socially unfit”—predominantly Women of Color, poor Women, and Women with disabilities (Mengesha, 2017).

Eugenicist fears of “race suicide” also resulted in the passage of involuntarily sterilization laws in thirty-two U.S. states (Harris & Wolfe, 2014) and the sterilization of more than 60,000 people (Yee & Simon, 2011). Forced and coercive sterilization of women of color remained prevalent into the 1960s and 70s; for instance, some estimates suggest that at least 25% of Native American women of reproductive age were sterilized by the Indian Health Service in the 1960s and 70s (Lawrence, 2000). A 1965 survey concluded that just over one third of Puerto Rican women of reproductive age had been medically sterilized (Presser, 1969), and inmates were coercively sterilized in California prisons as recently as 2010 (Mengesha, 2017; Stern, 2005). In the 1980s, with President Ronald Reagan's popularization of the racialized character of the “Welfare Queen” (Bridges, 2011), reproductive control was integrated with the country's welfare system, as some states provided financial incentives for beneficiaries who had the long-acting reversible contraception (LARC) Norplant implanted. Congress also implemented a “family cap”

so that welfare recipients would not earn additional benefits as their family size grew—essentially penalizing reproduction among low-income women (Harris & Wolfe, 2014).

In sum, colonialist and White supremacist tactics—including the construction of modern racialized/gendered subject formations and the master narrative of race as a biological reality—have made reproduction a political and racialized matter from the foundation of the United States. Even as biological explanations of racial difference have fallen out of fashion, neoliberal and colorblind racist narratives now characterize poverty as a heritable trait passed down to children via Black Culture (Bridges, 2011). Consequently, controlling Black Women’s reproduction has become recast as a poverty alleviation strategy. Governmental institutions such as foster care and prisons now enforce reproductive oppression by targeting Black Mothers with child removal and incarceration (D. E. Roberts, 1991, 2012). Here, then, we see how White supremacist reproductive oppression— e.g., the exploitation of the sexuality, labor, and fertility of racialized bodies aimed at perpetuating White patriarchy (Ross, 2017, p. 192)—remains commonplace today.

### **The Biomedical Model**

Healthcare providers (HPs) have been accomplices in the enactment of reproductive oppression for hundreds of years. HPs have forcibly sterilized marginalized peoples, pressure low-income women and women of color into using contraception, and report drug use among pregnant black women to social services and law enforcement at disproportionately high rates (D. E. Roberts, 1996; Rutecki, 2011; Solinger, 2005). Conceptualizing the biomedical model—the dominant ideology in Western medicine (Pangborn, 2017)— is useful for understanding how HPs have become complicit in reproductive oppression. The biomedical model regards disease “as a biological mechanism of cause and effect that can be effectively diagnosed and treated

through science and technology” (Harter, Japp, & Beck, 2005, p. 22). Biomedical norms reflect White supremacist, patriarchal, and Western values insofar as “competencies deemed relevant to develop superior medical skills are racially and culturally charged, including among other things intelligence, rationality, emotional detachment, high ambition, high competitive drive” and technical, abstract, generalizable reasoning (Barry, Stevenson, Britten, Barber, & Bradley, 2001; Essed, 2005, p. 231). The biomedical model also disregards social, political, economic, and contextual factors that shape health and illness (Dutta & Zoller, 2008, p. 31); claims that medicine is a benign and politically neutral endeavor (Lupton, 2012); and seeks to commercialize health and medicine (Essed, 2005).

There has been increasing dissatisfaction with and criticism of the biomedical approach in recent decades, leading to the development of alternative frameworks for approaching and understanding healthcare practice, including medical humanities (Evans, 2002) and narrative medicine (Charon, 2006). Nonetheless, the biomedical model remains central to Western medical practice, particularly as the values of biomedicine (such as personal autonomy, professional authority, knowledge and certainty, and emotional detachment) remain key to many medical providers’ identities (Monrouxe, 2009; Real, Bramson, & Poole, 2009).

### **Theorizing Master Narratives and Structures**

The core concepts I have introduced thus far (e.g., coloniality, White supremacy, capitalism/neoliberalism, and the biomedical model) function as both master narratives and structures. Master narratives —also called metanarratives, macronarratives (Harter, Japp, et al., 2005), dominant narratives (Dutta, 2011), stock stories (Delgado, 1989), canonical narratives (Tullis, Roscoe, & Dillon, 2017), or grand narratives (Zohar, 2018)—are the “stories that underlie, reflect, and perpetuate predominant cultural values and assumptions about how the



world is constituted and how society functions” (Sharf, Harter, Yamasaki, & Haidet, 2011, p. 40). Master narratives serve to maintain the stability of social hierarchies by emphasizing the dominant group’s goodness and fairness and by naturalizing socially constructed phenomena (Delgado, 1989). Master narratives operate by creating a hierarchy of characters, sacred objects and spaces, themes, motifs, plotlines, and moral interpretations (Harter, Japp, et al., 2005). These narratives are (re)produced and (re)told through powerful societal institutions, such as the texts of laws, the proceedings in courts, and school text books, so that their features come to be seen as common sense and incontrovertible (Delgado, 1989; Polletta, Chen, Gardner, & Motes, 2011). To take an example, White supremacy, neoliberalism, and colonization work to produce the *character* of the “Third World Other,” who is understood to be non-White, non-Western, primitive, unscientific, underdeveloped, and agency-less (Dutta, 2012). This character supports the stability of capitalism and Western colonialism by setting expectations that people in the Third World are not capable of governing themselves and are dependent on Western interventions to survive (Dutta, 2012). The “Third World Other” becomes widely recognized by cultural members, as this image is disseminated by powerful institutions (such as international non-profit organizations, research journals, and popular media), suggesting that Western intervention is needed to save Women and Children of the Third World (Mohanty, 1988; Rideout, 2011; Sensoy & Marshall, 2010).

Importantly, master narratives are not stable, unitary, or unalterable. It is possible for subordinated group to appropriate these dominant narratives and repurpose them or disrupt them to resist oppression (Buzzanell & Ellingson, 2005; Delgado, 1989; Dutta, 2011; Souto-Manning, 2014; Tullis et al., 2017). By pointing to inconsistencies in dominant narratives, offering alternative visions of the future, and centering the voices of marginalized peoples, counter-stories

can disrupt the taken-for-granted acceptance of dominant narratives (Dutta, 2011). The *adivasis* in West Bengal, India, for example, have disrupted the master narratives of neoliberalism and the character of the “Third World Other” by organizing political groups to share their stories, which demonstrate the inequalities and violence perpetrated by neoliberal economic policies (Dutta, 2011, p. 61)

As structures, capitalism, White supremacy, biomedicine, and coloniality work as “systems of organizing that constrain and enable access to resources” (Dutta, 2014a, p. 286). Biomedical-capitalist structures include hospitals and pharmaceutical companies which, motivated by profits, continuously raise prices for medical treatments and services (Dutta, 2015b). To illustrate the linkages between master narratives, structures, and material consequences as they manifest in reproductive health, I now turn my focus to the character of the Good Mother.

### **Understanding the “Good Mother” and the White Heteronormative Bourgeois Script**

The hegemonic character of the Good Mother in the U.S. is produced through interactions between the master narratives of White supremacy, neoliberalism, coloniality, and patriarchy. These master narratives depict the Good Mother as a cisgender woman who follows a heteronormative bourgeois life script by completing high school and college education, establishing a successful career which allows her to participate in consumerist culture and avoid reliance on government assistance, and entering into heterosexual marriage before having children (Mann, 2013). This bourgeois heteronormative script operates as a site of White racial formation, dating back to European colonization of the Americas (Mann, 2013; Morgensen, 2010). During this time, settlers constructed diverse practices of gender and sexuality among Native peoples as evidence of primitivism to bolster their claims that colonization was a

civilizing mission (Morgensen, 2010). the construction of modern sexual citizenship as contingent upon heterosexuality, marriage, and ownership of private property (Morgensen, 2010, p. 108). The veneration of the nuclear family, then, is a manifestation of White supremacy and coloniality (Smith, 2006).

Today, Good Mothers are expected to “plan” their pregnancies by postponing childbearing until they have realized the goals of the White heteronormative bourgeois script. Thus, promoting “family planning”—a discourse which suggests that Good (future) Mothers should intentionally plan and time their pregnancies using contraception (Stevens, 2015)—has become a key goal of reproductive medicine (Finer & Zolna, 2011). Biomedicine has collaborated in the production of this master narrative by developing public health campaigns which assert that “planning” pregnancy results in improved maternal and infant health, decreased unemployment and reduced “welfare dependency” (Lu & Halfon, 2003; Solinger, 2005). However, a significant body of research suggests that childbearing practices which fall outside the normative script are an adaptive response to structural oppression for many marginalized women, particularly low-income black women (Geronimus, 1996; Rich-Edwards, Buka, Brennan, & Earls, 2003). For instance, becoming a mother as a teenager may make sense for low-income young people as this is the stage of their life “when they have the fewest employment opportunities, the best health, and the most help from a network of relatives” (D. E. Roberts, 2017, p. 119).

A large body of research suggests that many RHPs accept master narratives about the Good Mother and work to fashion their patients in her image. Stevens (2015) demonstrates how providers’ views on reproduction are often explicitly ideological, as providers in her study sometimes self-identified as “old-fashioned,” meaning that they felt patients should be married,

financially secure, and generally stable in their life situation before becoming pregnant (p. 47). When patients who did not have these classed and racialized markers became pregnant—even when such patients had been intentionally trying to do so—providers often labeled their pregnancies as “unplanned.” The specter of the Good Mother creates a tension between public health aims/normative ideals and the tenets of patient-centered care and shared decision making (Stevens, 2015). For example, because of priorities to reduce rates of “unplanned” pregnancy, providers may encourage patients to use birth control through a variety of persuasive tactics that border on coercion. In qualitative studies, providers have described using “scare tactics” to convince patients to use contraception, selectively presenting information to influence patients’ choice of birth control, and employing authoritative and directive communication styles (Cusanno, Estlund, Madden, Buckel, & Politi, 2018; Henderson et al., 2011; Kelly et al., 2017).

In addition to affecting RHPs’ approaches to communication and medical treatment, the Good Mother provides ideological fuel for a number of structures which work to control and/or punish Women of Color, low-income Women, unmarried Women, queer parents, and teenage parents because they do not embody normative Motherhood. These structures include the scaling back of public services under the guise that “Welfare Queens” have children to take advantage of social support services (Gilman, 2014; D. E. Roberts, 2017) and population control programs which seek to limit the reproduction of Third World Women by promoting “family planning” behaviors (Dutta, 2014b). In sum, master narratives which perpetuate the character of the Good Mother colonize the minds of RHPs and support oppressive structures, with material consequences for patients’ lives. Still, these narratives-structures are not invulnerable, as I will show in the following section.

## **Resistance and the Reproductive Justice Movement**

Even in the face of patriarchal White supremacist terrorism and violence, marginalized people have always found ways to resist reproductive oppression (D. E. Roberts, 2017; Ross, Roberts, Derkas, Peoples, & Bridgewater Toure, 2017). Enslaved women resisted “breeding schemes” by abstaining from sex and using contraceptives and abortifacients (D. E. Roberts, 2017, p. 46; Silliman, Fried, Ross, & Gutiérrez, 2016). In the 1890s, black women began mobilizing through women’s clubs, so that by the end of the 1940s roughly 2.5 million women were enrolled in such organizations (Ross et al., 2017). Many of these groups “supported access to birth control and abortion while critiquing the eugenicist policies and programs often espoused by those organizations that supported birth control” (Silliman et al., 2016, p. 59). In the 1970s, Chicana activists came together to protest forced sterilization, publishing booklets, organizing rallies, fundraising for lawsuits, and demanding changes to hospital policies, all the while drawing attention to “the links between U.S. imperialism and the control of women’s bodies” (Gutiérrez, 2008, p. 99). Today, organizations like Forward Together and Sistersong Women of Color Reproductive Justice Collective continue to fight for change by organizing and mobilizing activists, offering trainings in leadership develop and reproductive justice, and supporting artists who use their crafts to “break down barriers, uncover plugged ears, raise new questions and conversations, inspire compassion, spark activism, and rally multitudes around a case” (“Sister Song,” 2019; “What is Reproductive Justice? Forward Together,” 2019).

Two social movements are especially key to understanding contemporary issues surrounding race and reproductive health in the U.S. First, the civil rights movement in the 1950s and 60s focused on securing voting rights for Black Americans and eliminating (legal) segregation in areas such as housing, education, and employment (Cashmore, 2004a). Second,

second-wave feminism was most prominent in the 1970s and addressed issues such as gender-based employment discrimination, unequal labor within homes and families, violence against women, and women's health (Baxandall & Gordon, 2005). During this era, feminists won major legal victories with the Supreme Court cases *Griswold v. Connecticut* (1965) and *Roe v. Wade* (1973), which legalized contraception for married couples and abortion services, respectively (Baxandall & Gordon, 2005; Joffe, 1987).

Although women of color were significant activists, theorists, and leaders within both movements, their voices, priorities, and contributions were often marginalized or ignored in leading organizations and media (Baxandall & Gordon, 2005; Lawson, 2005). This motivated contemporary anti-racist reproductive health activists to develop Reproductive Justice Theory (RJT), which places women of colors' experiences at the center of analysis and activism (Ross et al., 2017). RJT emphasizes, "three interconnected human rights values: the right *not to have children*... the right *to have children* under the conditions we choose; and the right *to parent the children we have* in safe and healthy environments" (Ross et al., 2017, p. 11).

RJT was first posited in 1994 by a group of twelve African American women who combined insights from reproductive rights, social justice, and human rights thinking to move beyond "constitutionally limited concepts of individual rights and privacy. [RJT] challenged how liberal ideology misused the concepts of rights and justice to situate responsibility for health and wellness in individual choices" (Ross et al., 2017, p. 19). RJT recognizes that reproductive health is deeply connected to environmental health, criminal (in)justice systems, economic inequality, and more (Ross et al., 2017). Thus, RJT broadens mainstream feminism's narrow focus on access to "choices" in regards to abortion, contraception, and sex education by understanding

reproductive health as embedded within a myriad of social structures and inequities (Ross et al., 2017). The Moriah Fund asserts the following criteria are crucial to RJT:

**Table 1.** Characteristics of Reproductive Justice Theory

<ul style="list-style-type: none"> <li>• Is intersectional</li> <li>• Connects the local to the global</li> <li>• Based on the human rights framework</li> <li>• Makes the link between the individual and community</li> <li>• Addresses corporate responsibility</li> <li>• Applies to everyone</li> <li>• Commits to individual/community leadership development that results in power shifts</li> </ul>	<ul style="list-style-type: none"> <li>• Fights all forms of population control (eugenics)</li> <li>• Puts marginalized communities at the center of the analysis</li> <li>• Understands that political power, participation of those impacted, and policy changes are necessary</li> <li>• Has its own intersectionality of involving theory, strategy, and practice</li> </ul>
Adapted from Moriah Fund, 2006 (cited in Ross et al., 2017, pp. 19-20)	

Insights from RJT are key for understanding how race, gender, class, and other identity formations intersect in structuring the reproductive lives of all people, and is foundational to my thinking on this project.

### **Project Justification**

This literature review has demonstrated that reproductive health care—often characterized by discourses about “family planning” and “choice”—is not a neutral field, but is deeply related to cultural assessments and evaluations of the worth of people. Research which disrupts dominant narratives around race and reproduction is urgently needed, given the current political climate in the U.S. The human rights to health and dignity are being endangered daily by racist, sexist, and xenophobic political actors (like Donald Trump), who use their privileged positions to perpetuate hegemonic master narratives (Gantt Shafer, 2017). These political actors are also supporting and implementing policies which reduce access to health insurance and needed reproductive health services (Franklin & Ginsburg, 2019). My thesis aims to understand

how RHPs contribute to maintaining (and resisting) oppressive master narratives by asking the following question:

**RQ: How do reproductive healthcare providers communicate about the intersections of race, reproductive health, and policy?**



CHAPTER THREE  
METHODS AND PROCESSES

**Study Design and Theoretical Stances**

Following Kim (2015), I used theories as tools throughout this project to help me clarify my research focus, design a methodological approach appropriate for my aims, and make sense of my research (and other life) experiences. I relied primarily on three theoretical frameworks to guide my research: critical-cultural health communication, Postcolonial Theory (PT), and Reproductive Justice Theory (RJT). Below, I outline insights scholars and activists have introduced using these theories, and discuss how these ideas influenced my research processes.

First, critical-cultural health communication is a paradigmatic approach which examines how meanings about health are constituted and circulated within broader relationships of power and control (Dutta & Zoller, 2008). In line with critical health communication scholarship, the goal of my study is to locate RHPs' narratives within the realm of power and to understand how their stories can reproduce taken-for-granted assumptions and/challenge dominant power formations (Dutta & Zoller, 2008). My focus on narratives also follows critical theorizing by examining how "locally situated narratives, identities, and relationships... are constituted within the broader framework of culture, and are negotiated in the realm of social structures that define the possibilities of discourse" (Dutta & Zoller, 2008, p. 14). In keeping with this paradigm, then, I designed an interview-based qualitative study with the goal of producing "thick descriptions" of negotiated meanings in healthcare settings (Dutta & Zoller, 2008, p. 15).

Postcolonial Theory shares with critical research a focus on situating discourses within broader relationships of power, but brings with this an impetus to examine the role of Western imperialism in (re)constructing relationships of dominance and subordination (Chavez, 2009; Shome & Hegde, 2002). An important insight of PT has been that, “whereas in the past, imperialism was about controlling the ‘native’ by colonizing her or him territorially, now imperialism is more about subjugating the ‘native’ by colonizing her or him discursively” (Shome, 1996, p. 42). Because discursive constructions and representations are the tools through which contemporary imperialism is accomplished, a communication perspective becomes key to postcolonial efforts (Shome & Hegde, 2002).

Postcolonial Theory has impacted my approach to this project, both analytically and methodologically. Analytically, PT motivated me to ground my conceptualizations of race and gender within broader histories of Western imperialism. Postcolonial work, which stresses the need to counter the universalizing and homogenizing tendencies of Western thinking (Mohanty, 2003), has also left me more open to looking for discontinuities and contradictions in my dataset, rather than focusing on what is generalizable across my interviews. Additionally, PT motivated me to question the Western construction of “the subject as a bounded, autonomous individual” (Hedge, 1998, p. 278). This has been an important reflexive step for me, as I am now embracing the power of what my therapist terms “emergent collective intelligence.” While I once believed that my thesis needed to be comprised of my own original ideas, I now recognize that my ideas are never really mine alone, but have been produced through interactions between myself, the authors I read, my mentors, my participants, and especially my co-investigator, Niv. Reading PT has helped me honor the ideas I co-produce through engagement in emergent collective intelligence. For instance, this thesis developed out of a conversation between Niv and I during

our first semester at USF, when we decided to collaborate on a project to investigate reproductive health, race, and policy as communicated by patients and RHPs. Niv ultimately co-conducted three RHP interviews with me (and I participated in two of her participant interviews). While we have not reviewed one another's data, we constantly discussed our ideas about our projects as they evolved. Through these discussions, Niv helped me to focus on the ways in which RHPs display contradictions in their thinking about structure, as they are often able to understand how structures constrain their own agency but do not consistently apply this insight when making sense of their patients' behaviors. I will discuss this idea further in my results and discussion, but mention it here to illustrate the ways in which collaboration and dialogue have been key to my research process.

Reproductive Justice Theory is the third key framework I have utilized throughout this project. As described in my literature review, a group of black women scholar-activists created Reproductive Justice in the 1990s to inspire both activism and scholarship (Ross et al., 2017). As an intersectional framework which centers the lives and experiences of women of color, RJT scholarship helped me to focus on the intersections of the prison industrial complex, foster care, and capitalist biomedicine in producing reproductive oppression.

RJT also influenced my decision to focus on narratives in my research. Leaders of the Reproductive Justice movement were inspired to develop RJT in part because they felt limited by the narratives and terminologies used by white reproductive rights advocates. Loretta Ross (one of the founders) writes: "We recognized that the lack of appropriate language [in the pro-choice movement] imprisoned our souls and frustrated our alliances" (2017, p. 176). Thus, RJ activists have always been concerned with the power of language, and have historically relied on storytelling as a tool for resisting White imperialist heterocapitalist patriarchy (Ross, 2017, p.

191). In sum, RJ scholarship, which connects narratives to reproductive oppression and resistance, inspired this project.

## **Data Production**

### **Semi-Structured Interviews**

Data for this study were produced through interviews with HPs who provide contraception and/or pregnancy care to patients. I employed a semi-structured interview approach (rather than using structured interviews or surveys) because this format is well-suited for soliciting rich, evocative narratives from participants (Lindlof & Taylor, 2019). My interview guide included questions addressing a broad range of issues (including contraception counseling, pregnancy ambivalence, and abortion care, see **Appendix A**). Rather than attempting to address every question with each participant, I tailored my questions to the interests and experiences of each RHP. Through an iterative process of journaling and reflecting after interviews (Lindlof & Taylor, 2019), I noticed that I developed the richest narratives by modifying my questions based on the unique experiences of each participant. For instance, I spent more time talking about abortion with Dr. Nancy than I did with other participants, because abortion care is a significant part of Dr. Nancy's job. With Dr. Allison, I found it was not as fruitful to ask many questions about abortion, since she does not perform this procedure. However, we had a long discussion about providing care to patients in prison, since Dr. Allison has experience treating this group of patients. Dr. Allison could not share many stories about abortion, and Dr. Nancy could not share stories about treating patients in prison but, by tailoring my questions based on each of their experiences, I was able to learn rich and powerful narratives related to race, reproductive health, and policy from both participants. Thus, the semi-structured interview approach provided me with flexibility which was key to my ability to co-produce narratives with participants.

## **Inclusion Criteria and Participant Recruitment**

Recruitment for the study began in August of 2018, after the project received USF Institutional Review Board (IRB) approval. All healthcare providers and staff who a) had completed their medical training; b) could participate in an English-only interview; and c) frequently discuss reproductive health with patients were eligible to participate. I chose to leave my inclusion criteria broad because prior research has demonstrated that discourses about reproductive health are produced by many different actors within healthcare settings (Gilliam & Hernandez, 2007), and I wanted my study to recognize this diversity. I recruited participants by sharing a study flyer to email list serves; attending OB/GYN Grand Rounds, faculty, and staff meetings; and through snowball sampling (Lindlof & Taylor, 2019). This approach enabled me to recruit a diverse group of participants with a range of experiences and perspectives on race, reproductive health, and policy. All participants in the Tampa Bay area were interviewed in person, while three participants who were not native to Florida were interviewed by phone. I explained the purpose of the study, informed participants that they could withdraw from the project at any time, and answered their questions before asking them to sign an informed consent form. After participants signed this form, I turned my audio recording devices on and began asking questions.

## **Transcription**

I transcribed each of my interviews myself. This process, which took roughly one-hundred and thirty hours to complete, enabled me to develop intimate familiarity with my data. I used transcribing as a tool to facilitate iterative inquiry (Tracy, 2013), as transcribing helped me to identify patterns and important issues in my data which, in turn, I could then search for in existing literature. While transcribing, I also reflected on my own interviewing techniques and

noted areas in which to probe further in future interviews. From a theoretical perspective, I view transcription as an interpretive process of translating data from audio into text (Bailey, 2008; Mishler, 1991). This process necessitates making choices about how I wish to present myself, my participants, and our interactions (Duff & Roberts, 1997). Ultimately, I chose to include some non-verbal cues (such as laughter, speaker emphasis, and pauses) because I felt that these cues were important for drawing attention to the performative and embodied dimensions of my data (Ellingson, 2012). I also found that these cues were also useful in conveying some information about participants’ personalities and the meanings of their words. At the same time, there are many non-verbal cues (tongue-clicking or throat clearing) which I did not include, primarily due to time constraints and because I found that describing too many nonverbal cues could distract me from my participants’ meanings. I describe the primary transcribing conventions I use throughout this thesis in **Table 2**. In some of the narratives I present, I use additional symbols to convey further information relevant to my analysis. In these cases, a key describing the symbols used is presented in a caption below the data.

**Table 2.** Transcription Conventions

Symbol	Meaning
<u>Underlined text</u>	Speaker emphasis
Underscore (e.g., __)	Speaker pause. Longer underscores indicate longer pauses
((Double parenthesis))	Non-verbal cue (e.g., laughter)
[Bracket]	Used to introduce clarifying information or mask identifying details

### Conceptualizing Narratives

As discussed previously, work by RJT activists first sparked my interest in narrative research. Dr. Durham’s recommendation that I use Critical Narrative Analysis for this project, as well as time constraints which made thematic analysis of my full dataset infeasible, solidified my

decision to utilize narrative analysis for my project. Since the “narrative turn” of 1980s and 1990s, a significant body of research on narratives has been developed by scholars from a broad range of fields, including sociology, linguistics, anthropology, history, and psychology, and communication (De Fina & Georgakopoulou, 2015; Mishler, 1995; Sharf, 2014). A wide variety of approaches to narrative analysis have been developed (Kim, 2015), and several scholars have created typologies which categorize these different approaches. For example, Riessman (2005) distinguishes between thematic, structural, interactional, and performative forms of narrative analysis; Mishler (1995) delineates approaches with respect to researchers’ focus (e.g., temporal ordering vs. coherence and structure vs. contexts and consequences); and Grbich (2013) separates “sociolinguistic” from “sociocultural” versions of narrative analysis. Even the word “narrative” itself has been defined in many ways, with some researchers distinguishing between “narratives” and “stories” and others using these terms interchangeably (Sharf, 2014).

Following Communication and Narrative Medicine scholars, I have found it useful to conceptualize narratives<sup>1</sup> as discursive and symbolic formations which “organize events across time and space, identify characters and their relationships, and determine causes and effects” (Harter & Chadwick, 2014, p. 912). Narratives serve a variety of social functions, as they help people: make sense of their lives, experiences, and identities; regain a sense of control over chaotic events; justify and explain their decisions; cope with change; build community; resist oppression; and move others to action (Sharf et al., 2011). Narratives which are told in interpersonal settings are dialogic accomplishments; they are always told with audiences in mind and are co-produced through interaction (Harter, 2009). At the same time, these dialogic

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<sup>1</sup> I view “stories” as narrative which focus on specific, bounded events or interactions. To illustrate, I regard Dr. Three’s narrative on treating uninsured patients as consisting of two stories. Each of the stories is about an interaction she had with a specific patient at a specific time. Thus, her narrative is made up of two stories (although each of the stories in isolation could also be seen as their own narrative).

performances also depend on larger relations of power, which determine “who can talk, what is tellable, and by whom” (De Fina & Georgakopoulou, 2015, p. 5) as well as the conventions of how narratives should be delivered (Harter, Japp, et al., 2005). For instance, in my interviews, contextual norms—such as the expectation that, as the interviewer, I would be asking most of the questions—and cultural norms—such as the Western expectation that stories have clear beginnings, middles, and ends (Mishler, 1991)—likely contributed to the ways in which participants told (and I responded to) their narratives.

After reading work by scholars who approach narrative analysis in a variety of ways, including from communication (Harter, 2009), sociological (Plummer, 1995), critical discourse (Souto-Manning, 2014), and Narrative Medicine (Charon, 2006) perspectives, I have developed an understanding of narratives and approach to Critical Narrative Analysis (CNA) which I believe is well-suited for my research topic and which incorporates insights from RJT, PT, and health Communication research. I view CNA as “a tool to identify, understand, and highlight the processes of language colonization and appropriation. It is a tool for the development of critical meta-awareness, which may allow individuals to be less discursively colonized, thus using the language of power for appropriation purposes” (Souto-Manning, 2014, p. 165).

My Communication-informed approach to CNA involves the application of the tools of close reading (Charon, 2006) to participants’ narratives in order to address key questions in Postcolonial and critical-cultural Communication scholarship. These questions include: How do discursive practices represent the world and its subjects? And, how do these representations legitimize global power structures? How do these narratives construct definitions of race, gender, and class? And, in what ways do everyday narratives reflect and/or contest dominant narratives (Hedge, 1998; Shome, 1996)? Having described my theoretical approach to CNA, I now briefly



outline the steps I followed to conduct my analysis. Even as I present these steps in a linear chronological order, I emphasize that the reality of my process was not quite so direct. Each step involved continuous cycles of reflection, comparing my ideas to research literature, and talking ideas over with colleagues (Tracy, 2013).

### **Steps of Critical Narrative Analysis**

1. *Identifying narratives*: Before I could begin analyzing my narratives, I needed to find them. To do this, I re-read transcripts until I eventually identified three broad “types” of narratives which appeared in my data: (1) stories about specific patient cases or events; (2) broad experience narratives, which describe in a more abstract way what it is “like” to perform a job or work in a certain environment; and (3) hypothetical interactions in which participants perform an imaginary conversation to demonstrate how they would go about a particular situation. I then used NVivo to code instances of these various types of narratives across my interviews. As I coded, I journaled about patterns I noticed and narratives that stuck out to me as emotionally powerful or illustrative of a larger trend in my project. Once I completed this coding, I reviewed all the narratives I identified and selected a list of “finalist” narratives that I felt addressed important issues (such as the prison industrial complex) or patterns I had identified through my journaling (such as doctors’ feelings of limited agency).
2. *Return to the literature*: After creating my list of “finalist” narratives, I conducted a more focused literature review on a number of select topics which I had noted during my journaling process (such as the devaluation of Black Motherhood, teenage pregnancy, and American Exceptionalism). These readings helped me to better understand how master narratives were (and were not) reflected in my participants’ stories.

3. *Developing CNA*: At this point, I also conducted a literature review on approaches to narrative analysis. I noticed that many authors framed narrative analysis as, essentially, a process of asking “questions” about a given narrative (Yamasaki, Sharf, & Harter, 2014). I created an extensive list of “questions” various researchers recommend that other scholars “ask” of their narratives. I then grouped these questions into a rough taxonomy of “types” of questions. These “types” included questions about characters (e.g., Who is the protagonist in this narrative? Who is the antagonist?) and questions to facilitate critique (e.g., What values does this narrative support? What is taken for granted in this story?).
4. *Analysis of narratives*: Using this basic taxonomy of questions I developed through my literature review, I created a CNA “toolkit worksheet” (see **Appendix B**) which allowed me to perform a “close reading” of each of my finalist narratives (Charon, 2006). This toolkit guided me through my analysis, so that I began by asking questions about the basic content and construction of each narrative (e.g., Where does this narrative take place? Who are the characters? What metaphors are used?) and slowly moved towards understanding the underlying meanings and implications of narratives by considering more complex questions about power and researcher reflexivity (e.g., How does the narrator engage with master narratives? What emotions does this story bring up for me, and why?). I filled out a “toolkit worksheet” for each of my narratives and then wrote short summaries about the conclusions I came to through my close reading exercise.
5. *Writing*: After journaling about the connections I made between my dataset, literature on master narratives circulating in the U.S., and literature on race and reproductive health, I selected ten narratives for inclusion in my thesis. As I began writing (and discussed my thought processes with Niv), I ultimately added one narrative to this list (Dr. Albertha’s

narrative) and, due to time constraints, dropped three narratives from my project. The process of writing my analyses served as a form of re-storying; writing enabled me to create my own narratives about my data (Riley & Hawe, 2004). This re-storying, as well as the process of drawing connections across my narratives, was the final stage of analysis for my thesis.

## CHAPTER FOUR

### DATA AND ANALYSIS

#### **Participants**

I conducted interviews with twenty-four RHPs for this project. Interview lengths ranged from 36 to 162 minutes ( $n = 89$  minutes), resulting in a total of 35.65 hours of audio-recorded data and 816 single-spaced pages of transcripts. Just over half of my participants ( $n=13$ ) were OB/GYN physicians, with most of these RHPs identifying as generalists. My sample also included several physicians with non-OB/GYN specialties (including pediatrics and integrative medicine), as well as nurses, family nurse practitioners, and a midwife. Two-thirds of participants ( $n=16$ ) identified as “White” and/or “Caucasian,” and the large majority ( $n=22$ ) identified as “female.” The number of years participants had spent working in the field of reproductive medicine varied widely, from a low of four to high of forty years. More detailed information about participants’ demographic characteristics are reported in **Table 3**.

The RHPs I interviewed had worked in university-affiliated practices, free clinics, county health departments, prisons and jails, private practices, academic medical centers, high-risk clinics, and psychiatric institutions. I spoke with providers who had extensive experience attending to the reproductive health concerns of patients with drug use disorders, patients living with HIV/AIDS, undocumented patients, wealthy patients, poor patients, transgender patients, teenagers, and military veterans. I interviewed RHPs who provide contraceptive counseling, deliver babies, treat fetuses with significant genetic anomalies, do surgery, provide sex

education, and perform second trimester abortion care. The diversity of my sample reflects the reality that reproductive medicine is far from a monolithic or homogenous field and points to the ways in which power has become increasingly decentralized, dispersed across a wide range of practices and disciplines, and dynamic in the contemporary U.S. (Scott, 2014).

**Table 3.** Demographic Characteristics of Full Sample (N = 24)

Characteristic	<i>n</i>	%
Field*		
Family medicine, integrative medicine, or preventive medicine (MD)	3	12.5
Family medicine (FNP)	2	8.3
Generalist OB-GYN (DO)	1	4.2
Generalist OB or OB-GYN (MD)	10	41.7
Midwifery	1	4.2
Obstetrical nursing (AS, MSN, RN, and/or PhD)	5	20.8
Pediatrics (MD)	3	12.5
Psychiatry (MD)	1	4.2
Gender (self-identified)**		
Female	22	91.7
Male	2	8.3
Race (self-identified)		
Asian / Korean American	1	4.2
Black	1	4.2
Black / African American	1	4.2
Caucasian / White	17	70.8
Human (White)	1	4.2
Indian	1	4.2
Southeast Asian	1	4.2
White / Hispanic	1	4.2
Years working in reproductive medicine**		
4 – 9	7	29.2
10 – 15	5	20.8
16 – 20	3	12.5
21 – 40	8	33.3
*Several RHPs identified with more than one field		
**Failed to collect information from one participant		

I try to “set the scene” before each narrative by sharing some of my observations about the participant and offering some context about our conversation. However, I do not provide demographic information about participants at the individual level in an effort to maintain confidentiality. In **Table 4**, I do provide aggregated demographic information about the subset of six participants whose narratives I present. Every participant (except Dr. Three, whom I forgot to ask) chose their own pseudonym. I am concerned that my narratives, by naming RHPs but not patients, may serve to dehumanize and other the patients described. However, I ultimately chose not to assign pseudonyms to patients, as I recognize that names are raced, gendered, and classed and take on great significance with material implications in the context of White supremacist imperialist heterocapitalist patriarchy (Ross, 2017, p. 194). I did not wish to exercise the power of naming over the patients represented in RHP’s stories.

**Table 4.** Demographic Characteristics of Subsample (*n* = 6)

Characteristic	<i>n</i>	%
Practitioner type		
OB-GYN (generalist and specialist)	3	50
Obstetrics nurse	1	16.7
Pediatrician	2	33.3
Gender (self-identified)*		
Female	5	83.3
Race (self-identified)		
Black	1	16.7
Black / African American	1	16.7
Caucasian / White	2	33.3
Southeast Asian	1	16.7
White / Hispanic	1	16.7
Years working in reproductive medicine**		
4 – 5	2	30.3
15 – 25	2	30.3
> 30	1	16.7
*Failed to collect information from one participant		

As I described in Chapter Three, I selected narratives told by six of my participants for presentation here. I do not claim these narratives are representative of my full dataset or that these findings are broadly generalizable. While I sought to select narratives which I felt exemplified some of the patterns across my data (such as focus on issues of physician identity and agency and the characters of the Good Mother and Bad (m)Other), my analysis is focused on attending to *particular situated meanings* and locating these within broader configurations of power. My aim, then, is not to relativize accounts into abstraction or to speak about universal truths but, rather, to examine how “partial, locatable, critical knowledges” are embedded within and sustain webs of connection and meaning (Mishler, 1995, p. 114, citing Haraway, 1991). Understanding these configurations, I hope, can create opportunities for building solidarity and resisting master narratives/structures (Mishler, 1995). As with all research projects, my findings and the ways in which I present them are, inescapably, partial accounts based on my own priorities, interests, and institutional expectations (Ellingson, 2009). With this said, I now turn to narratives shared by Dr. Three, Dr. Christine, Nurse Jane, Dr. Albertha, Dr. Mary, and Dr. Stacy (and co-produced and re-presented by myself).

### **Dr. Three**

Dr. Three is a pediatrician who focuses on adolescent medicine. In addition to conducting research, Dr. Three oversees residents and treats patients at several clinics. The patient populations Dr. Three interacts with are different at each clinic, and range from privately insured to publicly insured to “unfunded” young adults. During our interview, Dr. Three seemed eager to share her experiences and often demonstrated her passionate feelings by raising her voice and pounding her desk for emphasis. My impression of her was that of a passionate, energetic woman who cared deeply about her patients and feels frustrated by both her patients’ behaviors

and injustices in larger society. Our interview was somewhat rushed, as Dr. Three had a commitment come up unexpectedly just before our appointment. The following exchange occurred towards the end of our interview, as I was trying to decide how to prioritize the limited time we had left.

### **Dr. Three's Narrative About Performing Contraception Counseling**

**Table 5.** "This Is Gonna Be Another Child That's Born into Poverty."

Bria:	Uhh, so I'm trying to think, what's the most important thing to talk about? Umm, let's talk about your patients of color. How—do you notice anything different about ((clicks tongue)) their experiences, or the care that they've received?
Dr. Three:	Yeah.
Bria:	Or something like that.
Dr. Three:	They are, much less trusting.
Bria:	Mmm
Dr. Three:	Takes time to get their trust. Um. I have to, work a little harder and longer for them to trust me. Umm--
Bria:	Why do you think that is?
Dr. Three:	Well, I mean. How could that not be the case?
Bria:	Mhm
Dr. Three:	I mean, we live in a country where Tuskegee happened.
Bria:	Right.
Dr. Three:	I—__ and,
Bria:	True
Dr. Three:	And like the blatant examples of racism you see every single day today? We have a president who's clearly racist.
Bria:	Yeah.
Dr. Three:	Like there's soo much racism!
Bria:	Yeah
Dr. Three:	Um, I think it would be really naïve and just frankly stupid to think that that wouldn't be the case.
Bria:	Right
Dr. Three:	Y'know, and I'm white.
Bria:	Right. So how do you approach that with them? Like how—what—how would you do to build trust?
Dr. Three:	I don't necessarily do anything differently.



Bria: Mhm

Dr. Three: I just do it longer and more persistently

Bria: Mhm

Dr. Three: You know, and I tell them,  
                           'I work in this clinic because I care about young people like you.'

Bria: Mhm

Dr. Three:             'You know, what, it's-- it's not like I'm getting a paid—paid a ton of money to work here.'

Bria: Yeah ((laughs))

Dr. Three:             'This is a clinic where we're here because we really care about you.'

Bria: Mhm

Dr. Three: And I will say that our clinic staff is very brown and black and wh—we're very diverse

Bria: Mhm

Dr. Three: Um, as a matter of fact, most of us are brown or black. There's not very many white.

Bria: Mhm

Dr. Three: Um, so I think that helps.

Bria: Mhm

Dr. Three: But you know ultimately the doctor's the one whose having this discussion and I'm white

Bria: Mhm

Dr. Three: Um, so I do say—you know, I talk to them about, ummm, my daughter happened to have a device similar to a LARC...

[comments have been removed her to ensure that this participant's identity remains confidential]

Dr. Three: ...And so I say—I try to make it so that,  
                           'If you were my daughter, I would do the same thing for you. If you were my child this is what I would do for you.' Umm, and 'I'm not, you know, getting any money or anything out of this. It's not, y'know—'

Cause I get a little pushy. Like, I really worry about them. And I say,  
                           'You know, I hope you don't think I'm being pushy. Maybe I am being a little pushy. But I'm really just doing this cause I really think it's what's best for you.'

Bria: Mhm

Dr. Three:             'You know, I'll do—ultimately I'll do whatever you want.'

Bria: Mhm

Dr. Three: You know,  
                           'Whatever you want me to prescribe or do, I will do. But I, I just want you to know that this is what I think is the best thing for you.'

Bria: Where does the pushiness come from? Like, what are you worried about for them?

Dr. Three: Well, because you're not gonna get contraception. And they all come back pregnant. And they all come back with STD's. Like,

Bria: Right. How does it affect their lives when they get pregnant, that you see?

Dr. Three: Welllll, we don't see a lot. Because then they go to the—they drop out of care.

Bria: Mhm

Dr. Three: Y'know? Like, or—well, we see them coming back later and they—y'know, they dropped out of school. And they, or they didn't-- they wanted to go to college and they didn't get to go to college. Or, y'know, this child is gonna be another child that's born in poverty.

Bria: Mhm

Dr. Three: And has another cycle. [inaudible] So, you know like, so we see a lot of this kind of institutional and intergenerational

Bria: Mhm

Dr. Three: Decrease socioeconomic status because they don't have the access to tools to keep them from getting pregnant. Y'know, there's ton of data to support that and we see that every day

Bria: Where do you think the ambivalence comes from? You're talking about sort of, pregnancy ambivalence, before.

Dr. Three: Well I think there's fear.

Bria: Mhm

Dr. Three So they don't-- you know, they're not in—you know, there's a cultural fear of, you know, 'Well, how do we know that they're-- you know, maybe the Nexplanon— Nexplanon has an—something in it. Like, there's a GPS track in it.'

I mean, I've had people ask me that.

Bria: Mhm

Dr. Three: Can people tell where I am because you put that in my arm? And I'm like, 'Whaaat?!'

Bria: Yeah

Dr. Three: You know. And I—I, I don't say that anymore cause I've heard it enough that now I don't get freaked out when people say that

Bria: Yeah

Dr. Three: But like, the first couple times I heard that I was like, 'Whhaaat?!?'

Bria: And that's mostly coming from your patients of color? That, have that fear?

Dr. Three: Yeah

Bria: Yeah?

Dr. Three: Well, no—

Bria: I guess—

Dr. Three: —not necessarily. I mean, some of my, \_\_\_ poorer white kids

Bria: Mhm

Dr. Three: Will have similar. You know. There's like this fear of the government

Bria: Mhm

Dr. Three: Conspiracy theory

Bria: Mhm

Dr. Three: Alt-right thing

Bria: Mhm

Dr. Three: Ummm, so yeah, we see that. Ummm, so there's just a lot of, uhh, fear.

Bria: Mhm

Dr. Three: That and having been raised in a culture where ((clears throat)) you know, they're trusting of the medical care and the medical advice. And I also think, umm, culturally, in the Black community there's a lot of young woman who are pregnant. And so, they don't necessarily see a lot of other alternatives.

Bria: Mhm

Dr. Three: You know, when you're raised in a home where education is really emphasized and your parents are super invested in you, pregnancy isn't an option that you take so seriously. Like you're not thinking of it as an option for your life. Whereas, a lot of these girls of color, that's, you know, a really viable option

Bria: Mhm

Dr. Three: Because so many people around 'em

Bria: Mhm

Dr. Three: So many of their family members and community members have done the same thing. It's a way to bring in money. Ummm, you know in terms of [inaudible]

Bria: Do you think they see that?

Dr. Three: \_\_\_ yeah.

Bria: Mhm

Dr. Three: Yeah

Bria: How do you approach—do you, talk about that?

Dr. Three: Oh man! I'm like,

‘Well you could do anything! You could go to school!’

Bria: Like, I \_ do a lot of motivational interviewing.

Dr. Three: ‘What do you want to do with your life?’

Bria: Uh-huh

Dr. Three: ‘Don't you think if you get pregnant that would be really hard?’

Bria: Mhm

Dr. Three: 'To go to college?' Umm, and I'll say, you know,  
'I had [redacted number] babies and it was super overwhelming and I had an amazing amount of support and I'd already gone to college.'

Bria: Uh-huh

Dr. Three: You know, like,  
'Why don't you think about--'  
And then the other way I will pose it to them is,  
'Do you want to be the best parent that you can be?'

Bria: Mhm

Dr. Three: 'Yeah.' And I say,  
'Well. So you're sixteen years old. Don't you think you would be a better parent to your child when you're twenty-two, you have a partner that you're married to so you're doing it together, rather than somebody you just met. You haven't even finished high school yet. Who's a better parent to your child?' And she's like— and they'll say,  
'Wellll, you know...'. And I'm like,  
'I'm not saying that you wouldn't love your child now. And do the best you could and be the best mom that you could. But you can't argue with me that at twenty-two you wouldn't probably be a better mom than you are now.'

Bria: Mhm

Dr. Three: And I'm like,  
'Okay, so this is your child. What do you think your child deserves?'

Bria: Does that—\_\_\_\_ do you think that that impacts them?

Dr. Three: I do. They think about it. I'm like,  
'I'm not saying that you shouldn't be a mom. It's just that maybe now is not the right time? And maybe this boy—'

Bria: Mhm

Dr. Three: And I also use the 'Mr. Right er—versu—versus Mr. Right Now.'

Bria: Mhm

Dr. Three: 'Is this guy Mr. Right? Or is he Mr. Right Now?'

Bria: Uh-huh

Dr. Three: 'Cause there's a wholeeee lot of Mr. Right Now's out there'

Bria: Uh-huh

Dr. Three: 'But there's not many Mr. Right's. So is this guy Mr. Right for you?'  
'Uhhhh.'  
'Okay, so then that is not the right person that you want to have a baby with.'

Bria: Mhm

Dr. Three: ‘Doesn’t your baby deserve a father who’s gonna be there for him?’

Bria: Mhm

Dr. Three: And um, unfortunately a lot of these women, these young women are in environments where there’s a lot of single parents. And so they—you know, the kind of concept of having a father who’s really engaged and involved it’s not something they really think about a lot

Bria: Mhm

Dr. Three: So that—y’know, I don’t know how—I think that is differentially depending on which population I’m talking to

Bria: Ummm. Alright. That’s--- it sounds like you have a lot of work that you do

Dr. Three: ((laughs))

Bria: That there’s a lot of like talking and–

Dr. Three: Yeah, yeah–

Bria: –Beyond the

Dr. Three: Yeah.

### **Dr. Three’s quest.**

I view the tale Dr. Three recounts above as a sort of quest story: Dr. Three casts herself as the intrepid hero who sacrifices financial gain (“it’s not like I’m getting paid- paid a ton of money to work here”) for noble and selfless ends. Specifically, Dr. Three hopes that her time, energy, and counseling skills will motivate poor teens of color to use contraception (ideally, LARCs), prevent pregnancy, and escape “institutional and intergenerational poverty.” Throughout this quest, Dr. Three encounters several trials which stand in the way of her goal, such as her patients’ distrust, her own Whiteness (which engenders this distrust), and cultural attitudes and expectations within “the Black community” which makes teenage pregnancy a “really viable option” for “these girls of color.” To overcome these trials, Dr. Three draws on a variety of communication strategies in her interactions with patients, such as emphasizing that she cares about her patients and that she is treating them the same as she would her own child. She also

tries to motivate patients to accept LARCs and thereby prevent pregnancies by arguing that they will have many other (presumably better) life options if they wait to have children. She insists to them that they will be better mothers when they are older. Dr. Three notes that she uses the technique of motivational interviewing—a research-driven counseling approach designed to “motivate” changes in patients’ health behaviors (Britt, Hudson, & Blampied, 2004)—to convey these messages.

Within the narrative world, Dr. Three creates, LARCs serve as what Frank (2004) terms the “Holy Grail,” objects endowed with “the power to heal and to redeem” (215). If they obtain LARCs and stave off pregnancy, Dr. Three suggests, her patients can go to college and escape poverty. LARCs have the power to “heal” the purported pathologies of young people of color: underachievement, teen pregnancy, and poverty (Mann, 2013; te Riele, 2006). Conversely, following in the footsteps of “their family members and community members” by having children as “a way to bring in money,” represents “Grendel,” the threatening force that must be kept at bay, lest it destroy the characters (Frank, 2004). The imagined future of teen pregnancy and poverty is the specter which haunts Dr. Three’s story; it is the monster she must heroically vanquish to complete her quest.

#### **Master narratives sustaining the quest.**

In order to construct this tale, Dr. Three draws on several master narratives. Interestingly, however, she begins by disrupting the discourse of “colorblindness” (Bonilla-Silva, 2007) which dominates in the world of biomedicine and in mainstream American culture (Cunningham & Scarlato, 2018; Omi & Winant, 2015). Dr. Three interrupts the myth of the U.S. as a “post-racial” society by acknowledging the presence and salience of racism in the present day,

identifying herself as a racialized subject, and acknowledging that patients of color are (at least somewhat) justified in their mistrust of the medical community.

However, Dr. Three simultaneously takes up color-blind racist discourses to *support* her own narrative. In particular, she draws on the frame of the biologization of culture (Bonilla-Silva, 2011) when she locates blame for “institutional and intergenerational poverty” within Black culture. Rather than pointing to institutions which differentially structure opportunities by race (Mann, 2013) through, for example, housing discrimination, predatory lending practices, and mass incarceration, Dr. Three suggests that a lack of emphasis on education and parental support is the cause of teen pregnancy, and that teen pregnancy, in turn, causes poverty. She also draws on the frames of minimization of racism and abstract liberalism, as she implies that the path towards higher education and gainful employment would be clear for her patients (“Well you could do anything! You could go to school!”) if they could only avoid early pregnancy.

As she constructs her narrative, Dr. Three also draws from the White bourgeois heteronormative script (Mann, 2013) and dominant narratives which pathologize the Black Family and devalue Black (teenage) Motherhood (Austin, 1989; D. E. Roberts, 1993). Dr. Three links her story with this master narrative when she positions it as undeniable (“you can’t argue with me”) that a woman who is done with high school, out of her teens, and married is a “better mom.” The implication is that mothers who do not follow the White bourgeois heteronormative script are intrinsically worse mothers. As these comments follow shortly after her statement that “culturally, in the Black community there’s a lot of young women who are pregnant,” these substandard mothers are also coded as Black. Simultaneously, Dr. Three invokes the neoliberal, White supremacist figure of the “Welfare Queen,” a poor Black Woman who has children to manipulate the welfare system and take advantage of White taxpayers (Gilman, 2014; Kaufman,

1997), when she comments that having children is seen by young women of color as “a way to bring in money.” These master narratives, then, provide a discursive resource for Dr. Three. They enable her to maintain White hegemony while simultaneously constructing herself as an ally to patients.

### **The functions of the quest.**

I have argued that Dr. Three constructs her narrative about providing contraception counseling to teenagers of color by recycling a stock of characters and themes from master narratives. These discursive resources enable Dr. Three to create a narrative world wherein the U.S. is a land of opportunity populated by at-risk young people of color. In this universe, a heroic and self-sacrificing physician (Dr. Three herself) is needed to save teens of color from poverty and their own deviant culture. Armed with LARCs, Dr. Three fights to vanquish the looming specter of the Welfare Queen and to transform deviant youths into college educated, middle class, married (White) homesteaders.

From my perspective, this narrative demonstrates the ways in which Dr. Three’s beliefs, explanations, and experiences of reproductive health and race have been colonized by master narratives. When I asked Dr. Three how getting pregnant as teenagers affects her patients, she admitted that she usually does not know, because the patients drop out of her care (likely moving to an OB/GYN). Upon further reflection, Dr. Three noted that when she sees the patients after they have given birth, they have often not gone to college or have dropped out of school. Does this prove that these young patients would have gone to college if they had not had children as teenagers? Dr. Three insists the answer is “yes.” Perhaps sensing that her credibility was somewhat weakened by her admission that she did not always see patients after they became pregnant, Dr. Three notes that “there’s tons of data” to back-up her position. In invoking data



and scientific evidence to support her conclusions, Dr. Three draws on the grand narrative that science is the ultimate source of authoritative knowledge (Denny, 1999) to ensure that her position is deemed credible and accepted as truth. However, as I discussed in my literature review, the “data” does not seem to support Dr. Three’s conclusion. There is little evidence that teenage pregnancy has long-term negative consequences on the life outcomes of low-income black teenagers and, in fact, there may be several benefits to teenage childbearing for black women living in poverty (Geronimus, 2003; D. E. Roberts, 2017).

Yet, both reproductive medicine as a discipline and Dr. Three as an individual have not incorporated this evidence into their stories about the relationship between teen pregnancy and poverty, perhaps because doing so would necessitate the creation of a completely new narrative. Frank (2004) discusses “narrative imperialism,” stories which dominate so that “no other story is allowed into the room” (212). As an example, he recounts the mythical tale of Parzival, a young prince who embarks on a quest to save a wounded king. Over the course of his quest, the previously isolated Parzival learns the manners and social customs of the outside world. When he finally meets the king, Parzival fails to ask the only question that can save the king: “What ails you?” Even as the stench of the king’s grievous wound fills the room, the social etiquettes Parzival has learned make him incapable of speaking about what it is right in front of him.

I cannot determine whether Dr. Three is so caught up in the arcs of master narratives that she cannot see or hear any other narratives about teenage pregnancy, or if she can see the limitations of the master narratives but, like Parzival, is unable to act upon or even speak about that which deviates from the normative script. In either case, what remains true is that Dr. Three witnesses the violence inflicted by poverty, sexism, and White supremacy on a daily basis, yet

remains unable (or unwilling) to say that these structures—not Black culture or teen pregnancy—are the factors which threaten her patients’ health and life chances.

As I interacted with RHPs, solicited, listened, questioned, and commented upon their stories, I noticed this phenomenon play out over and over again. In different ways, RHPs contested, recycled, remade, and disrupted master narratives about race, policy, motherhood, and reproductive health. However, even when they questioned or spoke counter to some pieces of master narratives, their conclusions often focused on patients’ “mistakes” or perceived inadequacies rather than injustices within a racist, sexist, and classist system. Master narratives, then, do not simply offer a stock of characters and plot devices RHPs can insert into their own stories when convenient. These narratives construct a logic through which RHPs come to understand cause and effect, responsibility and blame.

I will revisit the phenomenon of narrative imperialism throughout my results and analysis. However, I now turn to another exchange between myself and Dr. Three, this time focused on two specific patients Dr. Three had treated at a low-income and unfunded youth clinic. We had just about run out of time by this point in the interview and I knew that I needed to wrap-up our conversation quickly. I asked Dr. Three if she would like to share any stories which illustrate something important for policymakers to understand about race, reproductive health, or policy. Initially, she brought up the story of a patient she’d related to me earlier in our interview. This patient had a medical condition for which contraception was the recommended treatment, but her insurance company denied coverage for the medication. The patient’s insurance was sponsored by her mother’s employer, which took a religious exemption to paying for contraception. Dr. Three is referencing that patient story at the beginning of the exchange I share below.

## Dr. Three's Narrative About Treating Uninsured Patients

**Table 6.** "I Don't Have Any Way to Help Him."

Dr. Three:	So, I mean I think that's probably—that story probably encompasses what we do
Bria:	Mhm.
Dr. Three:	<u>Well</u> , not just that. I mean, like <u>that</u> story I think is really important in terms of the policy stuff. Another, another story maybe, um, is a little bit more general. But I had a young man come in who, you know, <b>had a burny penis</b> ((slaps leg))
Bria:	Mhm.
Dr. Three:	And <b>he comes in</b> and he ((slaps leg)) and <b>he fills out his health history form</b> . And ((laughs)) you know, you put nothing on there.
Bria:	Mhm.
Dr. Three:	Because they come in and they want their little piece and they don't want to have to talk about anything else.
Bria:	Mhm.
Dr. Three:	You know, like, 'I got a burny penis. Fix my burny penis. You'll never see me again.'
Bria:	Mhm.
Dr. Three:	So they come in and when they're first coming to see the provider they have to fill out a health history form
Bria:	Mhm.
Dr. Three:	And <b>he put <u>nothing</u></b> on it.
Bria:	Uh-huh
Dr. Three:	No medical problems. Nothing. No medicine, bla bla bla. And <b>he has a sternotomy scar</b> .
Bria:	Oh wow.
Dr. Three:	And I was like, 'Dude. __ What's th—'
Bria:	— 'What's up?'
Dr. Three:	'—at from?' And he goes, 'Ohhh, <b>I forgot</b> to write that down.' And I'm like, 'Obviously!'
Bria:	Yeah ((laughs))
Dr. Three:	And he goes, he goes, 'Oh yeah, <b>I had heart surgery</b> .' And I'm like, 'Well, when did you have heart surgery?' And he goes, 'Oh I've had it a couple times.' I'm like, 'Okay. So when was the last time?' And he goes, 'Oh, a couple years ago.' And I was like, 'Oh.' And I said, 'What did you have done?' And he goes,

'**I don't know**. There's something wrong with my heart.' And I was like,  
'Hm. Are you supposed to take antibiotics when you see the dentist?' He goes,  
'How did you know that?!' I was like, 'Oh, you just—\_guessing.'

Bria: Uh-huh.

Dr. Three: And I was like, 'Do you have any chest pain?' He was like,

'**Yeah! I have been** having some recently. How did you know that?'

Bria: ((laughs))

Dr. Three: And then, you know, and **he's a total weed smoker**,

Bria: Yeah.

Dr. Three: So off, up there. And I was just like, 'Do you have any medical care?'

Bria: Yeah.

Dr. Three: 'Have you ever se—**have you seen** a cardiologist since you had your surgery?'

Bria: Yeah.

Dr. Three: '**No. No. No.**'

Bria: Uh-huh.

Dr. Three: **He's\_ twenty-four.**

Bria: Uh-huh.

Dr. Three: His parents—**he's \_ an illegal.**

Bria: Mhm?

Dr. Three: Ummm, **his parents don't have any** insurance

Bria: Mhm?

Dr. Three: Umm\_\_\_\_\_

Bria: What does he—yeah.

Dr. Three: Right. So, I fixed \_ his penis.

Bria: Uh-huh.

Dr. Three: **He had an STD.**

Bria: Yeah.

Dr. Three: I treated him. And I tried to get him into [charity organization].

Bria: Uh-huh.

Dr. Three: We, umm, **tried to get him** with the ACA—like, we were ((hits table))  
met with ((hits table))  
obstacles ((hits table))  
every single place.

Bria: Yeah.

Dr. Three: He's this kid whose got like—I don't know what's wrong

Bria: Yeah.

Dr. Three: With his heart!

Bria: Yeah.

Dr. Three: I mean, **he's had multiple surgeries** so I'm assuming he had—you know—

Bria: – Something serious –

Dr. Three: – Was probably more than an A-S-D or V-S-D. I mean,

Bria: Yeah.

Dr. Three: Valve stuff, cause **he's gotta be on \_ meds.**

Bria: Mhm?

Dr. Three: I don't know what **he had done.**

Bria: Yeah.

Dr. Three: And I don't have any way to \_ help him.

Bria: --Find out? Because he's undocumented, mainly?

Dr. Three: ((nods))

Bria: Wow. \_\_ I hope he's okay ((laughs))

Dr. Three: I know! And I don't know, because **he didn't** come back.

We fixed his penis and **he didn't** come back.

Bria: Uh-huh. Yeah. Wow.

Dr. Three: So there's a llot of these patients that, um—it's just really hard to help them, because we don't have the tools to help them.

Bria: Mhm.

Dr. Three: Like, they come in for this little problem—I mean, to them it's huge.

Bria: Right.

Dr. Three: Cause having a burny penis is, you know, a big deal.

Bria: A really big deal.

Dr. Three: But, but to me? There's so much more I need to address. And I can't because I don't have primary care for them

Bria: Mhm.

Dr. Three: You know like this—I had another kid come in who doesn't have primary care. And she's having irregular periods. And you know I'm worried—she's got a little constipation, maybe she's got hypothyroid?

Bria: Mhm.

Dr. Three: Umm, she's got a little bit of Acanthosis Nigricans- Nicgricans, the um, kinda black stuff around her neck. Which is pre-diabetes. ((hits table))

Bria: [unintelligible]

Dr. Three: And she wants birth control,

Bria: Uh-huh?

Dr. Three: And she wants STD testing. And I'm like, 'Great. We'll do those.'

Bria: Mhm.

Dr. Three: 'You need your thyroid tested. ((hits table))

You need your lipids tested. ((hits table))

You need your sugar tested. ((hits table))

You need like ((hits table)) all the ((hits table))—

You need to work on weight,' ((hits table))

Bria: Mhm.

Dr. Three: So I spent a lot of time counseling her on obesity.

Bria: Mhm.

Dr. Three: And, there is a lab place that you can—people can pay out-of-pocket to get their labs done? And I'm like, 'Here's the labs. The total of what you need is about two hundred dollars.'

Bria: Mhm.

Dr. Three: 'If you get the money do that, that's great. Here's the phone number for a patient navigator. Umm, you could sign up for- for [Name] County health plan. It's not cheap. Umm, you could wait for the enrollment period for Obamacare, but I don't know that Obamacare's gonna survive.

Bria: Mhm.

Dr. Three: Because the Republicans are trying to kill it. And the premiums are going up ridiculously, because the—the--

Bria: They're destabilizing the markets?

Dr. Three: Well they're totally destabilizing the markets! They just made it so that the—the, um, healthy people don't need to be in it,

Bria: Right.

Dr. Three: So the premiums are gonna be ridiculous!

Bria: Mhm.

Dr. Three: Nobody's ever gonna be able to—I mean, the whole point is to allow everybody to be able to afford it, and they won't be able to.

Bria: Mhm. And Florida didn't a- expand Medicaid

Dr. Three: Right.

Bria: So there's that.

Dr. Three: Right. So I have these patients that \_ because of the politics in this state and this country—I mean, I'm doing Third World medicine!

Bria: Mhm?

Dr. Three: I would expect more if I was in Africa!

Bria: Uh-huh. Wow.

Dr. Three: The—that's, inexcusable

Bria: Mhm.

Dr. Three: You know, this is not a country that, that should—I mean, we have the resources here to be able to provide health care. Now, it doesn't have to be like, you know\_\_ premium health care for everybody. There could be different levels.

Bria: Mhm.

Dr. Three: But basic health care for everybody? It is inexcusable that we don't provide that.

Bria: Mhm. Yeah, I totally agree ((laughs)) Yeah, wow. Well thank you for sharing all of that.

Key: **Bold** = Verbs Dr. Three attaches to the Patient A | **Gray** = Dr. Three's lack of agency

NOTE: For the purposes of my analysis, I call the young man in Dr. Three's first story "Patient A" and the young woman in her second story "Patient B."

### **(Frustrated) hero or victim?**

The narrative I've represented above consists of two patient case stories which Dr. Three linked together, as neither patient had health insurance or "primary care." In both the cases, Dr. Three felt concerned about the patient's health, yet was unable to "help" them. Both patients are constructed primarily as victims: vulnerable individuals in need of rescue (Monrouxe & Rees, 2017) via insurance coverage and medical interventions. Interestingly, neither of these patients is presented in a way that mirrors master narratives in the U.S. about what kind of person is "good" victim. In dominant discourses, those who are undocumented immigrants, who use drugs, or who are overweight are not typically constructed as sympathetic characters or identified as members of the "deserving" poor (Katz, 2013; Lipman, 2006), especially if they happen to also be people of color (Gilman, 2014). In fact, conservatives might read Dr. Three's story as proof that social services should be *cut back*. Donald Trump, for example, has made it clear that he does not believe undocumented immigrants (like Patient A) should receive government-funded health care. Trump has expressed interest in implementing rules that would prevent immigrants who

collect public assistance from receiving legal status in the U.S. (Rhodan, 2018) and proposed creating stricter requirements so that fewer individuals would qualify for government assistance programs like Medicare (Samuels, 2019). Thus, in positioning these particular patients as the victims of poor policymaking and as individuals who deserve government-funded health care, Dr. Three seemingly counters master narratives about who deserves government assistance.

At first glance, it seems that Dr. Three discursively constructs herself as the hero who has come to save her marginalized patients (just as she did in her narrative about contraceptive counseling). Dr. Three positions herself as a caring and dedicated healthcare provider who wants to help. She begins each case story by talking about what she accomplished with the patient, using active verbs (“I *fixed* his penis”; “I *spent* a lot of time counseling”). However, Dr. Three changes her language when she moves away from the topic of how she tested/treated the patients’ STIs. Particularly when describing Patient A’s case, Dr. Three begins to negate her verbs, emphasizing what she *can’t* do and what she *doesn’t* know (examples are highlighted in gray in the transcript).

In each case story, Dr. Three then shifts her focus onto her own inability to act in the face of constraining policies (“I don’t know what he had done. And I don’t have any way to help him”; “So I have these patients that, because of the politics in this state and this country—I mean, I’m doing Third World medicine!”). Dr. Three does not discuss the goals patients voiced for themselves; in fact, it seems entirely possible that Patient A did not want further medical intervention or that he sought care elsewhere, as he did not return to Dr. Three’s clinic. In Patient B’s case, Dr. Three listed an array of tests she felt the patient required without any mention of the young woman’s response. Dr. Three also does not speculate about what health consequences



the patients may face without treatment. Rather, her narrative focuses on her own inability to accomplish the goals she herself laid out.

In effect, Dr. Three becomes both the (frustrated) hero—a noble protagonist who fights, in vain, to save others—and the victim—a helpless individual who is injured and incapacitated by more powerful forces—within this narrative (Monrouxe & Rees, 2017). The story functions to produce sympathy and compassion for Dr. Three’s personal struggles, the plight of an American doctor forced to practice in “Third World medicine.”

### **Deconstructing representations of self, other, and world.**

I argue that the personal injury Dr. Three depicts in this narrative is an assault on her identity as a physician. For example, prior research has found that physicians tend to depict their identity “in relation to the rewards of helping others” (Real et al., 2009, p. 581). They may also construct their identities through discourses about the privileged social position physicians occupy in terms of knowledge, expertise, autonomy, and authority (Broadhead, 1983; Monrouxe, 2009; Real et al., 2009; Starr, 1982). Here, we see how the values promulgated through the master narrative of biomedicine coalesce into the character of the Good Doctor, a (gendered-racialized) figure who acts autonomously for the benefit of patients by drawing on specialized scientific knowledge (Essed, 2005; Monrouxe, 2009). Dr. Three’s frustration stems from feeling that she does not *know* the cause of Patient A’s heart condition, that she can’t get *information* about Patient B through bloodwork, that she lacks the *ability to act* and move forward the way she wants, that she cannot *help* her patients. In other words, these conditions prevent her from becoming the Good Doctor. Ultimately, then, the policies which make her patients “uninsured” or “unfunded” wound Dr. Three’s sense of herself as a physician, making the doctor the victim of her own tale.

Dr. Three makes sense of her victimhood, in part, by decrying her situation as a provider forced to practice “Third World medicine” in the United States. She laments, that she “would expect more if I was in Africa!” The tragedy here, then, is that an American doctor has been reduced to the status of a Third World medical provider. She concludes that in “this country” it is “inexcusable” that health care is not available to everyone. In so doing, Dr. Three draws on master narratives which classify the West as “superior, civilized, developed, moral and scientific,” in opposition to the non-West which is characterized as “inferior, uncivilized, backward, immoral, and superstitious” (Jack et al., 2011, p. 277). By singling out “Africa,” she also draws on anti-Black racism and master narratives which have portrayed the diverse continent of Africa as homogenous, ahistorical, and tragically stricken by poverty, disease, and despair (Hunter-Gault, 2006, p. 93; Momoh, 2003). Insofar as national identity in the U.S. is constructed through “a norm of whiteness that shaped the national image and culture” (Omi & Winant, 2015, p. 77) the policies Dr. Three references can also be seen as assaults on her identity as a White person and member of the First World. In sum, it is through reference to master narratives about the rights owed to physicians, Whites, and citizens of the First World that Dr. Three constructs her victimhood.

Recognizing Dr. Three as the primary victim in the narrative, I now return to her depiction of Patient A (the original victim of the story). Upon reviewing the verbs Dr. Three employs, I noted three patterns in the way she positions Patient A. First, Dr. Three constructs Patient A through reference to his pathologies (e.g., “he had an STD”; “he’s had multiple surgeries”). Second, Dr. Three emphasizes all the ways in which Patient A is lacking (e.g., he doesn’t know what is wrong with his heart, his parents don’t have insurance, he doesn’t come back for his follow-up appointment). Finally, Dr. Three constructs Patient A as criminal / deviant

(e.g., “he’s an illegal”; “he’s a total weed-smoker”). Each of these descriptions draws on racist master narratives which cast immigrants as carriers of disease, criminals, and as generally inferior to American citizens (Flores, 2003; Gantt Shafer, 2017; Markel & Stern, 2002).

Dr. Three also constructs Patient A using humor; she performs her clinical interaction with Patient A through a comedic back-and-forth, emphasizing the young man’s apparent obliviousness about his heart condition throughout her act. One social function of humor is that it can “‘license’ more negative interpersonal communicative intent” (Holmes, 2000, p. 159). Within the context of an interview for a project focused on racism in medicine, it is possible that Dr. Three applied humor strategically so that she could portray a minority patient in a negative way without appearing outwardly hostile or racist.

#### **Narrative functions.**

Having situated Dr. Three’s narrative within the dominant narrative devices of the Good Doctor, the Third World Other, and White American Identity, I now turn to the ideological “work” Dr. Three accomplishes through this performance. First, her narrative counters dominant capitalist ideologies, which position health services as commodities within a free market (McGregor, 2001). Dr. Three’s argument that a collective “we” (presumably Americans acting through the government) should provide “health care for everybody,” disrupts master narratives about the free market as the best solution to society’s problems. Similarly, Dr. Three contradicts biomedical logics, which focus exclusively on organic causes of disease (Clarke, Shim, Mamo, Fosket, & Fishman, 2003; Kleinman, 1994), by positioning policymakers as responsible for the health circumstances of her patients. In these ways, Dr. Three’s narrative disrupts the stability of the biomedical master narrative.

At the same time, Dr. Three also makes concessions to capitalist logics. Take, for example, her concluding comments during the narrative: “I mean, we [in the U.S.] have the resources here to be able to provide health care. Now, it doesn’t have to be like, you know \_\_\_ premium health care for everybody. There could be different levels.” By suggesting that, even within a (presumably) socialized medical system, there should still be “levels” so that those in poverty are not entitled to the same “premium” health care as the wealthy, Dr. Three perpetuates capitalist logics which accept economic and social hierarchies as natural and even desirable (Erevelles, 1996). Listening to the recording, I felt as though Dr. Three’s manner implied that she was responding pre-emptively to an imagined counter-argument. To me, her tone sounds as though she expects her argument in favor of “health care for everybody” to be immediately discounted as overly idealistic or impossible. Thus, the concession that “there could be different levels” serves to fend off anticipated capitalist responses to her claim. I cannot conclude whether she shares the belief that “different levels” of health care for all is a just approach, or if she feels the need to make this concession in order for her counter-narrative to be tell-able at all within a capitalist context (De Fina & Georgakopoulou, 2015). In either case, the narrative functions both to resist capitalist and biomedical narratives about individualism and the value of the free market *and* to re-instill capitalist assumptions about social and economic hierarchies.

### **Dr. Christine**

Dr. Christine is an experienced pediatrician. She practices medicine at a university-based clinic and is also involved in teaching medical students and residents. Like most of my participants, Dr. Christine seemed constantly busy, always on the move. Despite her restlessness, she has kind eyes and a kind voice. She told me that she sometimes gives money from her wallet to parents who can’t afford baby diapers. Of the twenty-four RHPs I spoke with, Dr. Christine is

the only participant who raised her voice in anger during our interview. Her anger was always directed at policies and policymakers.

Dr. Christine told me the story I present below shortly after the beginning of our interview. For the first few minutes, she had seemed distracted and disengaged, frequently checking her phone and the clock. But, as we began discussing Medicaid, she became more focused on our discussion. Dr. Christine mentioned that she has been seeing more patients with Medicaid lately. I asked her why she thought that was, leading to the following exchange.

### **Dr. Christine’s Narrative About a Boy with a Concussion and Burnout**

**Table 7.** “It’s Really When I See My Patients, That I Can’t Help Them. I Think That’s the Biggest Thing.”

Dr. Christine:	Um. I know that a lot of groups <u>are</u> limiting the number of Medicaid patients that they see? So, we see them. <u>Because, um, ___</u> somebody should see them.
Bria:	Yeah, I mean. I agree. It’s been- I think that there’s <u>___</u> divides in <u>___</u> I- I won’t speak to other people, but—
Dr. Christine:	—I think it’s <u>hard</u> —
Bria:	—But there’s—
Dr. Christine:	—I think it’s hard,
Bria:	Yeah, people have different views—
Dr. Christine:	—Y’know, if you’re not the one who is in charge of your practice, and if you’re the one who’s seeing the patients, the practice group makes decisions for you.
Bria:	Mhm?
Dr. Christine:	So, kind of like I was talking to him [colleague she spoke with before the interview], I was trying to <u>refer</u> <u>_</u> one of my kiddos, cause I thought he had a <u>concussion</u> . And, because of the Medicaid he <u>had</u> , <u>_</u> even though he’s also a part of the university system, this concussion ces- center, they don’t <u>take</u> that Medicaid. So I have trouble with a lot of my patients, getting them to <u>see</u> even people within <u>___</u> <u>our</u> practice group, because they don’t take the same insurance that we do.
Bria:	Yeah, that sounds really frustrating.
Dr. Christine:	It’s sad. That’s- what’s, y’know, really been sad, with the- all the- I don’t know. <u>_</u> Kids should have insurance. Period. ((hits table)) Y’know, and people should see them. Period. Is what I think. <u>_</u> And, <u>_</u> if they can’t see people <u>_</u> it makes me sad? And, <u>___</u> well, we’re getting off topic, but—
Bria:	—No, that is actually on topic.

Dr. Christine: —Okay. Alright, —

Bria: —That’s where I was gonna go. Like, how does it make you feel?

Dr. Christine: It makes me feel—\_\_ this is what’s leading me to- to kinda be a little burnt out.

I can’t get them to see \_\_ y’know, I can see the breakdown of the family, that they have struggles, there’s \_\_ one mom? And no dad or \_\_ a not very involved dad, and \_\_ the mommy, and grandma, they try the best they can but, sometimes kids don’t listen as well to their mommies, and \_\_ y’know, I try to get them in to- to- to um, parent counseling or \_\_ any kinda family counseling, or any—to- the- gr- the providers that accept Medicaid \_\_ It’s like a four-month wait list, for these kids. For psychological services. And, everybody should be able to talk about what’s going on with them.

Bria: Yeah.

Dr. Christine: Y’know, and so that \_\_ w- when I went through residency, we didn’t have as much of anxiety and depression and \_\_ that stuff. Y’know, so you didn’t get trained, as a pediatrician how to take care of \_\_ these kiddos. And now that’s what I do. I try and counsel, I try and— ((sighs))

Bria: Yeah.

Dr. Christine: Do that stuff, because there’s not enough providers, for them. ((hits table)) Which kinda can go to some of the stuff that you’re talking about, too. \_

Bria: Yeah. How do you make that connection? In terms of policy you weren’t taught? Or?

Dr. Christine: ((Exhales)) \_

Bria: That’s- I mean, y’know, when I was a— \_

Dr. Christine: When I was in medical school, I was very involved for women’s issues. I went and- I went and, y’know, advocated for my patients. Y’know, one day we went and we talked \_\_ y’know, up in D.C. Like, to our senators. From—

Bria: —Med Students for Choice,

Dr. Christine: Yeah.

Bria: And, that?

Dr. Christine: Yeah, that kinda thing. Or, it was actually, uh, the— it was called [name blinded]. It was the women in medicine group of [blinded] that went up, and we were talking about, \_

‘Okay, \_ th-’ y’know, legislature for \_\_ just birth control. Just, like, saying that it should be paid for by insurance.

Bria: Mhm.

Dr. Christine: And, uh, so we went and we met and I felt so empowered that I could talk to \_\_ um, my legislature- legislator, or his person, and they were listen to me. Um, but how has that changed? I don’t- \_\_\_\_

Y’know, so I thought I was educated on policy, but there’s so many things that have keep coming out that are \_\_ the s- so different. Like, the gag order. Do you know the gag order?

Bria: The global gag rule, yeah.

Dr. Christine: There's the go- global one, but there's also one that they're trying to push—and I wasn't aware of this, until, like, probably April. I think April-May I heard about it—so they're trying to say, also here domestically, that we won't be able to talk to our patients about \_ certain things, also. Kind of like the global gl- gag order,

Bria: That seems like a first amendment violation.

Dr. Christine: It does to me, too. I should be able to talk to my patients,

Bria: Mhm.

Dr. Christine: About \_\_\_ ((hits table))

About \_ options to have a safe \_ y'know, whatever. If they wanna have a baby? If they wanna \_ have birth control? If they want to have, y'know, because of the situation that they're in, if they need to have an abortion, they should be able to have- they should have access to all options. If they wanna do an adoption—I shouldn't be gagged on what I can say to my patients, in the country of Amer- y'know, the United States.

Bria: Mhm.

Dr. Christine: Just based on who I get my- who I'm paid by.

So right now it's not r- it's a certain title- it's a- it's a \_ a certain type of funding.

Bria: Mhm.

Dr. Christine: So, right now—

Bria: — Like the Title Ten or something?

Dr. Christine: Something like that, but it's not Medicaid, right now. Which I'm very happy about. But it could change. Because that is from the government. And it shouldn't be \_ that kind of restriction in- in this country on \_ my ability to speak to my patients.

So, \_ so things are changing.

Bria: Yeah. And so is that what's making you feeling burnt out? Is this \_\_\_

Dr. Christine: Lack of being able to help my patients in the way that they need to be helped.

Bria: Can you think of a \_ story, maybe about a patient of color, where you felt like you weren't able to help them?

Dr. Christine: ((sighs))

Bria: In the way that you wanted to. \_

Dr. Christine: Well, this concussion one, but it's not birth control. I mean he's a person- he is a boy of color.

Bria: Mhm? \_

Dr. Christine: Um. \_

Bria: Does he really need help with his concussion?

Dr. Christine: He did. He was having some symptoms that \_\_\_ ((exhales))

I just wanted- his mom was really scared.

Bria: Yeah.

Dr. Christine: Cause he was- he was forgetting things, and \_\_ y'know, I tried to res- I was reassuring her, y'know,

'This is very normal, with a concussion. But I really do wanna get you into a concussion center, so we can figure out when he can start returning. Let's for now not have him do any sports, let's not have him jump.'

But I really wanted the concussion specialist to help her through it, and make her feel

Bria: \_\_ Like she's doing everything for her son?

Dr. Christine: —Yeah. And she was really scared. \_ And, um, \_ ((hits table))

I just felt really sad \_ that I couldn't find a provider \_ that would take- that would take his insurance. Y'know?

Um, \_\_ I'm trying to think of particularly with- with birth control. ((exhales))

Bria: What d'you do- so like, \_\_ I imagine that would be so sad. Like I can't, \_\_ imagine dealing with that. Like, I \_ start tearing up just thinking about \_ wanting to help patients and not being able to. What d'you do with that? Like, \_ do you go home and think about it? Or do you \_\_ go and teach? \_

Dr. Christine: I try. That's why I teach.

Bria: Mhm.

Dr. Christine: That's one of the reasons why I do teach, is cause I always hope that \_ people younger than me have more energy than me, that they can figure out the system that I've now \_ don't know how to navigate.

Uhm, \_ or \_ I encourage them to become psychiatrists and psychologists- ((laughing)) psychiatrists who will see my patients. Or,

Bria: Mhm.

Dr. Christine: Or to go and get training, in a way that I didn't get training. So if they do go into pediatrics, or if they go into family medicine, that they feel more comfortable with the ability to, \_ to take care of anxiety, to take care a depression, take care of the whole patient. Y'know?

And not that I couldn't take care of the concussion, but I felt that the mom would feel m- safer \_ with somebody else who's \_ y'know, like a 'concussion clinic.' Doesn't that sound, like, \_ y'know?

Bria: Doing the best for your kid?

Dr. Christine: Yeah. Yeah.

Bria: Yeah. \_ It's really interesting that you bring up—sorry, what were you gonna say?

Dr. Christine: I was just gonna say it does make me sad. \_ You're- you're- it does make me sad. And, it kinda \_ adds to itself and that's—

I read an article recently about- y'know, people will talk about \_ y'know, the electronic medical record,

'Oh, it's so frustrating and it leads to burnout. And, y'know, insurance companies,' \_\_

And, I mean, I am talking about insurance companies. But, it's not \_ necessarily \_ the medical record, or even that I have pressure to see more patients. It's really \_ when I



see my patients that I can't help them. I think that's the biggest thing. And I hadn't really put a finger on why, why I'm sad, for my patients? Or sad about work. \_

And it's really that part, I think. Is um—

Cause they're good people. My kids are good. These patients are good- they're good kids; everybody has a chan- should have chance to \_ y'know, succeed in life. And,

Bria: Yeah.

Dr. Christine: And, they don't. \_

Bria: I imagine that's not why you got- like, you got into medicine, because that's what you \_ believed in, so,

Dr. Christine: Yeah

Bria: It could be frustrating to feel like you're not \_

Dr. Christine: Yeah.

Bria: Fulfilling, necessarily, what you wanted. What your vision to—that's what I'm hearing anyway, I don't know if that's true--

Dr. Christine: —Yeah, no. It's true. It's true. You're gonna make me cry, so.

Bria: ((laughs)) I am the biggest cry-er,

Dr. Christine: ((laughs))

Bria: And you will not have been the first person who cried talking about this,

Dr. Christine: ((laughs))

Bria: So, \_ I just think it matters. Like, people cry cause it matters.

Dr. Christine: Mhm. \_ Yeah. You just wanna be tough and do something, though. Y'know?

### **Character analysis.**

As in Dr. Three's narrative about treating uninsured patients, here Dr. Christine tells the story of a patient of color who she felt unable to help. Rather than a linear plot, Dr. Christine's narrative moves fluidly between ongoing events (this patient's story, her teaching priorities), news from the wider world (the gag rule), and experiences in her past (lobbying in medical school). Within the narrative, the patient himself is only a minor character, essentially a prop—someone who has no voice and is inactive in the events described (Monrouxe & Rees, 2017). Instead, the young boy's mother, who was “really scared” for her son, is positioned as the victim in the tale. Dr.

Christine portrays her patient's mother as an attentive and loving mom who cannot get help for her son because of health systems issues.

Dr. Christine herself takes on several different roles in the narrative. At some points, she is the frustrated hero, doing the best she can for this patient and his mother despite structural obstacles. At other points, she embodies the "advocate," working to defend others and affect social change (Monrouxe & Rees, 2017). Dr. Christine takes on this role when she describes her lobbying efforts as a medical student, as well her hopes for creating change by teaching the next generation of physicians. Finally, as with Dr. Three, Dr. Christine also constructs herself as a victim in the story. Dr. Christine feels bewildered ("there's so many things that have keep coming out that are so different"), constrained, and attacked ("I shouldn't be gagged") by policies. These policies make her feel powerless to accomplish her goal; she feels she can't "help my patients in the way that they need to be helped." All of this has caused Dr. Christine to feel "sad" and "burnt out" about work and her patients.

As with Dr. Three, these policies may be seen as assaults to Dr. Christine's identity as a physician. Dr. Christine she feels her autonomy is threatened by the potential gag order, that she doesn't have the knowledge she needs ("when I went through residency, we didn't have as much anxiety and depression... so you didn't get trained"), and that she can't help her patients. I contributed to this process of identity construction and injury when I reiterated back to Dr. Christine, "I imagine I imagine that's not why you got like, you got into medicine, because that's what you \_ believed in, so... it could be frustrating to feel like you're not fulfilling, necessarily, what you wanted. What your vision to—that's what I'm hearing anyway." As the story "coaxer" then, I helped to create an environment which welcomed and validated Dr. Christine's portrayal of identity injury.

Also like Dr. Three, Dr. Christine draws on nationalist discourses to construct her arguments in support of progressive policies. She insists, “And it shouldn’t be that kind of restriction in- in this country.” Here, Dr. Christine suggests that the gag rule itself isn’t the problem; she does not denounce the *global* law (which, unlike the domestic rule, was already implemented at the time of our interview). Rather, the gag rule becomes problematic in the context of her rights as an *American*. Thus, even as she criticizes U.S. policies, Dr. Christine reifies the colonialist, White supremacist motif of American Exceptionalism—a thematic device which suggests that the U.S. is the best and most democratic nation in the world, the “ultimate bearer of Anglo-Saxon principles and ideals,” and is therefore singularly destined to expand control, civilize, and save the non-Western Other (Nayak & Malone, 2009, p. 265). I also promoted this motif, as Dr. Christine’s comments followed my observation that a domestic gag rule “seems like a First Amendment violation.” Although my intent was to refer to my doubts that such a policy would be able to be implemented without constitutional challenges, I failed to critique U.S. policy, which (at least nominally) protects the rights of those living in America while violating the human rights of those living in other countries. By drawing on (and failing to critique) American Exceptionalism, I partnered with Dr. Christine to perpetuate this discourse.

### **The disempowered physician.**

Like Dr. Three, Dr. Christine emphasizes her feelings of helplessness and impotence in the face of confusing and unjust policies. I spent a lot of time after this interview thinking about what Dr. Christine said, with such pain and anger in her voice, “I read an article recently about- y’know, people will talk about y’know, the electronic medical record, ‘Oh, it’s so frustrating and it leads to burnout. And, y’know, insurance companies,’ And, I mean, I am talking about insurance companies. But, it’s not necessarily the medical record, or even that I have pressure to see more

patients. It's really when I see my patients that I can't help them. I think that's the biggest thing.” I realized that these feelings of impotence and identity-injury were shared by many of my participants, even if they did not necessarily have the words to articulate why they felt powerless and hurt.

Researchers have long recognized that changes in Western cultures and health system structures over the last thirty years have been chipping away at physicians' authority and autonomy (Scambler & Britten, 2001). Real and colleagues (2009) note that physicians are becoming increasingly “deprofessionalized” as the Internet has given patients access to information that was once the exclusive property of medical providers. Even more significantly, over the last forty years the U.S. medical system has shifted away from small private physician-run practices and predominantly self-pay patients towards for-profit insurers and large (sometimes international) hospital systems led by executives and consultants with training in business rather than medicine (Clarke et al., 2003; Rosenthal, 2018). Health care is now run like a business, with physicians being tracked (and, sometimes, paid) according to their levels of productivity.

However, even as medicine becomes increasingly routinized, focused on profit, and decentralized, biomedical master narratives continue to valorize the Good Doctor (Monrouxe, 2009). Medical education continues to teach students “to believe that we as individuals have more power than we do... the image of physicians as singular heroes, as saviors, remains deeply embedded in medical culture” (Eisenstein, 2018, pp. 1–2). I argue that these narratives have colonized the minds of physicians, preventing them from developing new identities which reflect the complexities and contradictions of modern medicine in the U.S. Doval (2018) makes a similar point, speaking to the ways in which lingering attachments to old stories have caused

doctors to become demoralized: “the physician who once thought that his individual action alone was enough and... [who] even felt like a hero at times, now feels he has no power at all” (73).

### **Countering and recapitulating master narratives.**

Dr. Christine’s narrative is a story of contradictions (e.g., everyone *should* have a chance to succeed, but they don’t; Dr. Christine *should* be able to help her patients, but she can’t). How does Dr. Christine reconcile the contradictions between master narratives and her lived experiences? First, in contrast to Dr. Three, Dr. Christine uses her narrative as a platform to critique the neoliberal myth of meritocracy, which suggests that distributions of wealth, health, and power are fair and natural outcomes of a free market environment in which the hardest working and most talented individuals “come out on top” (M. Allen, 2017; Casad & Kasabian, 2010). While Dr. Three insisted that her patients “could do anything!” Dr. Christine argues, everybody “should have a chance to, y’know, succeed in life... And they don’t.” By disrupting the myth of equal opportunity, Dr. Christine counters colorblind racism and criticizes the unjust arrangement of resources in society. She emphasizes “Cause they’re good people. My kids are good. These patients are good- they’re good kids.” Here, Dr. Christine insists that poverty is not caused by laziness or moral failures, but that “good” people do not have a chance in this system. In so doing, she exposes inconsistencies in neoliberal logics which argue that people in poverty have not worked hard enough to earn entrée into the middle class. Dr. Christine also disrupts the biomedical assumption that medicine is a politically neutral profession by recalling the activist work she participated in as a medical student. This is the only portion of her story when Dr. Christine consistently constructs herself as an agent, emphasizing how lobbying made her feel “so empowered.”

Importantly, it was another narrative which enabled Dr. Christine to recognize the link between her feelings of helplessness and larger political issues. She says that she “hadn’t really put a finger on” why she was sad for her patients until she read a journal article which discussed these issues. I asked Dr. Christine to share this article with me, and she emailed an essay by a medical student titled, “To fight burnout, organize.” In this opinion piece, Eisenstein (2018) writes,

“I have received ample warning about the sources of burnout: death by a thousand clicks, too many hours at work, feeling like a cog in a machine, too many bureaucratic tasks... But from what I’ve observed... [there is] another source of burnout that receives insufficient attention. It is the experience of caring for patients when you know that their socioeconomic and structural circumstances are actively causing harm in ways no medicine can touch. As medical students, we are educated about the social determinants of health and increasingly warned about burnout, yet little is made of how the former may contribute to the latter — for example, how clinicians may feel worn down by the poverty and oppression their patients face; may feel powerless when they cannot offer more than, say, a form letter to a landlord explaining that turning off a patient’s heat would be deleterious to her health; and may feel demoralized when they realize that their instruction ‘Do not take this medication on an empty stomach’ translates into patients taking their medications only sporadically because they don’t have enough to eat” (1).

Here again, the power of narratives becomes evident. By reading the stories Eisenstein constructs, Dr. Christine was able to connect her experiences to a larger narrative and thus found a way to make sense of feelings that she had previously been unable to articulate. Interestingly, however, Dr. Christine largely ignores the second half of Eisenstein’s piece, which argues that

the continued emphasis on individual agency is destroying morale: “Facing patients’ adverse social circumstances as an individual clinician is a recipe for disillusionment: the physician who believed she was maximizing her individual agency comes to feel utterly powerless. No longer the lone hero — just alone” (2). Eisenstein concludes that organized political action is the best remedy for physician burnout: “Organizing is both strategic and therapeutic — strategic because our collective labor and voice are greater than the sum of their parts” and therapeutic becomes it restores a sense of power and community to physicians’ lives (2).

Dr. Christine does recognize relationality as part of the solution to her troubles, as she regards her teaching as a site for catalyzing change. However, she never discusses more explicit political involvement as a next step. She remains dedicated to the idea that her mission is to help patients, even as she recognizes that this goal is often impossible within current societal arrangements of power. I cannot explain why Dr. Christine stops short of developing a new physician identity in which activism is positioned as a key method for expressing agency. However, one possible explanation is that the master narrative of biomedicine retains a hold over Dr. Christine’s sense of self, making it difficult for her to imagine other ways of being a Good Doctor. I explore this issue further in my analysis of Dr. Christine’s second narrative.

### **Dr. Christine’s Narrative About Teenage Motherhood**

**Table 8.** “I Just Want Better Life Options for My Patients.”

Bria:	Do you ever see kids who are like _ ‘Uhh, _ I don’t really care if I get pregnant.’
Dr. Christine:	[makes facial expression]
Bria:	How do you feel about that?
Dr. Christine:	__ ((exhales)) It makes me sad. _ Umm, but, y’know, I have to keep it in check. Cause, who am I—again—who am I to judge? But, to <u>me</u> , if I think about it, I wonder, ‘Is it because they don’t have enough _ love somewhere in their life. Do they think they’re going to get love from this baby? _ Do they think—’ y’know, I’ve had- y’know, ‘This- that baby’s gonna be my <u>friend</u> , and—’

Y'know, I've had them say stuff like that. ((exhales))

Bria: Can you think of a \_ story of a patient of color like that? \_

Dr. Christine: It's definitely a patient—one of my patients of, y'know, uh, color that have said stuff like that. I said,

'Why- why would you want—'

Cause they've already had a baby. Y'know? And I'm like,

'I- Isn't this hard for you?' ((Exhales)) 'Y'know don't- y'know, don't you think you need a little bit a time?'

'No, I love when my baby's little. My baby loves- depends on me. I can do everything for my baby. \_ And, they- they love me no matter what.' \_ And, I'm like,

'But, what about when they screeeam?! And they cry!' And they're like,

'No, they still love me.' And, um, \_ ((exhales))

Bria: Wow. \_

Dr. Christine: And I'm just like,

'Uhh, \_ how bout we just check your pregnancy, and let's give you a Depo\* shot anyway!' ((laughs))

Bria: ((laughs))

Dr. Christine: I had someone who was really hoping she was pregnant, and she had a- y'know, like, it was positive at home, and I don't what happened, but it was negative in the clinic. And she was there for a Depo shot—this is an awful story, actually. Heee \_ was an ex-boyfriend that brought her, and he was- they were yelling, like, y- like, he was gonna beat her. Like, you—

Bria: —Oh wow—

Dr. Christine: —Could hear that was g- like, through the door,

Bria: That's scary.

Dr. Christine: And so my nurses went in, and we were like,

'You have to leave. You can't \_ be here with her.'

And so I talked to her—cause she was really just there to talk to my nurses. And she was like,

'I was really hoping I would be pregnant.' ((inhales)) 'I really wanted to be pregnant.' And I said,

'But you have a baby.' Y'know, 'Why?' And she's like, ((inhales))

'I just—' ((exhales)) y'know, she just really wanted it. \_

And, she started to cry, because the pregnancy test was negative. And I said,

'Well maybe it's just not the right time. It- who is—'

'Y'know, this isn't even the guy. He's not my man anymore.' \_ And, I was like,



‘Then why is here?’ \_\_

Y’know. It just was very \_\_ sad because \_\_ she needed a ride, so she had her ex-boyfriend bring her, but he’s upset that she’s with a newer person, \_\_ aand \_\_ it was just too much going on. Y’know, like?

Bria: Yeah

Dr. Christine: And she wanted this baby because of the new man. Cause she wants to tie- kind— it seemed to me like she was trying to tie herself to the new man.

Bria: Mm. \_\_

Dr. Christine: And, um, \_\_ I just wanted more options for her.

Bria: Yeah. Like, what other—like, in terms of contraception? Or in terms of, her broader life?

Dr. Christine: —Just, \_\_ her broader life. Cause, y’know, she did \_\_ agree, since the pregnancy test was negative, she said,

‘Okay, I’ll have the Depo.’

Y’know? Cause she was- \_\_ she was scheduled to get the Depo ((laughs))

Bria: Right, that’s what she was there for.

Dr. Christine: ((laughs))

Bria: Yeah. \_\_

Dr. Christine: So she reluctantly—I helped her with her tears, and y’know,

‘Maybe we should think about when’s a better time.’

I just r—I want better life options for my patients. \_\_

Bria: Yeah. It’s interesting cause I’ve read \_\_ a lot of, um, articles? That- that are with patients of color? And they sort of talk about, ‘Look,’

Dr. Christine: ((exhales))

Bria: \_\_ Umm— patients of color in poverty, specifically— And they’re kind of ambivalent about getting pregnant. They’re like,

‘I don’t really care either way.’

And, it’s basically because \_\_ the- they’re like,

‘Well, I’m not gonna go to college either way. Like, nobody in my family has gone to college, so, this whole, I’m gonna— this is gonna get in the way of me going to college—’

Dr. Christine: —Yeah, no, it’s not—yeah. It’s a different \_\_ way of seeing life. So that’s- like, I wanna just know,

‘What do you wanna do? I don’t care ((hits table))

If you don’t wan- if you wanna go to college, but don’t you want to \_\_

Y’know, isn’t there \_\_ ((hits table))

Y’know, something that you dreamed of becoming?’

Y’know?

Bria: Yeah.

Dr. Christine: But sometimes, yeah, there's no dream.

Bria: Except for being a mom, maybe. \_

Dr. Christine: Mhm. \_ Maybe. Yeah. \_\_\_\_ Yeah. No, it's awful. I mean, \_ I just- I just—because of the cycle of poverty, that's why it's awful. If they could have a baby— \_ if that is really what they wanted. If the really could have a baby, and that baby could be \_ provided for and taken care of by, y'know, insurance and \_ if that baby \_ could, y'know, go to a safe school, and then it wouldn't be considered a 'handout' or a \_ uhm,

Bria: Charity?

Dr. Christine: —Charity, or- y'know what they call it, 'entitlement' now. It's not any of that. So, this is—and I, and this is gonna be really controversial, and I hate it, but—people who make the decisions about what type of contraception I can give these kid- these, these kids. They're kids. \_ Are, y'know, so pro-life. 'Pro-life, pro-life.' And then, when these moms have kids, \_ they don't want to pay for the schools, for these \_ schools to be good schools. \_ They don't wanna pay for \_ the insurance for these kids to grow up healthy. \_ And, anything else, like, med- y'know, anything else like, uh, food stamps? Or, \_ y'know, the WIC program? Any of that stuff,

'It's entitlement, and then they think they should deserve the stuff—'

Well then, if they want to have an abortion, let them have an abortion! If they want to have ((voice breaks)), \_ y'know, contraception, let them have a contracept- have contraception. Have it be— \_ I don't know, it's like, 'You damned if you are, and damned—' y'know what I mean?

Bria: Yeah.

Dr. Christine: Like, they can't make a choice \_

Bria: That's what I always argue. I'm like,

'Look, I understand being pro-life on a \_ conceptual level, if you really think that that's—I don't agree—but if you really think that's a human being, but you've gotta support—'

Dr. Christine: —Then take care of that human being!

Bria: Yeah.

Dr. Christine: Take care of that human being \_ who \_ has to, y'know, has his mom his jail sometimes, because of something, and then has to live with grandma, or dad \_ has HIV—y'know, like they don't know the things that my kids live with. \_

Bria: Yeah.

Dr. Christine: Y'know? These kids live and see awful things. And, to judge them and \_ then make them say,

'Well you have to be a \_ productive part of society,' \_

It's not fair.

\* "Depo" stands for "Depo-Provera," a type of contraception that is administered as an injection once every three months

### **Contesting meritocracy.**

Here again there are several basic similarities between Dr. Christine's narrative and stories shared by Dr. Three. Like Dr. Three, Dr. Christine suggests that getting teenagers onto birth control is a primary goal for her clinics. Dr. Christine also associates teenage pregnancy with patients of color, views teen pregnancy as a problem ("it makes me sad"), connects teen pregnancy to the "cycle of poverty," and relates teen pregnancy to cultural norms ("it's a different way of seeing life").<sup>2</sup> Furthermore, Dr. Christine positions teenage pregnancy as a barrier which can prevent teens from achieving the entry into whatever profession they "dreamed of becoming."

However, unlike Dr. Three, Dr. Christine uses her narrative to problematize the neoliberal myth of meritocracy. Dr. Christine forcefully refutes the myth of equal opportunity when she insists that her patients "can't make a choice". She argues that judging those who live in poverty for not being "a productive part of society" is "not fair" because the government does not provide access to basic life necessities like food, safe schools, health insurance, or contraception. She believes that the painful daily realities her patients must face make it unreasonable to blame them for their poverty or view them as people who want "entitlements" or "handouts." At this level, then, Dr. Christine's narrative serves as a counter-story in support of progressive economic restructuring.

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<sup>2</sup> Of course, I also helped create this discourse, as I implied that being in an environment where family members have not gone to college makes college seem like a non-option for teenagers of color, rather than drawing attention structural forces which work to systematically exclude low-income people of color from universities.

### **Reviving the White bourgeois heteronormative script.**

However, even as Dr. Christine argues against dominant neoliberal ideas, she remains attached to the White bourgeois heteronormative script (which is rooted in the neoliberal worldview). While she starts her narrative by saying she needs to keep her judgements “in check,” Dr. Christine resists the idea that a life trajectory which does not follow the normative script could be a worthwhile and meaningful path for her patients. She performs an imagined dialogue between herself and a teen patient who wants another child, explaining the teen’s reasoning. However, even after hearing her hypothetical patient insist that she understands what having a baby entails and that being a mother to a young child is a source of happiness and self-esteem for her, Dr. Christine reasserts her personal views on motherhood, (e.g., that one should take time between babies because they are hard to handle and frustrating). Dr. Christine seems unable to “hear” what her patient is saying or respect the patient’s goals, as she ends the imagined appointment by saying “let’s give you a Depo shot anyway!” Dr. Christine concludes that patients want to become teen parents because they have “no dream” and no “better life options.”

In this way, Dr. Christine reauthorizes the White heteronormative bourgeois script by positioning this life trajectory as the “better” option which young girls of color would choose if they had the opportunity. This aligns with Mann’s (2013) finding that

Providers demonstrated empathy for Latina teen patients who depart from the bourgeois heteronormative script by attributing their sexual and reproductive practices as outside their control... Such expressions of empathy can be seen as attempts to normalize Latina youth’s perceived deviance while concomitantly encouraging Latina youth to modify their own behavior in order to adhere to this script. (688)

In sum, becoming a teen parent, in Dr. Christine's story, is emblematic of a larger lack of agency. Teen pregnancy is positioned as a path no one would *choose* if they had other options; it is not just a *bad* choice but a *non-choice*. This construction totally erases patient agency. During the interview, I did challenge Dr. Christine's perspective on this. When she said, "sometimes, yeah, there's no dream," I suggested that being a mom might be the dream some patients aspire to. First Dr. Christine responded by re-emphasizing the incomprehensibility of this choice, saying "it's awful" that teen pregnancy might be a young person's dream. She then clarified her statement, arguing that teen pregnancy is awful because of "the cycle of poverty." Again, she emphasizes her belief that teen pregnancy is a dream few would choose given other opportunities ("if that is really what they wanted") before saying that what makes it awful is knowing that her patients' babies will not have access to good insurance and safe schools, and that government assistance for such children would be considered a "handout" or "entitlement."

This leads Dr. Christine into her critique of neoliberalism (which I've already discussed). However, what I wish to draw attention to here is that, even as she contests neoliberalism, Dr. Christine continues to regard contraception as a tool for stopping the cycle of poverty. She strongly encourages her teenage patients who want children to use contraception, purportedly because she knows their babies will be born into a system which disparages and neglects them. Thus, even as she challenges meritocracy, Dr. Christine falls back on the same "solution" to poverty posited by neoliberal master narratives: contraception.

### **Constructing victims, erasing agency.**

As discussed above, Dr. Christine overlooks the agency asserted by teenage patients who are ambivalent about or who want to become pregnant. Their choices are not real choices, because they don't have "better" options to take advantage of. The patient whose story she shares, for

instance, is characterized as vulnerable, dependent, and helpless. The patient is a victim of her ex-boyfriend (“he was gonna beat her”), dependent on men (“she needed a ride, so she had her ex-boyfriend bring her”; “she was trying to tie herself to the new man”), unhappy (“she started to cry”), and discouraging to meet (“this is an awful story, actually”; “it just was very sad”). Even though this patient “really wanted to be pregnant” Dr. Christine ultimately convinces her to accept Depo, because Dr. Christine believed the patient had “too much going on” to have another baby.

Roberts (1996) has argued that physicians understand issues like consent through the prisms of race, class, and gender. The story Dr. Christine shares here illustrates this pattern. Dr. Christine was unable to recognize that the concept of “intended” or “wanted” pregnancy could apply to this patient, even as the patient actively and explicitly voiced her desire to become pregnant. Because of her race, age, and class, Dr. Christine feels that pregnancy in this case could not be truly “wanted,” and that her obligation to support patient autonomy, thus, does not apply. In sum, by discursively constructing this patient as devoid of agency, Dr. Christine becomes able to materially control her patient’s body, steering the patient towards medical interventions which stand in complete opposition to the patient’s stated goal.

By constructing teenage pregnancy as a symptom of powerlessness, Dr. Christine builds on White supremacist and imperialist master narratives which have depicted people of color as “agency-less subject[s] in need for being saved” by dominant actors (typically White Westerners) (Dutta, 2012, p. 4). Teenage pregnancy as “non-choice” enables Dr. Christine to administer contraception to young patients so as to “save” them from their own desires. Functionally, by preventing the patient from obtaining a *desired* pregnancy, Dr. Christine both

limits the reproduction of people of color (a primary goal of White supremacy) and stifles patients' abilities to resist dominant narratives about motherhood.

It is undoubtedly important to draw attention to systems which differentially structure opportunities by race, class, and gender. Still, there needs to be space to recognize parenthood as an expression of agency and a platform for building a positive self-image (Austin, 1989). Austin (1989) argues that many low-income teens of color who choose pregnancy “are responding to their unique material and social circumstances with conventions that seem to be of their own devising. The object is to make their lives better through means within their power” (p. 560). She suggests that, rather than promoting contraception or demonizing young Black Mothers, efforts should be made to listen to the perspectives shared by teen parents themselves. Austin also argues that working with teenagers to help “them to devote their energies to attacking the institutions and organizations that control the resources they need to survive and thrive should enlarge their sense of hope and power” (p. 563). However, Dr. Christine’s narrative forecloses these possibilities. She continues the patterns of disregarding the agency of people of color, prioritizing pregnancy prevention, and accepting systems as invulnerable to change. To explore issues of normative motherhood and patient resistance further, I now turn to a narrative shared by Nurse Jane.

### **Nurse Jane**

Nurse Jane works as a nurse and administrator at a clinic which focuses on high-risk obstetrics care. The large majority of patients at her clinic have Medicaid insurance, and many struggle with poverty and housing instability. During our interview, when I asked Nurse Jane how she would describe the racial make-up of her patient population she said “Everything. You

name it. It's been here." However, when we walked by the waiting room area on our way to meet Nurse Jane for the interview, Niv and I noticed that most of the patients waiting they were black.

A highly experienced medical provider, Nurse Jane seems very knowledgeable and efficient, if somewhat burnt out. She brings to my mind the movie trope of the detective two weeks shy of retirement: having seen everything she's grown gruff, tuff, and almost impossible to surprise or faze. Still, there were moments when her tough, somewhat callous demeanor would crack and Nurse Jane would express tenderness or affection for a patient. As the narrative below shows, Nurse Jane drew on many racist and White supremacist discourses during our interview. Niv, though she joined me in conducting this interview, was quiet for most of the interaction, and I could tell she felt very uncomfortable around Nurse Jane. I asked Niv what she would want to add to my description about Nurse Jane or her experiences with the interview and she said, "I just felt kinda like there was only so much space I should be taking up. And she [Nurse Jane] takes up a lot of space. Not even should take up, that I could take up."

The data I share below is one section of a larger discussion we had about Nurse Jane's views on why some patients do not take birth control. I had asked her if she believed that lack of insurance coverage for patients' preferred methods was a significant barrier. Nurse Jane's response was ambiguous; she admitted that some types of contraception could be expensive, but also felt some patients do not put enough effort into getting contraception after they give birth. Nurse Jane complained that the clinic staff discuss birth control options and bring up tubal ligations with patients at every visit, but patients don't make the effort to follow through with plans that are discussed. This is particularly frustrating for Nurse Jane because Medicaid requires the consent for this procedure to be signed at least thirty days in advance (this was a procedure put into place in an effort to prevent doctors from sterilizing Medicaid patients without their



consent). We were talking about the complexities of the regulations around the tubal consent forms when the following interaction took place.

### **Nurse Jane's Narrative About Two Patients Who Resist Birth Control**

**Table 9.** “She Keeps Wanting to Have More Kids, Thinking That She’s Gonna Be Able to Keep Em.”

Nurse Jane:	So it’s kinda- y’know what I mean?
Bria:	Yeahhh
Nurse Jane:	It’s kinda tricky.
Bria:	That is tricky.
Nurse Jane:	So that’s- that’s what I explain to them. ‘That’s why <b>we</b> keep asking you, because we wanna make sure that you get em signed in the right _ timeframe so that you’re not,’ _ ‘Ohh, I wanted my tubes tied and now I can’t, because they’re not thirty days,’ So then you gotta wait till they come back for their post-partum, and <u>they don’t come back, then they end up pregnant again!</u> ((hits table)) So it’s like a revolving __ thing here. Talking about birth control and tryin to get people to __ to use it. ((laughs))
Bria:	Why do you think people don’t use it? _
Nurse Jane:	I don’t know. _ I think- _ I think a lotta times it’s just that they’re lazy.
Bria:	Mm. _
Nurse Jane:	And they think it’s too much trouble,
Bria:	Mhm?
Nurse Jane:	To do it. _ But there is financial barriers, to it too. _ Because a lotta people _ they- if they had a—well, for instance, they may have <u>county</u> for their medical care but county doesn’t pay for anything, so they’re not gonna _ pay _ y’know, to __ cause it’s, can be expensive. _
Bria:	Yeah, definitely. I mean, four hundred dollars for an IUD, geeze. _
Nurse Jane:	That’s for the Mirena.
Bria:	Yeah.
Nurse Jane:	I mean, there’s other ones that are- that don’t have the hormones in em, like the Paraguard and stuff that could be _ I don’t know, three hundred. But still, that’s a <u>lot</u> .
Bria:	Yeah. __ It’s like, your rent ((laughs))
Nurse Jane:	Yeah. _
Bria:	Your groceries for the month. _
Nurse Jane:	Yeah. _
Bria:	Uhh, _

Nurse Jane: Yeah.

Bria: Yeah. So how does it—\_\_ does that get like, kind of frustrating for you? When you, feel like, ‘Oh, they could be using birth control and they’re not’? Or is it just sort of like, ‘You know, whatever, they’re choice. What- they do what they want.’ How do you feel about it?

Nurse Jane: No. It’s- it’s frustrating. I mean, you see these people that keep getting pregnant over and over and over and over again. Some of em, they don’t even have custody of their kids. \_ And they’re like,

‘Oh, I’m pregnant again!’ And we’re like,

‘What are you doing? Why are you pregnant again?’ ((hits table))

‘Oh, well, I- I never even came back. And I, didn’t use the- the pills you gave me, so. I’m just pregnant, oh well.’

So it’s like,

‘Noo.’

Bria: Do you try to talk to them, about that? Or?

Nurse Jane: Yeah.

Bria: What do you say?

Nurse Jane: \_ Well, the ones that are, \_\_—y’know they even have some people that are just, they just keep doing it and doing it and doing it. So you’re like,

‘Listen, you really need to,’ you know, ‘You’re bringing these kids into the world and then they’re getting taken over by, y’know, foster care, and everything because they- they’re not fit to be parents.’

So why do they keep getting pregnant? I mean, we- we even had a lady that had a court order that she had to come here and get her Depo shot. \_\_ A court order! Kay?

Bria: What did you—

Nurse Jane: —And—

Bria: —What- what would you do to get a court order? To get a?

Nurse Jane: Because she’s has, like, nine children and they’re all in D-C-F \_ custody.

Bria: Wow.

Nurse Jane: So she had a court order that she had to come here and get Depo. I don’t know if you’re supposed to talk about patient stuff in here but—

Bria: As long as it’s not identifiable.

Nurse Jane: Right. So she has a court order for Depo, and she switches her urine in the bathroom? \_ So that, the urine was positive, so she wouldn’t have to get her Depo. Cause if she’s positive, we don’t give the Depo. But she wasn’t never pregnant. She just used somebody else’s urine in there, so that we would dip it and say,

‘Oh, you’re pregnant. You can’t get your Depo.’

Bria: Why didn’t she want the Depo? Did she want another \_ kid?

Nurse Jane: Yeah. She wants to keep getting—she, cause she keeps thinking that she’s gonna be able to keep custody of the next one. \_

Bria: Oh wow.

Nurse Jane: So that’s a whole other issue. ((small laugh)) Y’know?

Bria: That sounds really sad.

Nurse Jane: It’s very sad. \_\_ Very sad. I’ve known her for years. Through all her kids.

Bria: \_\_ Wow.

Nurse Jane: Mhm. \_\_ So. I mean there’s different- there’s all different reasons why people don’t use birth control. Be it, they’re lazy or maybe they can’t afford it, or maybe they—in that lady’s case she wanted to see how many babies she could have. \_

Niv: How did you find out she switched the urine?

Nurse Jane: She told us at the end.

Niv: She told you—

Nurse Jane: After, after she—well we said,

‘Oop! You’re pregnant now, so we can’t give you the Depo.’

Then she leaves, and then, when she came back, we said,

‘Well, we thought you were pregnant?’ She goes,

‘No, I just switched the urine cause I didn’t wanna get the Depo. Cause I wanted to try to get pregnant again.’ \_ So we’re like,

‘You can’t do that. I mean, you know, it’s bad for you. It’s bad for the kids you’re having. It’s bad for, all the way around.’ \_

She ended up confessing. But we didn’t know at the time; we just thought she was pregnant again.

Bria: Do you know why her children were getting taken away?

Nurse Jane: She’s just, she’s been in jail. \_ She- prostitution. \_ Drugs. \_ She has a lot of other social issues, the reason why her kids aren’t with her. But, ((hits table))

she’s still, continuing to have kids and think that, she can keep them ((small laugh))

Bria: Was this a patient of color, or is this a White patient?

Nurse Jane: It’s a White patient. \_

Bria: Mm. Can you think of any examples of a patient of color that you \_ were seein- you were kinda frustrated about them having kids? Or, even just someone that you \_ thought, ‘Oh then, we got through to them and they- they’re using birth control.’ Just, I don’t know. Something related to this—

Nurse Jane: —Well there is another patient of color, that’s in the same, \_ doing the same thing that she is. But this patient said that God told her, that she should have as many kids as she can. \_

Bria: Are they getting taken, away by child services? Or are they \_ hers?

Nurse Jane: Ssss- she has some. And some, are living with other people. ((knocks at door)) This other lady. I don't know, she's probably— ((knocks at door))

[Non-participant came into the room to ask Nurse Jane a question. Transcript begins again after this person left the room.]

Nurse Jane: —So anyways, that's, that's just this person—

Bria: —So, does- does she have like a mental health condition? Or?

Nurse Jane: Ehh, yeah. I would say that. I mean, she's been on the news and everything. This one- one lady. Because she's \_ has all these kids and she doesn't have a place to live and, y'know, D-C-F is investigating her, and then she's saying that God told her to have kids and, that's another whole crazy issue.

Bria: Right.

Nurse Jane: But, \_ she doesn't wanna use birth control. That's another— religious reasons is another\_ thing, people don't wanta use birth control for.

Bria: Di- she doesn't have a court order, does she?

Nurse Jane: No. \_ No. The only person I've ever seen that court order, is ((small laugh)) that one lady that I told you about.

Bria: Yeah.

Nurse Jane: And I've been doin this a long time.

Bria: Yeah, that's a really \_

Nurse Jane: Yeah.

Bria: Quite a lot ((exhales)). So when you have a patient like that, where you feel like, uh, 'They're getting pregnant again, again.' What d'yo—\_ do you sort of talk to each other about it? Like, how do you kind of, work through that frustration?

Nurse Jane: Yeah, I mean we- we \_ try to \_ y'know, all forms of birth control, maybe it would work for her and \_ y'know, told her it's not good for her body, to continue to get pregnant one right after the other? \_ Y'know, she did take \_ birth control for a little while. But, y'know, she keeps \_ wanting to have more kids, thinking that she's gonna be able to keep em. So that's a- kind of a different circumstance, her. Those two that I told you.

Bria: Right. That's not average—

Nurse Jane: —But, y'know, there's somebody- ehh, some other people, y'know,

'W- we'll make it as easy as we can for you,' Um. If uh, if you \_ y'know,

'If you want the IUD, we can get it ordered and get it \_ before you- you're insurance runs out,'

Nurse Jane: Y'know, we're always trying to, \_ y'know, do whatever we can to \_ get these people \_ on birth control.

Note: For the purposes of my writing, I will call the first patient Nurse Jane mentions (who had court ordered contraception) "Patient X" and the second patient she talks about "Patient Y."

### **“We” versus “them.”**

Nurse Jane’s narrative shares some basic features with stories shared by Dr. Three and Dr. Christine. At a basic level, all three RHPs were discussing their experiences trying to convince reluctant patients to take contraception. However, whereas Dr. Christine and Dr. Three tended to present their patient characters as victims or props, Nurse Jane portrays her patients as antagonists. Patients are constantly ignoring or outright disobeying the instructions of the clinic staff in this narrative. Nurse Jane believes some patients are just “lazy” and don’t want to put the effort into taking contraception, whereas others (like Patient X) develop sophisticated plans to resist those who seek to control their fertility.

Interestingly, Nurse Jane herself is somewhat absent from the stories. Most of the actions in are committed by the patients or the non-specific group “we” which presumably comprises Nurse Jane and other HPs and staff members at her clinic. It’s unclear if Nurse Jane uses “we” because she was not actually the person speaking to the two patients she mentions, if Nurse Jane has a more team-based approach to her work, because she finds the solidarity implied by “we” beneficial for her credibility, or for another reason. In any case, this discursive move sets up an adversarial relationship, whereby the clinic staff are portrayed as engaging in an ongoing struggle *against* the patients.

What’s more, everything Nurse Jane says seems to indicate the patients are winning in this struggle. Even though “We” is constantly trying to “do whatever we can to get these people on birth control,” patients “keep getting pregnant.” “We” seems stuck in a time loop, with events constantly repeating themselves, no matter what “We” does. Nurse Jane emphasizes the with phrases like, “so it’s like a revolving thing here,” “you see these people that keep getting pregnant over and over and over and over again,” and “they just keep doing it and doing it and

doing it and doing it.” As such, Nurse Jane constructs this narrative as an unending, unchanging struggle between an amorphous “We” (likely the clinic staff team) and patients, who are both lazy and wily in their efforts to reproduce (Bridges, 2011).

### **The good mother and the bad (m)Other.**

Like Dr. Christine and Dr. Three, Nurse Jane demonstrates attachment to the Good Mother character. Nurse Jane’s frustration with patients who become pregnant repeatedly (before every introducing Patients X and Y) is suggestive of a general disregard and devaluation of the reproduction of her patients (who are almost all low-income and who are disproportionately black). In describing her patients as “lazy,” promiscuous (“they just keep doing it and doing it...”) and hyper-fertile (“they keep getting pregnant over and over...”), Nurse Jane summons the characters of the Black Jezebel and Welfare Queen (Ehrenreich, 1993; D. E. Roberts, 2017) to position her patients as Bad Mothers who do not follow the White bourgeois heteronormative script. Thus, Nurse Jane reaffirms White supremacist, patriarchal, neoliberal narratives which “assert that single women in poverty have neither the right to become mothers nor the legitimacy to claim that their care work for dependent children and family members is meaningful” (Bloom & Kilgore, 2003, pp. 365–366).

Nurse Jane is even more vociferous about her frustration with Patients X and Y for daring to reproduce despite their histories of drug use, sex work, incarceration, housing instability, and oversight by foster care. Nurse Jane expressed no sympathy for these patients until I commented “that’s really sad”—prior to this, Nurse Jane primarily expressed anger that Patient X dared to reproduce despite the court order! Bloom and Kilgore’s (2003) delineation of the process of (m)othering is useful for understanding how Nurse Jane has come to embrace the idea that Patients X and Y should be forcibly disqualified from motherhood. (m)Othering is a process

whereby marginalized women are constructed as so irrevocably different from the dominant group that they must be shut out from motherhood through institutionalized surveillance, management, and punishment. The figure of the Bad (m)Other is the mirror image of the Good Mother: poor, unmarried, Black, and jobless, this character overlaps significantly with the figures of the Welfare Queen and Jezebel (Bloom & Kilgore, 2003; D. E. Roberts, 2012). In Nurse Jane's narrative, Patients X and Y are prototypical Bad (m)Others, as they exist completely outside the norms of private property ownership, respectable participation in labor markets, and middle-class lifestyles which characterize the Good Mother.

Nurse Jane's narrative demonstrates clearly how the character of the Bad (m)Other is not just a discursive formation, but becomes violently, materially produced through interpersonal interactions. By understanding her patients as foes who must be prevented from motherhood, Nurse Jane becomes conscripted into state efforts to forcibly control Patient X's reproduction by administering court-ordered contraception. Here, the basic bioethical principles of respect for patient autonomy and nonmaleficence seem to have been totally abandoned without second thought. The figure of the Bad (m)Other is also structurally significant, as her image is used to justify the expansion of "the punitive machinery of law enforcement and child protection" even as funding for social services which might address food insecurity, housing instability, and poverty is cut (D. E. Roberts, 2012, p. 1492).

### **Punishing resistance.**

Ehrenreich (1993) argues that "court-ordered treatment of women of color may constitute a coercive response to their acts of resistance to doctors' control of their reproduction" (D. E. Roberts, 1996, p. 134). I contend that we should interpret Patient X's court-mandated contraception in the same way, i.e. as a punitive response to her defiance of normative

motherhood. While Patient X is white, the systems which seek to control Patient X should be regarded as White supremacist systems, as women of color are disproportionately surveilled, disciplined, and assaulted by prison, foster care, biomedical structures (D. E. Roberts, 2017). Roberts (1993) argues that when white mothers are affected by these systems, their punishment can be understood as a consequence of “acting too much like Black women” by deviating from the White heteronormative bourgeois script (26).

Akiyela (2002) asserts that a central goal of postcolonial, narrative-informed therapy should be to recognize that those patients who are labeled aggressive, resistant to change, or otherwise “frustrating” are often given these labels because they resist the behaviors and roles prescribed by normative Western therapies. He argues that therapists should shift their understandings to reframe patients’ behaviors as “means to resist and hold onto their humanity and dignity in spite of forces that are larger than them” (39). I argue that Patient X’s efforts to evade her court-ordered contraception and Patient Y’s insistence that she deserves to be a mother outside the conditions of normative motherhood both represent resistive tactics in the face of oppressive foster care and prison systems which seek to denigrate their motherhood and deny their humanity. If RHPs like Nurse Jane could develop new stories around patients behaviors which reflect the postcolonial therapy perspective outlined by Akinyela, these new narratives would undoubtedly have material consequences for women like Patients X and Y (and their children). However, so long as master narratives about Good Motherhood continue to be taken for granted, oppressive (m)Othering practices will continue uninterrupted. I now introduce a narrative from Dr. Albertha, which clarifies how the hegemonic construction of the Bad (m)Other functions as a tool for targeting and punishing Black Mothers.



## Dr. Albertha

Dr. Albertha is an obstetrician-gynecologist who is involved in both clinical work and research. Still in the earlier stages of her career, Dr. Albertha seemed (at least marginally) less jaded than some of the veterans I'd interviewed. She seemed warm and energetic to me, the sort of person who puts others at ease. During this section of our interview, Dr. Albertha mentioned that the hospital at which she did her residency always ran drug tests on laboring patients who had a history of drug use. I asked Dr. Albertha how patients responded to this requirement, leading to the following interaction.

### Dr. Albertha's Narrative About Pregnant Patients Who Test Positive for Drugs

**Table 10.** "Yeah, I Think It's Racialized. But, I'm Not Thinking About It All the Time? Because There're so Many Other Things That I Could Be Thinking About."

Dr. Albertha:	Um, the other thing is, patients sometimes will fight us on that, because like, y- they're afraid, if it's <u>positive</u> , that the baby- that it's gonna be reported to Child Services, and the baby will be taken.
Bria:	Does that happen?
Dr. Albertha:	Uhh, our p—like, before it was um, it was usually if- if they were positive for cocaine, the baby could be, taken.
Bria:	Do you think that that's racialized at all?
Dr. Albertha:	_ Umm, I think it could be.
Bria:	Mhm
Dr. Albertha:	It- you know, it's interesting because—the whole cocaine thing is very interesting. Cause it's like, you got <u>cocaine</u> , and you have crack. And, y'know, cocaine is manag—like, even if- if you look back to like the eighties. Like, y'know when, when yuppies were doing cocaine. Like, it wasn't like that punishable,
Bria:	((laughs))
Dr. Albertha:	You like, pay a fine. Like maybe get a li- little slap on the wrist,
Bria:	Yeah
Dr. Albertha:	But like, <u>crack</u> —which is actually <u>not</u> as <u>strong</u> ,
Bria:	Mhm
Dr. Albertha:	Or potent as cocaine? Like, you would get like, serious jail time.
Bria:	Mhm.

Dr. Albertha: And it's, y'know, because like, y'know, yuppies, y'know, we were usin \_ coc—like, they were using cocaine, like, poor people in the projects, were using crack.

Bria: Mhm.

Dr. Albertha: So,

Bria: There the ones that got penalized?

Dr. Albertha: Yeah.

Bria: And it's interesting how the opioid epidemic has been treated very differently, than

Dr. Albertha: Mhm

Bria: Uh, the crack epidemic was. And the people are treated, [inaudible]

Dr. Albertha: Right,

Bria: [inaudible] much differently,

Dr. Albertha: Cause it's- it's a very different population.

Bria: Mhm?

Dr. Albertha: The vast majority of patients that I saw that were dependent on opiates, in [residency], were White. Very rarely would see a Black person come in, saying they were using heroine. So, um, now with opiates, uh, it's medical- it's a medical condition. It's not a crime. It's a medical condition now. Um, but I'm sure if Black people started doing it, it will be a crime

Both: ((laughs))

Bria: Is that frustrating, for you?

Dr. Albertha: \_ Um, yes? ((laughs)) Um, it- well, because I feel like um, y'know, people aren't getting their fair shot. Y'know like, y'know, treat everybody the same. If it's gonna be a crime for one person, let it be a crime for another person. If it's gonna be a- if, y'know, if it's gonna be a disease, y'know, like let it be like a disease for everybody. Like, treat everybody, like, similarly? And, and with dignity. Like, I mean I've always kind of thought that drugs, um, y'know, for the most part, um, and drug use are coming out of a place of, y'know, people being in a certain situation, where they like, y'know, need to use it? With, with addiction. Not, um, w- with addiction, I mean.

Bria: Mhm

Dr. Albertha: I don't think that people, like recreationally using,

Bria: The yuppies ((laughs))

Dr. Albertha: Like, marijuana, like, is coming from like—y'know, so many people are using it? Like, I don't think that it's like, really coming, y'know like, from that place. But when you're seeing people on like, y'know, that are,

Bria: Addicted?

Dr. Albertha: On crack. Like, or one, uh, y'know like heroine, you're like, 'That's comin from like, someplace of-' Well, like, even if they were, um, even if they were somebody that was like, otherwise like well-off, like,

'Well what's going on in their life that like, y'know, that, became, y'know, something that they went to?'

When they're like, dependent on the substance. Um, y'know so I- I think it's really frustrating that, y'know, a lotta things are, y'know, depend—y'know, how you're treated, in any situation, um, y'know, kinda like, it depends on your race. Y'know, you talk about, um, y'know people, y'know with like, Black Lives Matter and stuff it's like, y'know, you see like a kid, just like, is out there with like a toy gun, and get's like shot, but then, y'know another kid. So, like, y'know, you see that, but then, y'know, another kid, a rich gets drunk and illegally drives, when he's not even- he doesn't even have a license, and kills like three or four people. And like, everyone says he has afluenza. And I'm like, ((hits table))

Bria: ((laughs))

Dr. Albertha: 'Whaaat?!'

So, um, I mean I think it's interesting that, ((SFW)) y'know like, y'know, people from like, certain backgrounds just kinda like, get a pass? And like, other people like, don't get a chance? When really probably the people that are coming from other backgrounds might need more of a chance, and- and stuff. Y'know, I think that also comes from like our, um, y'know, justice system's not justice, for one. But um, there's no rehabilitation component of it. So, y'know, it's not like you're sending somebody to prison, and then you say,

'Okay, well we're gonna like, rehabilitate you so that you are able to, y'know, come back in society and like, not feel like you need to commit crimes.'

Um, no. It- it's like, y'know, people are there, and like, y'know, there's n- there's no rehabilitation. They're basically kind of like, y'know, in a holding cell, so that like, y'know, whenever they get out, they're just kind of conditioned to like, come back in. Cause it's, probably, for some people, the only like, stable thing that they know in their lives. So then they're gonna, y'know, come back into the system. Sooo, you kinda wonder like, y'know, we're not even- we're, we're putting, y'know, minorities in jail, and in prison, and we're not even like, rehabilitating them. We're just kinda creating a system where then they just, like, kinda, will end up, right back into it—

Bria: —Can never get a job, or vote.

Dr. Albertha: Right. Cause like, once you're labeled that, like, everyone's gonna ask about your history, and they're gonna like, y'know, they're gonna be like,

'Oh, I don't want that person to' ((hits table))

Bria: Your options are just getting less and less.

Dr. Albertha: Yeah. So it's like, y'know, you go to prison once and like, that's- like, your life is, over.

Bria: Yeah.

Dr. Albertha: Like, y'know, for most people. If you have means, and you go to prison, and you have a family that like, supports you or whatever, you'll be able to like, y'know, like work through it. But like, if you don't really have, that kinda stuff than, y'know, you're gonna end up, y'know, right back, in prison. It's like, y'know, Robert Downey Junior went to prison,

Bria: ((laughs))

Dr. Albertha: And he's like, on Iron Man. And I'm, 'Oh!' Like, 'He's doing great!'

Bria: Yeah.

Dr. Albertha: But, y'know, the average Joe is, is

Bria: [inaudible]

Dr. Albertha: Not in that situation.

Bria: Yeah. So you were saying—with the, with the um—it used to just be, uh, when um mothers had cocaine they would- their babies would get taken away.

Dr. Albertha: Mhm.

Bria: Is it—did they change that policy now? Or how's it that?

Dr. Albertha: It's still report to, um, Child Services. So,

Bria: Regardless of the drug? Or on- still only cocaine?

Dr. Albertha: Cocaine is the main one that were like, like- you're like,  
                   'Oh, shoot.' Like, 'She's got cocaine.' Like, 'Y'know, there's a chance that  
                   this—'  
                   Like, that's something that like, they always report?

Bria: Mhm.

Dr. Albertha: Um, they don't necessarily— they would necessarily do that with like, every drug. Like, they don't— I don't think they technically do that with like, marijuana. But like, cocaine's the one where you're like,  
                   'Ooo,' like, 'There could be a—'

Bria: —Yeah  
                   'There could be a situation.'

Dr. Albertha: Like, even like opiates, marijuana, like, that baby could still go home. We send babies home with a lotta people that your- shouldn't be taking babies home probably ((laughs)) But like, y'know, they'll like, those babies like, usually will get to go home. But like, a mom who was like, on cocaine, you- then, usually there's, like, a little bit more investigation that happens.

Bria: Mhm. \_\_\_ Yeah, that feels kinda racialized to me. I don't know.

Dr. Albertha: Yeah. \_

Bria: How do you deal, with that? \_\_\_ D- do you think that people are aware, of that? Or do you think that it's just kind of like, not something that's talked about?

Dr. Albertha: Mm, I don't think people think about it. With—I don't- I don't think they're like,  
                   'Oh yeah, these people are easy—'  
                   And, y'know, also cause on the drug screen, it just says cocaine, it doesn't say crack. When, y'know, you know that your patients are doing crack. Or they're like, y'know, having substances that are laced with, laced with cocaine.

Bria: Mhm

Dr. Albertha: So just like, a little bit in it. Um, so, I- I don't think that people are really thinkin about it.

Bria: Mhm. \_\_ Is that hard? Or is it just sort of like, ‘Oh,’ y’know, ‘This is how life is. In this profession.’

Dr. Albertha: ((Inhales)) Wellll, \_\_ I would say, I don’t think it’s something that I like—I don’t think that that particular thing, is something that I think of, on a day to day basis.

Bria: Mhm.

Dr. Albertha: Umm, \_ I think there’s probably—like, at least in, in our profession? There’s a lot of, a lot of other things ((laughs a bit)) that I concern myself, with. Like, before I worry about the, like, ‘Oh, they’re investigating this lady further because she’s positive for cocaine. Yeah, they may be more that are Black that are, y’know, on crack, so like, maybe that’s why like—’ I don’t think I, in my like daily life, would like, get down to it. Like, if somebody had a conversation with, with me—like, like you did—and said like,

‘Oh, do you think that’s racialized?’

Yeah, I think it’s racialized.

Bria: ((laughs))

Dr. Albertha: But, I’m not like, thinking about it, all the time? Because there’re like, so many other things? That like, I could be, kind of like, thinking about. Like, I could- y’know, work on—instead of worrying about, like, ‘Oh, it’s like racialized that, y’know, she’s- she has cocaine and they’re investigating this a little bit more,’ I’m like, ‘Well, what got her to the place she’s using cocaine.’ ((snaps)). So like, I kinda like, think more about that, than about the other thing. Cause, \_ I mean, I’m not like a criminal justice person. Like, I can’t change that.

Bria: Mhm.

Dr. Albertha: That system? There? But, y’know, we can try to say,

‘Okay, well, what are the situ- what’s the situation that like, that happened to begin with?’ Like, ‘Does she need like a referral, to like, other programs?’

And that’s what I would do for any patient that like—not for, not for marijuana. Cause that, way too many ((laughs))

Bria: ((laughs))

Dr. Albertha: Like, way too many things—But like, that’s what I would do for like, any patient that like, had a positive drug screen that we’re concerned about? Like, not just cocaine. So I think they should all be, kinda treated—like, th- these illicit substances need to be treated the same.

Bria: Mhm.

Dr. Albertha: So.

Bria: And that’s just what you try to do?

Dr. Albertha: Yeah. I mean, it’s just- y’know, it’s just like, ‘Okay. Clearly this person’s using drugs. Shouldn’t be using drugs. They definitely shouldn’t be using drugs when they’re pregnant, and like, how is them using drugs gonna affect like, how they’re gonna care for this baby, and themselves like, afterwards. So, the type of drug doesn’t really like, matter to me? Um, I mean, I think for Child Serv- like, that’s just the thing with like Child Services,

Bria: Mhm

Dr. Albertha: Doe—y’know, that the social worker and Child Services does. But, it’s like, to me, it doesn’t matter. Um, and I mean I think to most medical professions? Most medical professionals, I don’t think the type of drug matters. So we’re not thinking about that. But, y’know, when we’re planning discharge for patients, like, ‘Oh okay, well y’know they’re’-- y’know, making sure that the baby’s really clear to go home. With this patient.

Bria: Mhm. Mhm. That makes sense. So, just basically, doing what you can do, and focusing on, what you can do for that patient.

Dr. Albertha: Right. Cause you can’t- you can’t be, like, everybody’s everything. You can’t cure like, all of society’s ills.

Bria: Yeah ((laughs))

Dr. Albertha: So, it’s like, ‘Y’know, I can try to like, work on this patient.’ Like, ‘Y’know, I can try to like, y’know, make sure she has resources to like, not use drugs, but, I can’t fight the, y’know, system that social work and Child Services has set up.’

Bria: \_ Yeah. That makes a lot of sense.

Dr. Albertha: So.

### **The systematic punishment of Black (m)Others.**

Dr. Albertha’s narrative provides a clear illustration of how the systematic punishment of Black Motherhood is enacted through the collusion of biomedical and foster care systems in the contemporary U.S. at the local level. The denigration of Black Motherhood is evident in the practice Dr. Albertha describes, which allows women who use drugs associated with Whiteness to keep their babies, while women who use drugs associated with Blackness are denied their right to Mother.

No other participant in my study described having witnessed similar policies at their hospital, and I cannot estimate how widespread such practices might be. This narrative does not provide evidence of discrimination across all medical institutions. That said, this story corresponds with the extensive literature which documents how Black Mothers have been the primary targets of biomedical and legal systems which stigmatize, criminalize, and punish their Motherhood (Geronimus, 2003; D. E. Roberts, 1991, 1996). Here, then, we see further confirmation that even when White Mothers (like Nurse Jane’s Patient A) are caught up in the

prison and foster care systems, these structures continue to expressly Other and assault Black Mothers.

**Colorblind expectations versus White supremacist reality.**

The flagrant attack on Black Motherhood which Dr. Albertha discusses creates a central tension which runs throughout this narrative: the paradox of blatant anti-Black racism which exists in a purportedly colorblind nation. Dr. Albertha moves back and forth across this tension throughout her narrative. On one hand, she insists that colorblind neoliberal morals should set the bar for treatment (e.g., everyone should be treated the same and given a fair shot). But, on the other, Dr. Albertha sees that this is clearly not the case: Robert Downey Jr. (a rich white man) can go to prison and still play a superhero in a massively successful film franchise, whereas poor black men who go to jail become systematically excluded from citizenship following their imprisonment. A rich young white man can kill three people and be regarded with sympathy, whereas a black boy playing with a toy is vilified by the media after being murdered by the police. Dr. Albertha actually goes so far as to implicate biomedicine in this contradiction; she expresses frustration that “now with opiates... it’s a medical condition. It’s not a crime. It’s a medical condition now. Um, but I’m sure if Black people started doing it, it will be a crime.” Here, Dr. Albertha suggests that the construction of disease is a politicized, racialized human process (an idea which is antithetical to biomedicine’s insistence on neutrality and objectivity).

Still, even as Dr. Albertha draws attention to these contradictions, she maintains loyalty to the master narrative of biomedicine as a colorblind enterprise. While she agrees that the differential treatment given to mothers who use cocaine is “racialized,” she insists that most medical professionals are not “thinking” about race when they report these patients to social work. She reasserts the importance of colorblind equality ( “I think they should all be, kinda

treated... these illicit substances need to be treated the same”) and emphasizes that other healthcare providers share these values (“Most medical professionals, I don’t think the type of drug matters. So we’re not thinking about that”). This is a curious position to take, considering that it directly contradicts her previous statement that providers say to themselves, “Oh, Shoot. She’s got cocaine... There could be a situation,” and report these mothers, but allow mothers who test positive for other drugs to go home with their babies. It’s as if Dr. Albertha is not aware that RHPs are making a *choice* when they report patients to child services. Here, the question of agency is totally disregarded. At the same time, it is taken-for-granted that RHPs do not “see” race or care about which types of drugs their patients use.

In other words, though it is RHPs (like Dr. Albertha) who decide which patients are reported to social work and which are not, Dr. Albertha does not recognize the process as something she can do differently. This does not mean that Dr. Albertha does not want to help these patients. However, she believes her responsibility is to find referrals for drug treatment programs that she can share with *any* patient who uses drugs, not just those patients who use cocaine. By maintaining her allegiance to colorblind racism, Dr. Albertha enables White supremacist patriarchal structures to operate without interference.

### **Blinded by the system.**

Dr. Albertha says that because she is “not a criminal justice person” she can’t change racist practices in biomedicine. Why has Dr. Albertha developed this particular, rather peculiar view of her own agency? Dr. Albertha answers this question: “There’s a lot of, a lot of other things that I concern myself with.” Dr. Albertha explains, “Like, if somebody had a conversation with me—like you did—and said like, ‘Oh, do you think that’s racialized?’ Yeah, I think it’s racialized. But I’m not like, thinking about it all the time? Because there are like, so many other things? That



like, I could be kind of like thinking about.” Essentially, then, Dr. Albertha has a narrative about what a Good Doctor she should focus on, what a physician’s priorities should be, and what is possible for her an RHP to accomplish. Noticing racism is not part of her script, so she doesn’t attend to it. Her story is busy enough as it is without having to add in further complexities. The master narrative of biomedicine suggests that the ideal physician is one who focuses on each patient as an individual, treats each patient equally, and stays out of politics, so this is what Dr. Albertha does.

Here, then, we see the power of master narratives to conceal a RHP’s agency (and complicity) from themselves. Master narratives can both make Dr. Albertha’s own daily decisions seem completely out of her control, and prevent Dr. Albertha from envisioning herself expressing agency in a different setting. At the same time, I argue that there are material constraints which structure Dr. Albertha’s ability to realize her agency. In particular, the number of tasks medical residents are expected to complete and their low rank within medical hierarchies affords residents with little time for reflection or resistance. It is important to recognize the ways in which systems are constructed so that those who are least enculturated into biomedicine have the least time or power to affect change. The hierarchical arrangement of medical power and the difficult working conditions residents are expected to endure, then, maintain the stability of heterocapitalist White supremacist imperialist biomedicine. These health system structures (and narratives) enable providers like Dr. Albertha to collaborate in the gendered-racist treatment of Black Mothers without ever recognizing their complicity (Essed, 1991). My next narrative, told by Dr. Mary, will provide further illustration of these processes.

## Dr. Mary

I met Dr. Mary at a café off the side of a busy road. She was wearing sweatpants and a pink t-shirt when she came to sit down across from me on the patio. To me, Dr. Mary seemed nervous, restless, passionate, and burdened by difficult memories. She tended to alternate between long pauses and speaking in fast steams of words. Often, she seemed to struggle to find language to describe her ideas, drawing out the first syllable of a word or stuttering a bit at the beginning of a sentence. Both of us cried during her interview.

Knowing that Dr. Mary had had a long career, I asked her at the beginning of our interview about the various settings she'd worked in over the years. She told me that she did her residency and fellowship during the 1980s in the downtown area of a city I knew had been hit hard by the crack epidemic. Below, I've included transcripts from the two portions of our interview in which Dr. Mary and I talked about her time in residency. Although Dr. Mary named the city during our interview, I ultimately chose to remove the city's name from the transcripts because I was concerned that including the name made Dr. Mary too identifiable.

### Dr. Mary's Narrative About Treating Patients During the Crack Epidemic

**Table 11.** "You'd Come to That Part of the ER, Everyone Was Handcuffed to Something."

Bria:	So I'm really interested to hear about your experiences working in [City], in the eighties.
Dr. Mary:	Ugh, god. ____
Bria:	Yeah?
Dr. Mary:	Um, __ it was just like hell. Um, _ it was very busy. Um, _____ the population of women—I mean, we had <u>everything</u> . We had, um, __ y'know, from uh, __ people on Motown record labels, who I will not mention names.
Bria:	Uh-huh
Dr. Mary:	To __ people who had zero prenatal care ever, _ um, and- and everything in between. But the, <u>the largest majority was African American</u> . Of course, it was in the middle of [City]. Um, _ <u>huge</u> , amount of uh, drug use. Lots of—u—crack was the thing then. And so that was huge. Um, _____ and, ____ ((exhales)) lots of preterm labor, because, y'know, African American women are _ much higher risk. Um, _____ lots of diabetes. ____ I feel like not as much obesity as- as recently. But I think that's just over time? Um, ____ And- and it was—it wore on <u>you</u> , I think. Y'know? The _ people walking in with no prenatal care and

high and, y'know. Many many times there'd be a dead baby, or whatever. It was hard \_ to take.

Bria: Can you think of an- a, a case that really affected you? That you saw then?

Dr. Mary: \_ Oh god, there's a million ((laughs))

Bria: ((laughs)) Yeah. Just one?

Dr. Mary: Umm, \_ I don't know. I- I, like I, I measure things in ho- u- how, how burnt out I got, I think?

Bria: Mm.

Dr. Mary: Um. \_\_\_ **You-** \_\_\_ we just saw so many, \_ so many high women, that—honestly I remember—and this u- horrible—and I think about this now and it's horrible. But, \_ I just walked into the room, I never introduced myself to the patient, I—I'd walked in and I said,

'When's the last time you used crack?'

That was my introduction.

Bria: Woww.

To her. And she said,

'What time is it?'

Bria: \_ Wow.

Dr. Mary: ((laughing)) It was just like,

'Oh, my god, where am I?'

Bria: Oh my god.

Dr. Mary: But I mean **you** get—it was just—it- it was really hard work, and we were- we were really overworked. Cause there were no resident \_ hours at that point? So **you** could, **you** could work forty some \_ hours at a time. And uh,

Bria: Dear god.

If **you** spent a night—like, like we would find— ((SFW)) you know when, when checks came out?

Bria: Mhm?

In the beginning of the month? That's when **you** would see more people? So **you'd** do a night in the beginning few days of a month,

Dr. Mary: and every ((hits table))

person ((hits table))

would come in \_ high and \_ their baby's in distress, u—you know.

((SFW)) Y- It got old. And- and we got worn down, I think. So it was hard.

Bria: Yeah. \_\_\_ So, \_ the hardest thing for you— when you're dealing with a high patient, right? Was it \_ their attitude towards youuu? Or just knowing that they're hurting—

Dr. Mary: —No!—

Bria: —that they're hurting their health?

Dr. Mary: Yeah, and—

Bria: —What made it so hard?

Dr. Mary: There's no reasoning—**you** can't reason with someone who's that high. M—o-often, often, something was going wrong. They were bleeding or their blood pressure was sky high, or, or their baby was in distress, so **you** had to do things really fast? And, and then **you're** \_ operating on these women, um, and **you're- you're** delivering these, y'know, little babies that are, \_ are so sick. Um, ii—it was hard. It—you know—every part of it is hard. And, and \_ they didn't have any prenatal care, many many of them. Um, \_ so, \_\_\_ y'know, it's just like a failure. And we- we did do clinics. And- and **you** did see **your** own patients. And there was \_ a different \_ aspect of that job. Y'know, like, \_\_\_ we had our own continuity patients, and, and uh, and they had just started that kinda during residency but uh, patients that **you'd** see over time and **you** might operate on, or **you** might come in special and do their delivery—if **you** could. Um, so there were the up sides of it too? But the—the part that wore **you** down was that kinda down side. Y'know?

Bria: Mhm.

Dr. Mary: The \_\_\_ it- just ((SFW)) **you** feel like **you** can't get anywhere. Y'know? —

Bria: — Mhm.

Dr. Mary: Because **you** can't do the care **you're** supposed to do because they don't show up, or, \_ whatever.

Bria: And it's kinda too late by the time you see them?

Dr. Mary: \_ Right right right.

Bria: Mm.

Dr. Mary: And but it — ((SFW)) y'know, just as many times **you** had, had, \_\_\_ patients prenatally that \_ that **you** could make an impact on. There were those.

Bria: Mhm.

Dr. Mary: Y'know? \_\_\_ So, um—or, or, y'know, people who're there with chronic pain, or whatever. And **you** took care of them and- over time. So, \_ but it- it— the things that I remember, that I, I—that would just be exhausting were those- the ER visits and the, the walk-in and delivery people that, y'know, they don't even know they had a baby.

Bria: Mhm.

Dr. Mary: So.

[We moved on to other topics at this point. Later in the interview, I decided to ask follow-up with more questions about Dr. Mary's experiences during the crack epidemic. During this part of the interview, we had just moved to a different part of the café area, because it had begun to rain.]

Bria: So when you talk about the, crack epidemic, \_\_\_ is there anything that you think about in retrospect that you wish you would have differently? Or you wish on a policy level would have been done differently? \_\_\_\_\_ Are you still getting wet?

Dr. Mary: Naw, it's fine. I'm- I'm wearing crappy clothes, I don't care. Um, \_\_\_\_\_ ((exhales)) Umm, ss- I think, \_\_\_\_\_ I'm trying to think of what they were doing—if anything. Arresting everyone, I suppose.

Bria: Was that something you saw a lot of?

Dr. Mary: There was a \_ police precinct in the medical center.

Bria: Are you serious?!

Dr. Mary: ((laughing a bit)) Yeah, I'm totally serious. This is [City]—

Bria: —What did—

Dr. Mary: —Downtown [City].

Bria: They had a police precinct in the—

Dr. Mary: —Mhm—

Bria: —Medical? What was that- was that for if patients get violent? Like what was that—

Dr. Mary: —Or- or, many of them were already under arrest.

Bria: Uh-huh?

Dr. Mary: And- but had medical issues. So, \_ ((SFW)) you'd, you'd \_ you'd, \_\_\_ come to that part of the ER, everyone was handcuffed to something. \_

Bria: Oh my god.

Dr. Mary: Yeah. So it— it makes you hard. Y'know?

Bria: Yeah.

Dr. Mary: It- it- it—

Bria: —In what way?

Dr. Mary: Pardon? Because ((SFW)) \_ y'know, you're in this area, and people are ssc- y'know, there's a- a huge number of high and drunk,

Bria: Mhm.

Dr. Mary: And whatever people there. And they're yelling at you. And- and you're just trying to do your thing.

Bria: Mhm.

Dr. Mary: Right? Um. \_ But uh, \_\_\_ umm, \_\_\_ it- it, it har- it- it, it— you just try to get your job done. And you, I think you lose some of the humanity of what, what's there? Um, because you're so busy. And you have to get these things done. Um, \_\_\_ soo, \_\_\_ ((SFW)) that was a weird \_ [unintelligible word], y'know?

Bria: Yeah. \_\_\_\_\_

Dr. Mary: I can't even remember what you asked me.

Bria: No, no. I was just—I was just asking more about \_ what it was like in that situation, if you think you- should have been done differently.

Dr. Mary: Ooo. ((Exhales)). Yeah. I, \_\_\_\_\_ like I don't know what, a substitute for that would have been. Y'know, \_ ((SFW)) trying to make people's lives otherwise better?

Bria: Mhm.

Dr. Mary: Is, \_\_\_ um, [City] was, pretty awful there, then. Um,

Bria: In what way?

Dr. Mary: Oh it was like a- a— y’know that whole \_ area in downtown [City] was just like this wasteland. Y’know? Um, \_\_\_ the, the living situations were bad. \_ Um, \_ no one had jobs. Um, and so- and y’know, ((SFW)) if- if trying to mentally get out of that situation was why you used drugs then, then- or, or to combat some inner pain? Um. \_\_\_ There was plenty of that, there. And so, y’know, \_\_\_ it woulda had to been suh- ssssss- something so big to change that population. Y’know? And I think, it’s different now, I believe— I haven’t been back there in a long time. \_ But I think uh, ((SFW)) the, the situation is different there. And I don’t know white- what quite turned it around? Like, people investing money and trying to, to, \_ um, improve the living situations? And that kinda thing? Um, \_\_\_ but I don’t think it’s as bad as it was back then. ((SFW)) But, drugs were huge then; I don’t think it’s quite as—although, maybe it’s just different. Like, opioids, or something that’s quieter.

Bria: Mhm.

Dr. Mary: Um, whatever. Y’know?

Bria: Yeah. \_\_\_ Did you want to go to [City]?

Dr. Mary: Mhm

Bria: Or was it just sort of— What made you wanna go there?

Dr. Mary: ((laughs)) When—

Bria: —Do you feel like—

Dr. Mary: —On match day at residency I—y’know, I matched in [City]—and people were like, ‘Oh, I’m so sorry.’ I was like, ‘No. This was really nu- my number one choice.’

Bria: Yeah.

Dr. Mary: Um, because of the experience ((hits table)).

Bria: Mhm?

Dr. Mary: Like, as residents we saw everything. Y’know? Every kind of crazy complication walked in there. Um, \_ and it was a huge, \_ huge number of patients. And, \_ and so that- that is why I wanted to go there. And I felt like I- I saw a lot there. I had a lot of opportunities there. There was fer—plenty of research going around,-around there. And even, when I went to do fellowship, I interviewed around and then I stayed there, just because there wasn’t anything the same.

Bria: Mhm.

Dr. Mary: It was good. So, \_ um, \_ you know ((hits table)) you get to work with sort of all these, \_\_\_ pretty famous people as they’re starting their careers and stuff? It was- it was a different setting. So tha—in that sentence it was good, we got to see a lot of stuff?

Bria: Mhm.

Dr. Mary: Umm, \_ but ii—you also saw some pretty crappy things, too. Y’know?

Bria: \_\_\_ Yeah. When you talk about, sort of, ‘It made you hard.’ Can you sort of think of a case that, \_\_\_\_\_ made you hard, in some way? Or that, maybe in retrospect you thought you were a little bit too hard on? Or, \_ maybe would have approached differently if you’d had more time? —

Dr. Mary: —Time? Yeah, maybe. Let me think. \_\_\_ ((SFW)) It was probably a daily event there, right?

Bria: Yeah.

Dr. Mary: Umm, \_\_\_\_\_ I- I just there— just some weird things happened, there. Y’know? Like, I- I can remember, interview this young woman, in the ER. We thought she had an ectopic pregnancy; it was in the middle of the night. I uh, \_ I woke up sitting in the ER? With my—y’know, I was writing notes about her—

Bria: —Oo—

Dr. Mary: —She’s just sitting there, waiting for me. To wake up.

Bria: —Ooo!

Dr. Mary: And then, she has an ectopic pregnancy, so we take her ((hits table)) to the OR.

Bria: Mhm?

Dr. Mary: So now I’m gonna operate on this lady, right? Oh my god! ((laughing a little)) ((SFW)) Y’know, could I—

Bria: —Was she scared?

Dr. Mary: I—she was young. She was probably like eighteen or somethin’.

Bria: Oo.

Dr. Mary: And she was just like,

‘It’s okay, that you fall asleep.’ Y’know, it’s just like,

‘Oh my goddd. This is horrifying!’ Y’know?

And I wasn’t operating on her by myself but, but still, those kind of situations. And the patients are really like, \_ umm, \_\_ there were pretty forgiving for that kinda thing.

Bria: Mm.

Dr. Mary: Y’know? Um, \_\_\_ and- and- just, \_\_ ((SFW)) youu—you \_ would \_ be surprised about humanity, in- in different ways, y’know? Like, um, \_\_\_ ((SFW)) we learned to laugh with patients in- and in weird situations. Y’ know? Um. I- I can remember I have—in some patient, she—I had done her delivery, and- and, I think I was sewing up an episiotomy or something, and I- I did something, and she said,

‘Miss Thing! Don’t touch me there!’

Bria: ((laughs))

Dr. Mary: And I just said, ((laughing))

‘It’s Doctor Thing.’

And I just kept going.

Bria: ((laughs))

Dr. Mary: You- we would laughed about it,

Bria: Yeah.

Dr. Mary: And, y’know, ((SFW)) it just ((SFW)) **you** had to \_ make contact some way. So, aa- and some patients, y’know, if they knew that **you** were a real person? Behind all that sometimes? That was good. But, y’know, I’m sure there are situations in which I was, I was \_ terrible. Um, \_\_ I- I can’t think of anything, like, really really bad now, but.

Bria:	It's hard when you're in a situation like that to—y'know, you can't really blame yourself so much as the system that forces you to work forty hour shifts—
Dr. Mary:	—I, sh—yeah, I sorta've come to terms with that. It's been a long time. But yeah, y- you ((SFW)) when <b>you</b> come out? <b>You, you</b> realize—like after <b>you</b> sleep, for awhile? <b>You</b> realize how <b>your personality</b> changed. I think my <u>whole</u> personality changed there. Because of lack of sleep, basically. Uu- y'know?
Bria:	Yeah. Have you—is that different now with your residents, then?
Dr. Mary:	Mhm!
Key: ((SFW)) = Struggling for words   Gray = Describing the City   <b>Bold</b> = generalized “you”	

### A chaos narrative.

Dr. Mary's story is quite unlike the narratives shared by Dr. Three and Dr. Christine, who included heroes, victims, and movement towards some imagined (if impossible) goal. Even Nurse Jane's narrative, though it has the maddening feel of living in a time loop, is grounded by some sense that “We” shares a common perspective and purpose. In contrast, Dr. Mary's narrative has no sense of underlying stability, order, or purpose. Instead, Dr. Mary falls within the genre which Frank (2013) terms the “chaos narrative.” These stories come from “the pit of narrative wreckage” (110), represent times in which,

Consciousness has given up the struggle for sovereignty over its own experience. When such a struggle can be told, then there is some distance from the chaos; some part of the teller has emerged. Thus just as the chaos narrative is an anti-narrative, so it is a non-self story. Where life can be given narrative order, chaos is already at bay. In stories told of the deepest chaos, no sense of sequence redeems suffering as orderly, and no self finds purpose in suffering. (pp. 104-105)

I do not see Dr. Mary constructing herself as a hero, or even a victim, in this narrative. She does not focus on her noble aims or perceived injustices. Rather, she seems to struggle to communicate the experience as one of basic survival, of just trying to “get your job done.” For Dr. Mary, getting the job done required giving up her sense of humanity (of others and herself).



She says, “I think you lose some of the humanity of what, what’s there?” and “when you come out? You, you realize—like after you sleep, for awhile? You realize how your personality changed. I think my whole personality changed there.” These statements also indicate a key characteristic of the chaos narrative: “the person who has lived chaos can only be responsible to that experience retrospectively, when distance allows reflection and some narrative ordering of temporality”(Frank, 2013, pp. 108–109). Dr. Mary says she has only been able to come to terms with her experiences in the City now since it’s “been a long time” and that she needed to “come out” of the experience before she could fully understand how her personality was warped during residency.

The sense of distance from her own experiences is emphasized by Dr. Mary’s choice of pronouns. Dr. Mary tends to avoid using the word “I,” often reserving this pronoun for instances when she is making sense retrospectively (e.g., “I can remember”; “I sorta’ve come to terms with that”). Dr. Mary relies heavily on the generalized form of the pronoun “you” throughout her narrative. For instance, she says “**you** feel like **you** can’t get anywhere” and “it makes **you** hard.” This is consistent with the genre of the chaos narrative, which Frank (2013) describes as “non-self” stories. Dr. Mary’s use of generalized “you” suggests that her sense of her own individual selfhood is blurred or even lost when she tries to describe her experiences in residency. The fact that it is difficult for her to locate “I” in her account suggests that this narrative represents a time where her identity was displaced or erased. I think the issue of generalized “you” is worth exploring further here, as I noticed that many of my participants used this discursive strategy when speaking about difficult emotional experiences.

## “You” and “I.”

Stirling and Manderson (2011) describe two different forms of generalized “you” commonly drawn upon by their participants. The first is the “structural knowledge description” type which speakers use to emphasize their membership in a larger group of people who share the same experience. This type of “you” is seen, for instance, when Dr. Mary says “**you** could work forty-some hours at a time” or “**you’re** operating on these women.” Here, Dr. Mary is referencing experiences that she personally had, but which applied equally to others (presumably other residents in her program). Stirling and Manderson argue that “you” here functions to both bolster the credibility of the narrator by positioning them as a witness, while also conferring “externalization and objectivity” by “diffusing the responsibility for accountability concerning what is witnessed to the audience and beyond” (1600). I argue that this form of generalized “you” helped Dr. Mary to dilute her responsibility for acts which she recognizes (retrospectively) as morally wrong. Take, for instance, when Dr. Mary says, “And **you**, I think **you** lose some of the humanity of what, what’s there? Um, because **you’re** so busy. And **you** have to get these things done.” Here “you” allows Dr. Mary to reference a “generalized other” (Stirling & Manderson, 2011, p. 1599) which, facing the same constraints, lost their “humanity” in the same way as Dr. Mary. Therefore, Dr. Mary cannot be held individually accountable, since she was just one member of a larger group.

Perhaps even more interesting is what Stirling and Manderson term the “personal experience” form of generalized “you.” With this type of “you” it is feasible that a more general category of people is being indexed, but the events or emotions being discussed are private enough that “I” or “me” would work just as well—in fact, the speaker may switch fluidly between “you” and “I” in some instances. Dr. Mary uses this type of “you” often, such as when

she says, “**you** feel like **you** can’t get anywhere,” “the part that wore **you** down was that kinda down side,” and “like after **you** sleep, for a while? **You** realize how **your** personality changed. I think my whole personality changed there.” This type of “you” helps the speaker to construct their feelings as more objective or valid, by implying “anyone would have felt the same way.” This discursive strategy also allows speakers to distance themselves from painful emotional experiences. To me, Dr. Mary’s use of “you” in these situations indicates her wish to avoid approaching painful feelings (including guilt) which she associates with her memories of residency.

There are two other functions of generalized “you” I hope to draw attention to before moving on. First, “you” may provide Dr. Mary with a needed sense of community and solidarity. Freedman (1999) argues that generalized “you” is sometimes used when describing experiences in which solitude would be unbearable; “you” allows the speaker to avoid emotional isolation by positioning them within a larger group. Here, again, “you” is a discursive tool which allows Dr. Mary to discuss painful memories without exposing herself to isolation (and, therefore, culpability or emotional vulnerability).

Finally, “you” may be deployed in situations where the speaker is referencing acts which are “socially stigmatized, illegal, or morally questionable” (Stirling & Manderson, 2011, p. 1598). This is certainly the case here, as Dr. Mary admits that she was sometimes “horrible” to her patients. In these cases, the effect on the audience “is unavoidable incorporation (Stirling & Manderson, 2011, p. 1598). Here, “you” forces the listener into the story so that the listener becomes a partner in the actions being described (O’Connor, 2009). By utilizing “you” in this way, Dr. Mary is able to include her audience (me) in her narrative, so that I become involved and complicit in the events she describes. In other words, this type of “you” is a colonizing tool;

it serves to naturalize the dehumanizing treatment of (predominantly) Black patients by positioning the listener as a partner in the events that unfolded and therefore as someone who understands and condones what went on. I now turn to focus in more detail on the human rights abuses Dr. Mary details during this narrative.

### **White supremacy in the “dark” city.**

One of the first things that struck me when I transcribed, (re)listened to, and (re)read this interview was the importance of place in Dr. Mary’s narrative. This is not necessarily surprising, since I framed this interaction as focused on the City (e.g., “so I’m really interested to hear about your experiences working in [City], in the eighties”). However, I still find it notable that Dr. Mary focused so much on describing the setting of her residency, whereas Nurse Jane, Dr. Christine, and Dr. Three barely discussed place at all in their narratives. I argue that examining the ways in which Dr. Mary constructs the City may be a useful way for understanding the way Dr. Mary draws on master narratives to dehumanize her patients. In calling attention to these descriptions, I do not seek to define what the City was “actually” like or endorse a particular vision of the City as true or complete. Rather, I aim to identify and deconstruct the ways in which Dr. Mary’s portrayal of the City reflects White supremacist master narratives.

The first thing we learn about the City is “it was just like hell.” Dr. Mary then goes on to describe the City as a crime-ridden “wasteland.” She characterizes the City as “just like a failure,” and constructs it as a foreign land which makes her stop and wonder “my god, where am I?” Dr. Mary describes the City as a place of disease (“you’re delivering these, y’know, little babies that are, are so sick”); death (e.g., “many many times there’d be a dead baby”); and despair (e.g., “if trying to mentally get out of that situation was why you used drugs then, then- or, or to combat some inner pain? Um. There was plenty of that, there”).

Dr. Mary's description of the City reflects White supremacist and colonialist master narratives which have coalesced into the discourse of "Afro-pessimism." Afro-pessimism characterizes Africa as the "Dark Continent" (Bassil, 2011; Mudimbe, 1988) afflicted with death, disease, disaster, and despair (Hunter-Gault, 2006, p. 93). These narratives create a "pessimism about the continent's ability to overcome pressing challenges" (Nothias, 2012, p. 54). This pessimism is then used to justify (White) Western interventions to "save" Africa (Momoh, 2003) through military intervention and "development" projects. Here, again, we see the basic characters of the colonialist master narrative being employed, as Afro-pessimism continues to the non-Western Other as "the agency-less subject in need of being saved" (Dutta, 2012, p. 4). Dr. Mary reflects this sense of pessimism when she says, "it woulda had to be... something so big to change that population." Even as she acknowledges that things have improved in the City since she left, Dr. Mary makes a telling Freudian slip: "I don't know white- what quite turned it around." While unintentional, saying the word "white" instead of "what" in her description of how the City was "turned around" reflects the colonialist discourse of the "White man's burden" (Sastry, 2014).

A distinguishing feature of Afro-pessimism is that it works as a racial project in which "Africa" becomes a label or stand-in for Blackness (Nothias, 2012). The same can be said of Dr. Mary's narrative, as she constructs the City as synonymous with Blackness ("the largest majority was African American. Of course, it was the middle of [City]"). Dr. Mary also draws on White supremacist and colonialist characterizations of Natives and Black people as subhuman (Cashmore, 2004b). In her story, the natives of the City (her patients) are described in animalistic terms; they are "yelling," irrational ("you can't reason with someone who's that high"), and chained ("you'd come to that part of the ER, everyone was handcuffed to something"). The

patients are constructed as so entirely sub-human that is rare and surprising to be able to make any connection with patients at all. Dr. Mary notes that “you would be surprised about humanity” and, to illustrate her point, shares an example of a time she joked with a patient. Here, Dr. Mary seems amazed that one of her patients could engage in humor at all.

Even the supposedly humorous interaction Dr. Mary describes exposes power imbalances and abuses. Dr. Mary says she was sewing up a patient’s episiotomy (a surgical cut that may be made to enlarge the opening of a laboring patient’s vagina) when the patient protested, asking Dr. Mary (whom she called “Ms. Thing”) to stop touching her vagina. Dr. Mary, rather than seeking to comfort the patient or create a bond of trust between the two of them, simply replied “It’s Doctor Thing,” and continued with the procedure. Here, Dr. Mary responds to a patient’s request for bodily autonomy and respect by emphasizing her authoritative status. She reminds the patient that she is powerful (a doctor, not a regular woman), and continues stitching the patient’s vagina. While it is possible that the patient may have found this humorous, this experience may well have been a traumatizing experience of assault. Yet, this is an experience Dr. Mary frames as a moment of “humanity” and “contact” between herself and a the patient.

Dr. Mary also draws on colonialist and White supremacist tropes in her narrative when she describes the “Dark City” as a site for learning and advancing her own education. Historically, biomedicine has constructed European colonies as “vast laboratories” (Lock & Nguyen, 2018, p. 105) and Black and Brown people as “experimental bodies,” e.g. objects to be studied to produce Western scientific knowledge (Towghi & Vora, 2014). For instance, J. Marion Sims (the supposed “father” of American gynecology) developed his techniques for repairing vesicovaginal fistulas by subjecting enslaved women to series of brutal experimental surgeries (Washington, 2008). In the U.S., physicians have tested nuclear radiation, infectious

disease progression, and surgical technology on black people, with prison inmates particularly targeted for experimentation (Washington, 2008). Even as black people's bodies have been used as sites of biomedical knowledge production, however, Whites continue to benefit disproportionately from this knowledge, through the fame and wealth generated by "discoveries" as well as by their greater access to respectful and affordable medical care (Washington, 2008).

Dr. Mary reflects these narratives when she notes that she chose to do her training in the City because there was "plenty of research going around" and she and her fellow residents got to see "every kind of crazy complication." Here, Dr. Mary describes the pathological bodies of her Black patients as valuable because they provided her with unique opportunities to learn medical procedures ("when I went to do fellowship, I interviewed around and then I stayed there, just because there wasn't anything the same"). This dynamic allowed Dr. Mary to develop knowledge and status ("It was good... you get to work with sort of all these pretty famous people as they're starting their careers and stuff"), but the patients themselves seem to have benefited little from this arrangement—Dr. Mary admits that she felt unable to improve the health of most of her patients when she says "you feel like you can't get anywhere."

In sum, Dr. Mary describes the City (degenerate and hopeless, valuable only in terms of the knowledge she can gain there) and its people (Black, poor, sick, and sub-human), by drawing on a series of White supremacist, imperialist, and biomedical master narratives. These stock settings and characters enable Dr. Mary to make sense of the degrading treatment of patients to which she was a witness and participant.

At the same time, biomedicine as a *structure* also perpetuates the oppression of Black patients. By requiring residents to work without sleep for so long and to perform so many tasks, the biomedical structure created a set of material conditions which warped Dr. Mary's sense of

self and reality. Residency afforded Dr. Mary very few opportunities to reflect on her situation or behaviors, making it difficult for Dr. Mary to recognize oppression or protest dehumanizing practices in the moment. In other words, the hierarchical structure of physician training directly attacks the very capacities (e.g., empathy, self-awareness, reflexivity) that are needed to recognize and challenge domination. Thus far, the stories I've shared have illustrated how gendered-racist colonialist violence is carried out in the field of reproductive health in a variety of capacities. Courts force Women onto contraception and take their babies from them (because they are poor or non-White, or both), doctors push contraception onto patients (because they are young, poor, non-White, or all three), and the carceral state joins seamlessly with the biomedical industrial complex to chain Black bodies to their hospital beds. Across these sites of violence, master narratives which characterize Women of Color (especially Black Women) as lazy, irresponsible, welfare-dependent, unfit (m)Others have been key to naturalizing reproductive oppression in RHP's stories. Throughout, I have attempted to draw attention to the feelings of victimization, impotence, and futility shared by RHPs as they work within a system that oppresses their patients (often in ways they do not recognize). For this last narrative, I want to bring greater focus to this point: the ways in which biomedical capitalist health care breaks providers so that they can break patients.

### **Dr. Stacy**

Dr. Stacy is an obstetrician-gynecologist who spends most of her time doing clinical work. She primarily sees privately insured patients, doing a mix of office-based care and surgery. During our interview, Dr. Stacy spoke at a deliberate, even speed. She seemed to me like a woman who thinks carefully about what she says and who takes her words seriously. I noticed that she would often laugh after saying something particularly sad, cynical, or poignant. I



thought this might be in an effort to lighten the impact of her words or dilute the intensity of the moment, but Niv said Dr. Stacy’s laughter reminded her of “when you’re just so exhausted or so done you just laugh.” Niv thinks Dr. Stacy would laugh because there was nothing else to do. This seems like an equally valid interpretation to me.

Much of our conversation focused on Dr. Stacy’s experiences with burnout and depression during residency. Even though she spoke more openly and directly about her pain than any of my other participants, she did not cry. I thought it was extraordinarily brave of Dr. Stacy to speak about her mental health difficulties with strangers, particularly since mental illness remains highly stigmatized in biomedical communities (McNeill, Smyth, & Mavor, 2017). I am certainly not as open about my experiences with mental illness as Dr. Stacy was with us, and I admired her greatly for this.

I asked Niv how she would describe Dr. Stacy in one or two words and she said, “genuine” or “steady.” I also found Dr. Stacy intensely genuine but, despite her measured tone and deliberate words, I did not find her particularly steady. I thought Dr. Stacy was in a lot of pain and trying very hard to appear even. When she went to fill out the demographic form after we finished our interview, Dr. Stacy’s hands were shaking. The transcripts I present below are from the very end of our interview, when we had been talking for nearly two hours.

### **Dr. Stacy’s Narrative About the Things That Keep Her up at Night**

**Table 12.** “It’s Because We Don’t Acknowledge That It’s a Broken System. Uhm, That Is Designed to Destroy.”

Bria:	Umm, okay. _ I guess, the last thing is just, do you have a story .ST that you think is _ um—it could just be something that like, <u>keeps you up at night</u> , or like, a really positive experience that you had. _ Umm, but just something that _ maybe made you think about reproductive health differently. Or, _ that made you feel- like a story about __ that shows _ why res- residency is so problematic. Or speaks to any of the themes, really, that we’ve touched on. I know it’s really broad and hard. _____
Dr. Stacy:	_ Uhhmm, _____ that’s hard. _____ I don’t know that I can think of something that’s changed how I think of reproductive health. I can _____ I mean, cause the things that

keep me up at night? Aren't \_ about reproductive health in- in the abstract sense, so much as they're \_\_ just horrible patient experiences ((laughs)).

Bria: Mhm. \_

Dr. Stacy: Um.

Bria: Horrible in \_ what \_ way? Like, just something bad happened to someone? Or-

Dr. Stacy: -Yeah. Like, emotionally difficult \_ things that **you** either assume blame for \_ or that \_ are just beyond the limits of what **you** think \_ **you** can \_ accept or endure. \_\_ That kinda thing. \_ Um.

Bria: So not necessarily things related to systems or policy, but just interpersonal things? \_\_\_\_\_ Because if it's something related to \_ system or policy? Than that would be a- an important thing for us to talk about? But if it's just something interpersonal, I don't wanna make you drudge up like, terrible emotional thing that's gonna make you feel \_ crappy. \_ Excuse me. That's gonna make you feel bad. \_\_

Dr. Stacy: Umm, \_\_ no I wouldn't say that they're \_ the things that come to my mind aren't policy or systems things. They're like- they are medical things and dead babies and \_\_\_\_\_ decision-making, and- and the things that make medicine challenging? But it's not \_ the fault of a system. \_ That I can think of off the top of my head. \_ Y'know? It's things like the patient who is \_\_ um, \_ a multiple drug-user who comes in in distress and who has a \_ stillbirth. Um, \_\_ an unanticipated \_ but not, I guess, technically surprising stillbirth. Um, it's the- it's the people that **you can't** save, or those kinds of things. Those are the things that I mean. As opposed to \_\_ uhm, \_ I don't off the top of my head have a lot of catastrophic events \_ that were the result of \_ a- a system that failed us. \_\_ Uhm, \_\_ and that could be because \_ I didn't take them personally? \_ Or because we worked \_ to \_ overcome our combat that? We do a lot of work arounds. Uhm, \_\_\_\_\_ so no, I guess they're more just \_\_ personally difficult \_ situations than things that I think are \_ a systems or policy failure. \_

Bria: Mm. \_\_ Well, I mean, I'm glad that you can't think of things that \_ were just, y'know, would be different if a policy was different. When you say u- um, like a patient who had drug \_ misuse, \_ issues. Was that frustrating to you because \_ I guess, what's the most frustrating \_ or sad thing \_ about that, to you? \_\_\_\_\_

Dr. Stacy: Um, \_\_ ((laughs)) I think that that \_ situation had a lot of layers.

Bria: Mm.

Dr. Stacy: Uhm, \_ I think it was frustrating because we were not able to save that kid? I think it was frustrating because we \_ uhm, \_\_\_\_\_ ughhh, because we would never have sectioned her if we \_ realized that the baby was dead? Um, cause she had a lot of other things going on. Or maybe we would have sectioned her, I don't know. Umm, \_ I think it's frustrating \_ or not frustrating, but I think it's emotional because it \_ I think \_\_\_\_\_ very clearly identities one of the \_ most challenging things in obstetrics. Um, which is where **you can't** do anything about it, and something horrible happens, um, and then having to sit down \_ with \_\_ her family and tell them that this baby had died, when **you yourself** haven't really processed it or dealt with it. Um, but it's not \_ appropriate for **you** to be the one that's emotional and out of control in that situation. **You're** allowed to show some emotion, but it can only be so much that it doesn't interfere with **your** ability to practice. And the reality is, in a situation like that? \_

There is no some.

It's either **you** open the floodgates, or **you** hold it in.

Um, \_\_ and it is \_\_ one of the \_\_ challenging things about medicine. Is, y'know, in a situation like that, when **you** have a horrible event, that is obviously going to affect \_\_ multiple people, how do **you** \_\_ how do **you** manage your emotions? \_\_ In \_\_ the most effective way \_\_ to be able to provide the patient \_\_ and the patient's family with that support, um, while not allowing that situation to completely destroy **you**. While also recognizing that as a part of the team, depending on where **you** are in the team, **you're** also responsible for other team members. \_\_ Y'know, as the \_\_ attending, **you're** really supposed to also be looking out for the mental and emotional health of the residents that are on that team. \_\_ Um, how and when do **you** deal with that? When **you** yourself also have to deal with it. \_\_ Uhm, \_\_ and \_\_ not in that specific situation, but in a lot of those situations there's also an element of, 'Will I also have to acknowledge the risk of litigation?' \_\_ Um, especially in obstetrics. Because we've done such a good job of convincing the world that \_\_ having a baby is the most natural and safe thing in the world, and nothing ever goes wrong, and if something goes wrong it must be our fault. Um, \_\_

Bria: If anything, I've learned from this project \_\_ having a baby is terrifying. Um.

Dr. Stacy: –And it is! But the reality is, because everybody does it, people think,

'Oh, well nothing ever goes wrong. And if something goes wrong than it must be because the doctor didn't do something. Or the doctor did do something.'

And that's a lot of people's approach to it. And it's part of why malpractice is so high in \_\_ OB/GYN. Because if anything's not perfect, their first thought is,

'Well, what did you do wrongly?'

Uhm, \_\_ and it's not appropriate to say,

'Hey, a hundred years ago women were just dying in childbirth with nobody watching over them. We can just stop doing this if you'd like that better.'

Everyone: ((laughs))

Dr. Stacy: Uhm, \_\_ and then **you** have the frustrations, when there are people who are going into the woods to have their babies, because they don't wanna be anywhere near health care, because health care is the big bad. But then when one of those people \_\_ has a baby that dies, everybody cries for her and nobody thinks,

'Well, she made the decision to take that risk, because she thought doctors were stupid.'

Um, \_\_ and now it's my job to say,

'Okay, well, it wasn't your fault.'

Dr. Stacy: I don't know that I feel that way. ((laughs)) Like, ((sound like a verbal shrug))

Bria: Yeah. \_\_

Dr. Stacy: Uhm, y'know? Because, y'know, then you wanna \_\_ go out and write articles that demonize my profession and act as though I'm the devil incarnate. Like, you can't have it both ways. Either I'm the devil incarnate, or I'm really not that bad \_\_ ((laughs)) \_\_ and it's okay to wanna have a home birth, but can I suggest that you do it close to a hospital, so that you don't walk in with a train wreck and expect me to fix it and then get mad at me when I can't. \_\_ So like, there- there are a lot of frustrations in \_\_ obstetrics. Um, there are a lot of frustrations with \_\_ those patients. They are a lot of frustrations when \_\_ things

don't go well? And **you** can identify that **you** should have done something different, but there are also a lot of frustrations when things don't go well and it's because patients did something that they \_ really shouldn't have done. Uhm, and it wasn't out of ignorance. Like when somebody comes in and they lose a baby, uhm, \_ because they're on \_ all the drugs.

Uhm, \_ yeah there's a level of guilt. Like I- I took that very very personally. And I probably shouldn't have, but I did. And it's still something that \_ it's been \_ maybe a year? And it's still something that \_\_ um, doesn't make me feel good.

Um, but there's also some anger. Because, like it's not a secret that using \_ all the drugs when you're pregnant is dangerous. But, y'know, \_ delivering that patient and watching her roll away intubated to the ICU because she was in heart failure, cause of all the drugs she was taking was like, kind of a crappy feeling? And it felt \_\_ uhm, \_ it felt like a failure for us, but it also felt \_\_\_ it is hard looking back to not feel like she was so selfish. ((laughs)) \_ Because, \_ those decisions that she made, not only killed her baby but also led to a lot of mental health issues for a lot of people taking care of them. Like, \_\_ it's just so selfish. And people think,

'Oh, well it's my body and I'm doing what I want to.'

But I'm like, I- I can't— \_ this is why I can't care about you more than you care about yourself.

Bria: Mm. \_

Dr. Stacy: Um, because \_ I carry those \_\_\_ scars. \_ Uhm, for something that I don't have control over. And then she got pregnant again, like \_ six or seven months after she got out of the ICU. Like, it's selfish. ((laughs)) ((laughing)) Like, \_ it's so selfish.

Uhm, \_ and it's not. It's more complicated than that, and addiction is a big deal. But that's \_ it's hard to not feel that way. Because, nobody \_\_\_ everybody cares about what the patient experiences when something horrible happens. Nobody really cares about what the providers feel, and I don't just mean the physicians. I mean the nurses. I mean the people who have to take care of these people afterward. Like, nobody \_ when- when people hear that story they say,

'Oh my gosh, it sounds so horrible for her.'

But nobody thinks about what it's like to deliver a dead baby. Nobody thinks about what it's like to watch a patient die in front of **your** eyes. Nobody thinks about what- about the toll that that takes on the people who take care of them.

Uhm, \_ and I have sat in rooms and watched nurses sob over things that they had absolutely no control over. \_ Uhm, \_ and it's just frustrating. Medicine is a very frustrating thing to do. \_ So. \_\_\_

Bria: Thank you for sharing all of that. I've just \_\_ I feel like \_ I've learned a lot about the emotional labor that nobody talks about [inaudible] talking to you, so I really appreciate—

Dr. Stacy: —I'm still very broken, so ((laughs)) Like, \_

Bria: It's a broken world.

Niv: Yeah.

Bria: So. \_ But. \_\_\_ Is what you just said something that \_ you would feel comfortable putting in the book? Or is that not something that you want \_ in the book? \_\_\_

Dr. Stacy: I don't know which part you mean, but I think I'm fine with everything I said being \_ public knowledge—

Bria: –I think just that last part–

Dr. Stacy: –I don't think I said anything that was identifying, about the patient.

Bria: Mhm. No it's not. \_\_\_ I just think that's a really important—to me? What you just said is really important in terms of acknowledging that \_ emotional labor \_ and the emotional cost of seeing \_ these really hard terrible things happen, that is not acknowledged.  
[inaudible]

Dr. Stacy: –I think, sometimes that's harder in obstetrics because of the fact that babies are involved.

Bria: Yeah. \_\_\_

Dr. Stacy: People feel sad when old people die. People feel \_\_\_ everything, when babies die. \_\_\_ Um, but yes. I'm fine with you \_\_\_ it's not a secret. I think I've told a lot of people about this patient cause \_ she's- she was the trigger for me ending up in therapy. So ((laughs)) \_ So I'm \_ I'm fine with it being \_

Bria: Thank you for being so open about \_

Dr. Stacy: Yeah

Bria: Being in therapy, too. Cause there's a huge stigma around that in medicine and \_ I think it's like, really important,

Dr. Stacy: I think when **you** get to a certain point that **you** need it.

Bria: Yeah

Dr. Stacy: I got to a point where my mother was asking me if I was gonna finish the last few months of residency. Which is crazy. Cause after all of the work that I'd done, to think that I would leave then.

Um, \_ but, \_ I \_ I honestly think that there are probably way more residents out there \_ who are way more damaged than they will admit, or than anybody will ever acknowledge.

Um, \_ because we have done such a great job of normalizing abnormality, and because we have done such a great job of telling people that \_ if they're okay? If they are \_\_\_ if they're good at what they do, and if they're \_ strong, that they will never feel that way. And it's just very frustrating, and it's very exhausting, and it's why people leave residency and say things like,

‘I hate the person that I became in residency.’ \_

It's because we don't acknowledge \_ that \_ it's a broken system. \_ Uhm, \_ that is designed \_ to destroy, to some extent ((laughs)).

That's a very negative thing to say, but it's also \_ not untrue. ((laughs))

Key: **Bold** = Generalized “you”

### **The physician as victim, the patient as perpetrator.**

Dr. Stacy's narrative is consistent with Dr. Three and Dr. Christine's stories insofar as Dr. Stacy herself is constructed as the victim. Dr. Stacy repeatedly emphasizes her own helplessness and

the helplessness of other HPs throughout her story (“I carry those scars... for something that I don’t have control over”; “we were not able to save that kid”; “you can’t do anything about it”). She also draws attention to her impotence by positioning herself as the passive object pushed by others’ actions (“she was the trigger for me ending up in therapy”) and by describing herself as a viewer who is unable to intervene in the actions going on around her (e.g., “nobody thinks about what it’s like to watch a patient die in front of your eyes”). In contrast, Dr. Stacy constructs her patients as quite agentic. She describes her patients as actively making choices which have real consequences (“it’s because patients did something that they really shouldn’t have done”; “those decisions that she made, not only killed her baby but also led to a lot of mental health issues for a lot of people taking care of them”; “[patients] go out and write articles that demonize my profession”). In Dr. Stacy’s narrative world, patients have the power to write articles which (negatively) define what it means to be a physician, patients have the power to sue doctors who have done nothing wrong, and patients have the power to inflict mental anguish upon their healthcare providers. While a great deal has been written about the power of physicians (Brody, 1994; Starr, 1982), Dr. Stacy suggests that doctors are at the mercy of litigious patients, slanderous writers, and (most centrally) master narratives which dictate how physicians can and cannot express emotion.

While Dr. Stacy avoids the paternalistic (often colonialist) trap of constructing her patients as props or victims devoid of agency who must be saved, patients still do not fare well in her story. By framing drug use or “going into the woods” to have babies as choices made actively by patients, patients become culpable. Dr. Stacy insists that the stories she tells are “not the fault of a system” but are “just personally difficult situations.” It does not occur to her that patients’ fear of physicians may stem from awareness of institutionalized medical oppression, or

that drug misuse may be related to lack of support services or treatment programs. Here, then, patient agency becomes a site of responsabilization (Wakefield & Fleming, 2009).

### **A wounding story.**

Narratives are widely understood as tools for healing identities which have been disrupted by illness (Frank, 2013), shaken by grief (Bosticco & Thompson, 2005) or damaged by dominant narratives (Nelson & Lindemann, 2001). By constructing narratives, “wounded storytellers” are able to restore a sense of order, intelligibility, and agency in their lives (Bosticco & Thompson, 2005; Nelson & Lindemann, 2001). However, I do not see quest, restitution, or even chaos in Dr. Stacy’s narrative (Frank, 2013). There is no goal in sight, lesson learned, or even a sense of retrospectively picking up the pieces to make sense of past disorder. Dr. Stacy’s narrative is not disordered: she delivered a dead baby, watched the patient taken to the ICU in heart failure, and went to give the bad news to her patient’s family in a controlled, respectful manner. Dr. Stacy knew the steps she was expected to take and she followed the steps exactly. I think what makes this story different from the others is that it’s a story of *wounding*. The injury is not in the past, but an ongoing assault. As Dr. Stacy says, “I’m still very broken.”

### **“You” again.**

Like Dr. Mary, Dr. Stacy frequently uses generalized “you” to distance herself from painful emotions and dilute responsibility. For instance, Dr. Stacy says that the things that keep her up at night aren’t the fault of a system, but are patients who come in with stillbirths and “the people **you** can’t save.” Here, it is understandable that Dr. Stacy would not want to accept full responsibility for the patient’s death by saying “the people *I* couldn’t save.” This sentence construction might also be impossibly painful to speak. Many times, Dr. Stacy seems to use “you” to distance herself from the anguish centering herself would entail. How painful it would

be switch her sentence about the things that keep her up at night from “emotionally difficult things that **you** either assume blame for or that are just beyond the limits of what **you** think **you** can accept or endure” to “emotionally difficult things that... are just beyond the limits of what I think **I** can accept or endure.”

In Dr. Stacy’s case, I argue that generalized “you” also works as a resistive device. By positioning Dr. Stacy as speaking for a broader group of people who share her experiences and ideas, “you” provides Dr. Stacy with credibility and authority needed to effectively challenge master narratives about how the Good Doctor should experience and perform emotions. For instance, Dr. Stacy justifies her decision to begin therapy by saying “I think when **you** get to a certain point that **you** need it.” Generalized “you,” by implying that other HPs may also reach a point where they need to seek therapy, enables Dr. Stacy to contests dominant narratives which construct the Good Doctor as a physician who is emotionally detached and able to witness death and suffering without experiencing power emotions in response.

#### **A resistance narrative.**

In many ways, Dr. Stacy’s story represents a resistance narrative (Tullis et al., 2017). Dr. Stacy uses her narrative as a platform to counter stories she hears coming from the public which portray “health care is the big bad” and physicians as “the devil incarnate.” She also expresses frustration with the script she knows she is supposed to follow after patients experience a tragedy. Dr. Stacy recognizes that she is socially expected to absolve patients of their responsibility to make them feel better: “and now it’s my job to say, ‘Okay, well, it wasn’t your fault.’” Even when Dr. Stacy does not believe this. Most centrally, Dr. Stacy expresses the hurt caused by the emotional rules expected of doctors, which require doctors to push their own sadness and anger to the background to provide technical care to their patients and emotional



support to patients, families, and other HPs: “It’s not appropriate for you to be the one that’s emotional and out of control in that situation. You’re allowed to show some emotion, but it can only be so much...”; “When people hear that story they say, ‘Oh my gosh, it sounds so horrible for her.’ But nobody thinks about what it’s like to deliver a dead baby”; “Because we have done such a great job of normalizing abnormality, and because we have done such a great job of telling people that if they’re okay? If they are... good at what they do, and if they’re strong, that they will never feel that way”. Thus, Dr. Stacy’s narrative is actively waging war with norms about how physicians should behave and with narratives about what it means to be a doctor. When Dr. Stacy says, “It’s a broken system... that is designed to destroy,” she does not mean the prison industrial complex or the foster care system, she is speaking about a system of narratives which demand that doctors “be strong” by showing emotions in only very specific ways and by always putting the emotional needs of others before their own.

Locating myself within this story, I believe that Dr. Stacy has every right to feel let down and angry about the situation she describes. However, I do not agree with the direction in which she targets her anger. Her story draws our attention to further ways in which the biomedical system is set up to create barriers between patients and HPs. Take this extended quote from Dr. Stacy:

I carry those scars. Uhm, for something that I don’t have control over. And then she got pregnant again, like six or seven months after she got out of the ICU. Like, it’s selfish. Like, it’s so selfish. Uhm, and it’s not. It’s more complicated than that, and addiction is a big deal. But that’s- it’s hard to not feel that way. Because, nobody- everybody cares about what the patient experiences when something horrible happens. Nobody really cares about what the providers feel... When people hear that story they say, ‘Oh my

gosh, it sounds so horrible for her.’ But nobody thinks about what it’s like to deliver a dead baby. Nobody thinks about what it’s like to watch a patient die in front of your eyes. Nobody thinks about what- about the toll that that takes on the people who take care of them.

Here, it becomes clear that Dr. Stacy’s pain comes not from witnessing death, but from the fact that “nobody” cares about her pain. Logically, Dr. Stacy understand that addiction is complicated and not just evidence of selfishness. However, “it’s hard not to feel” that patients who misuse substances are selfish, because “nobody really cares about what providers feel.” By sustaining a system in which HPs emotions are invalidated and silenced, we create a system in which it becomes difficult for HPs to recognize or affiliate with the pain their patients experience. Unable to find validation or care for her pain, Dr. Stacy’s anger becomes narrowly directed towards patients, the most visible and immediate targets for her frustration. Thus, neoliberal master narratives which characterize drug addiction as a sign of personal moral weakness (Harding, 1986) and White supremacist narratives which differentially assign blame for this supposed moral weakness (Netherland & Hansen, 2017) develop further power, giving greater support to the institutions of prison and foster care which punish (m)Others who use drugs because they are regarded as selfish (D. E. Roberts, 2012). In other words, feeling “broken” leads Dr. Stacy to accept master narratives which individualize responsibility for addiction and, therefore, fuel harsh treatment and punishment of Mothers who use substances. By dehumanizing HPs, these master narratives thus engender further opportunities for dehumanizing patients.

## CHAPTER FIVE

### DISCUSSION AND CONCLUSION

*So, I'm just telling what I've seen. Which, a lot of people haven't. Or haven't been tuned in to see it. Once you kind of realize what's going on, you can't unlearn it. You can't un-see it anymore. (Dr. Allison, OB/GYN)*

*If we look at the literature based on field work in the United States, we find a relatively abundant literature on the poor... the disadvantaged; there is comparatively little field research on the middle class and very little firsthand work on the upper class. Anthropologists might indeed ask themselves whether the entirety of field work does not depend upon a certain power relationship in favor of the anthropologist, and whether indeed such dominant-subordinate relationships may not be affecting the kinds of theories we are weaving. What if, in reinventing anthropology, anthropologists were to study the colonizers rather than the colonized, the culture of power rather than the culture of the powerless, the culture of affluence rather than the culture of poverty? (Nader, 2018, p. 16)*

*Recently I attended a medical-school symposium on pain and ethics.... [It] concluded with the chair of anesthesiology. He spoke gravely and precisely about the burdensome demands on his budget and staff, citing multiple troubles that included university cut-backs in funding and state directives about mandatory care for the poor. His grave and measured tones left me unprepared for his sweeping conclusion. When it comes to the treatment of pain in his department, he stated, "It is no longer possible to do the right thing."... This particular medical quandary is not about the failure of specific moral agents but about the insignificance of individual moral agency. The problem is less with persons than with their relation to an amorphous, impersonal, unfixable system... In his confession of powerlessness, the chair of anesthesiology identifies a point where medicine needs to take seriously the understanding that ethics involves more than principles: it also involves, as ethicists are beginning to recognize, stories. (Morris, 2001, pp. 61–62)*

In this thesis study, I applied the method of Critical Narrative Analysis to investigate the ways in which reproductive healthcare providers communicate about the intersections of race, reproductive health, and policy. By combining insights from critical health communication, Postcolonial, and Reproductive Justice theories (which draw attention to relations of power and control, structural oppression, and the intersections of race, gender, and class) and narrative

inquiry (which provides tools for closely examining meanings constructed through everyday interactions) my thesis contributes to a larger social justice project of connecting the personal with the political to identify opportunities for resistance and transformation (Dutta, 2014a; Harter, Japp, et al., 2005; Joffe, 1987).

After conducting interviews, transcribing audio-recordings, re-reading and re-presenting transcripts, and writing, I conclude that the RHPs I interviewed communicated about race, reproductive health, and policy by connecting their lived experiences with master narratives. The stories these RHPs told responded, recycled, and rejected the characters (e.g., the Welfare Queen, the Good Mother; the Good Doctor; the Black (m)Other, the teenage (m)Other); settings (e.g., the Dark City, the idealized U.S.); themes (e.g., American Exceptionalism, meritocracy, personal responsibility); and sacred objects (e.g., contraception) of dominant narratives. However, even as the characters and settings recurred across stories, their trajectories and interpretations diverged. While Dr. Christine constructed her patients as victims who are rendered helpless by an unjust system, Nurse Jane portrayed her patients as wily deviants who need to be controlled. While Dr. Three envisioned herself as a hero on a noble quest to save her patients, Dr. Stacy represented herself as a victim. Dr. Christine insisted that meritocracy is a myth, even as Dr. Three encourages her patients that they can achieve anything.

In other words, a search for “the” perspective of RHPs would be futile—my participants often contradicted each other, and sometimes contradicted themselves. Insisting that we must uncover a single story will lead us nowhere. Today, “multiple forms of power are at work creating tensions, alignments and disjunctures between biomedicine, public health and a politics of life (Rose, 2001) that is constitutive of human subjectivity. Understanding the contemporary politics of [reproductive health] necessitates a move beyond antimedicine” (Mykhalovskiy,

Mccooy, & Bresalier, 2004, p. 321). To understand how RHPs become enlisted in patriarchal White supremacist imperialist reproductive oppression, then, we must recognize contradictions as well as continuities.

Attention to the disjunctures and contradictions in RHPs' stories exposes master narratives as unstable and, therefore, vulnerable to counter-stories which can challenge their dominance (Harter, Japp, et al., 2005; Nelson & Lindemann, 2001). These contradictions are evident in many of the accounts I've shared, such as the frustration and conflict expressed by Dr. Albertha when she recounted instances in which Black people have been systematically punished more harshly than Whites, thereby disrupting the myth of colorblindness in the U.S. Yet, Dr. Albertha maintained her personal commitment to colorblindness and treating all patients "the same," even as she recognized that this is not how her patients are treated by the wider world. While this contradiction suggests the tenacity of master narratives, it also demonstrates that there are discursive openings for challenging these narratives. For example, an effective counter-story may begin by discussing racial inequities Dr. Albertha already recognizes. The counter-story could use this shared understanding as a springboard for launching a larger critique of gendered-racist practices in reproductive medicine.

In short, I argue that recognizing the fissures and contradictions within and across RHPs' narratives is important for developing effective narratives of resistance. With this said, I now turn to patterns I observed across narratives. Again, each of these points will not apply to every narrative but, in drawing these connections, I seek to expose areas where master narratives are vulnerable and/or where counter-stories are most needed.

## **Drawing Connections Across Participants' Narratives**

- 1. The capitalist, biomedical model of health care in the U.S. attacks the humanity of RHPs, particularly those who might challenge dominant narratives and practices. When RHPs are systematically harmed, they may be unable to understand or interrupt practices which oppress their patients.*

As Real and colleagues (2009) point out: “individual physicians are challenged by a myriad of material forces, including economic (third-party payers), legal (malpractice), and organizational (newer forms of health-care delivery), that affect the way they communicate with patients and how they view themselves as professionals” (575). To make sense of my participants’ narratives, then, it is important to place them within these context(s).

One often discussed characteristic of healthcare delivery in the U.S. is the standard fifteen-minute physician visit (Rabin, 2014). Across my interviews, RHPs reported frustration with the appointment time limits imposed by clinics and hospitals. Historically, these time limits were implemented as organizations sought to maximize revenues after Medicare changed reimbursement policies in a manner which provides relatively low compensation for time spent on patient counseling, as compared to time spent performing procedures (Linzer et al., 2015; Rabin, 2014; Rosenthal, 2018). Consistent with other research, my participants cited time pressure as a major source of stress in their work (Dugdale, Epstein, & Pantilat, 1999) and believed that the expectation that they complete each patient visit in fifteen minutes makes it difficult to connect with patients or maintain an awareness of the human side of medicine. The rigidly hierarchical structure of healthcare delivery in the U.S. means that those doctors who are least enculturated into biomedicine (e.g., residents and trainees) also have the least time to spend with patients or develop relationships with them.

In fact, across my narratives, participants voiced again and again the ways in which they felt disenfranchised by the structure of medical residency. Beyond limiting the time they can spend with patients, the intense schedules assigned to trainees mean that they have few opportunities to reflect on their behavior. Dr. Mary, for instance, was so busy and tired during her residency that she did not realize she was treating her patients “terribly” until after she finished her training. Even if residents find time to critically reflect on their work, they have little organizational authority to make changes. I argue that residents who are overtired or feel powerless may be more easily conscripted into gendered-racist projects. Perhaps Dr. Albertha would not have viewed the oppressive foster care policies she witnessed as unalterable facts if she had not been a resident, accustomed to following the example set by her attendings, when she was exposed to these policies. In sum, I argue that narratives shared by a section of my participants suggests that the hierarchical structure of medical training maintains the stability of the biomedical system by overworking, devaluing, and silencing group members who are least enculturated into biomedicine and, therefore, most likely to recognize problems with dominant narratives.

My data, especially Dr. Stacy’s narrative, also suggests that biomedical systems marginalize HPs whose emotional experiences challenge the model of “detached concern” promoted in biomedical master narratives (Crowe & Brugha, 2018; Marcum, 2008). RHPs may find that there is no acknowledgement, acceptance, or validation of their sadness and grief within their organizations. When their emotions are dismissed or denigrated, RHPs like Dr. Stacy may develop feelings of bitterness or anger towards patients. In this way, the dehumanization of RHPs, perpetuated through dominant narratives, may encourage RHPs to regard their patients as antagonists, so that patients (rather than systems) become the targets for blame and stigma.

In sum, my data indicate that the capitalist biomedical system and its narratives dehumanize providers by limiting the time they have to communicate and connect with patients, silencing and devaluing trainees who could bring new and subversive perspectives to medical practice, and punishing RHPs whose emotional experiences fall outside dominant scripts. Providers who do not have time or space to question the taken-for-granted, to form relationships with patients, or to experience the full range of human emotions, are unlikely to challenge oppressive medical practices (such as the criminalization of addiction, White supremacist foster care protocols, or court-ordered contraception). These narratives demonstrate, then, the ways in which the U.S. capitalist biomedical system operates: breaking the humanity of providers so that they are conscripted into the denigration of marginalized patients' rights.

2. *Participants recognized structural constraints in their own lives, but had difficulty applying this awareness to the lives of their patients. This tendency may lead to the obfuscation of structural oppression and discourage the practice of relationship-centered medicine.*

Many of my participants were quick to point out the ways in which their own agency is circumscribed by structural conditions. Dr. Three, for instance, realizes that immigration and insurance policies limit her ability to treat marginalized patients. Dr. Stacy recognizes that dominant narratives about emotional performances among physicians can wreak havoc on providers experiencing depression. Still, Dr. Three expects her patients do break out of the “cycle of poverty” by postponing pregnancy and going to college and Dr. Stacy believes that a patient who has multiple pregnancies while using drugs is selfish. Even when RHPs do recognize that their patients face structural oppression they may continue to blame patients for failing to follow normative cultural scripts. Nurse Jane exemplifies this, as she admitted that contraception can be expensive for patients but, simultaneously, argued that patients become pregnant



repeatedly because they are “lazy” or irresponsible. These providers miss that patients (just like RHPs) face structural barriers which limit their resources or which insist they follow a set of norms that contradict their lived experiences.

I believe that this cognitive contradiction produces a dynamic in which my participants came to understand themselves as victims with little power, while regarding their patients as agents who can be blamed for their own suffering. Nurse Jane, for example, described her patients as antagonists who need to be subdued and Dr. Stacy described a patient who used drugs as the killer of her own baby and the cause of mental health issues for her providers. Such a perspective seems not only distorted but also unlikely to promote the foundations of relationship-centered medicine, such as compassion, trust, and openness (Duggan, 2014). Furthermore, RHPs who do not recognize structural oppression in their patients’ lives are unlikely to advocate for political changes to address reproductive oppression.

*3. Participants regarded contraception as a solution to social problems, even when they recognized structural oppression, and their narratives about contraception and motherhood may be used to support ongoing projects of reproductive coercion.*

Dr. Three, Dr. Christine, and Nurse Jane all explicitly argued that low-income and young or teenage patients should not be parents and suggested that convincing patients to take contraception (especially LARCs) is an important priority. Although their narratives do not focus on contraception, Doctors Albertha, Mary, and Stacy also suggested that women who use drugs cannot be fit Mothers and implied that such women should control their fertility. Thus, participants recycled master narratives which distinguish the Good Mother (White, middle-class, married, adult) from the Bad (m)Other (Black, poor, young, single) when performing their stories.

Either directly or indirectly, then, participants positioned contraception as a “Holy Grail” (Frank, 2004) which can rescue their (poor Women of Color) patients from poverty and save unborn babies from being born to unfit Bad (m)Others. This discourse aligns with historical biomedical-colonialist narratives which have portrayed modern technical innovations as the solutions to poverty (Trujillo-Pagan, 2013). This framing positions poverty as an essentially technological and apolitical problem, thereby leaving structural forms of oppression uncontested (even unnoticed). Constructing contraception as the solution to poverty also revives the colonialist and White supremacist theme that non-White cultures are “barriers” which must be eliminated and re-made to follow the White Western model (Trujillo-Pagan, 2013). Here, Black Women’s mistrust of contraception or desires to have children become regarded as emblems of ignorance or symptoms of a pathological culture. This mistrust, in turn, is utilized as justification for the criminalization and control of Black Women’s reproduction (D. E. Roberts, 1993). Although occasionally structural racism or health system failures were acknowledged or challenged in some fashion (as by Dr. Three, Dr. Christine, and Dr. Albertha), my participants mostly maintained a commitment to dominant depictions of contraception, Good Mothers, and Bad (m)Others. Consequently, even when they advocated for structural change, their stories rarely subverted the master narratives that uphold these structures.

*4. Participants tended to be represent their patients either as active antagonists or helpless victims. This trend may be particularly harmful to patients of color, since it aligns with master narratives which position people of color as either dependent upon Whites or pathologically resistant.*

RHPs varied in the extent to which they acknowledged their patients as agents, but recognizing agency—e.g., the capacity to live within, engage with, and transform societal

structures (Dutta & Basu, 2017)— in patients often created resentment or blame rather than feelings of affiliation or solidarity. Nurse Jane saw her patient who resisted her court-ordered contraception as quite active, but her agency comes from defying the expectations of courts and RHPs, making her Nurse Jane’s foe. On the other end of the spectrum, Dr. Christine showed great compassion for her patients, but regarded them primarily as helpless victims who need to be saved. Here patients face a double-bind: they can be regarded as helpless victims or as empowered enemies. This irony may be rooted in the biomedical master narrative which suggests that physicians should be “helping” patients and that patients should passively obey their providers’ orders (Real et al., 2009; Trostle, 1988). Thus, patients who demonstrate agency are immediately defying the master narrative of biomedicine, and may easily become regarded as deviants or adversaries. This is particularly true of poor patients of color in the reproductive health setting, since White supremacist narratives demand that they always use contraception and do not have children.

Patients of color are also doubly vulnerable to this dilemma, since both roles reflect White supremacist and colonialist stereotypes about people of color. Patients of color who are constructed as “victims” became ensconced within colonialist narratives which depict non-White Others as dependent on science-wielding Whites (as with Dr. Three’s uninsured patients). On the other hand, patients of color whose agency is recognized become constructed as defiant individuals who make selfish and irresponsible decisions, following colonialist and White supremacist narratives which construct resistance as a symptom of pathology (Akinyela, 2002; Trujillo-Pagan, 2013).

5. *Consistent with the biomedical master narratives, participants tended to regard their agency as restricted to the practice of medicine.*

Participants in this study tended to construct their agency in fairly narrow terms, presenting their influence as confined to clinical spaces. Dr. Albertha, for instance, argued that it is not worthwhile for her to spend time in her daily life worrying about how Black Mothers are disproportionately punished by foster care, since she believes the criminal (in)justice system is something that she cannot affect. Even as Dr. Christine referenced an article which advocates for physicians to engage in political activism and organizing, she focused the conversation on her feelings of impotence rather than on opportunities for her to use her authority as a physician to advocate for change.

As previously argued in my results chapter, the ways in which RHPs define the limits of their agency may be related to identities they've developed in relation to the master narrative of biomedicine. The biomedical model characterizes the Good Doctor as one who is apolitical and focused on caring for patients within the boundaries of clinics and hospitals (Lupton, 2012; D. E. Roberts, 1996). It also suggests that HPs may lament but cannot change oppressive structures and that they should, therefore, focus their energies on spreading modern technologies if they hope to reduce poverty (Trujillo-Pagan, 2013, p. 218). These master narratives appear to have profoundly influenced my participants' conceptions of themselves as actors. I do not wish to discount the time constraints and emotional pressures RHPs must navigate. Even so, doctors occupy privileged spaces within U.S. society, both materially and in terms of social status (Charrow, 2018; Scambler & Britten, 2001). The fact that my physician participants so rarely considered activism or organizing for structural change as an option, despite their position of economic advantage and cultural authority, suggests that master narratives have powerfully influenced their self-concepts.

6. *Participants' lived experiences of practicing medicine rarely aligned with dominant depictions of the Good Doctor.*

Few of my participants felt empowered to affect large-scale political change. However, even within clinical spaces, my participants rarely characterized themselves as empowered victors. Rather, Dr. Mary feels her personality was warped by residency, Dr. Christine and Dr. Three feel powerless to help their patients, Nurse Jane is stuck in a time loop in which the same unwanted results repeat again and again, and Dr. Stacy feels broken by the erasure of her pain. While their adversaries varied from story to story (sometimes it was patients, sometimes policymakers, sometimes blame was not pointed in any clear direction), many of my participants described similar experiences of frustration, sadness, and burn out related to their work.

As I have argued, I believe that the biomedical narrative about what it means to be a Good Doctor has provided unrealistic expectations which sets physicians up for failure. The idealized Good Doctor's emotional detachment, singular responsibility to "save" the Other, and narrow focus on individual patients creates demands which are both emotionally draining and materially impossible to fulfill, leaving actual doctors feeling disempowered and burnt out.

It is possible that the feelings of burn out, helplessness, sadness, and brokenness several of my participants described may actually create an opportunity. Dissatisfaction with the status quo indicates that some RHPs may be open to counter-stories which contest the neutral beneficence of biomedicine and capitalism. Dr. Christine's feelings of frustration and sadness that she could not help her patients, for instance, led her to identify with an article which argued that recognizing and changing the systemic oppressions patients face is key to addressing physician burnout. I argue, then, that further efforts should be made to explore physician identity as a site of narrative intervention. Specifically, efforts to develop stories which describe new

ways of embodying the Good Doctor could both help physicians realize their power as political agents *and* address burnout by developing a new set of expectations for doctoring which would be more achievable within the constraints of the current U.S. health system. I will discuss this issue further in my “Contributions” section.

### 7. *Narratives matter.*

If I have demonstrated anything with this thesis, I hope that I have illustrated that narratives matter for reproductive justice (Ross et al., 2017). For the mothers whose babies are stolen from them because they used a drug associated with Blackness; to the woman who is forced to take contraception by court order because she cannot be a normative Mother; to the patients handcuffed to their hospital beds because White supremacy labeled their addiction a crime, rather than a disease; to the young woman who comes to a health clinic hoping she is pregnant but leaves with a LARC because her doctor does not think now is the “right time” for her to have a child; reproductive justice is a matter of love, life, and death. Access to abortion and contraception are vital, but they will not address the multiple, interlocking forms of oppression which assault these patients. Stories about Good Mothers and Bad m(Others) create the conditions which determine which parents are allowed to raise their children. Stories about what it means to be a Good Doctor create environments where mental anguish is silenced, where abuse of patients goes unquestioned, and where potential for change remains unrealized. By sharing these stories and contextualizing them within White supremacist, colonial, biomedical, patriarchal, and neoliberal conditions, I hope this thesis adds to an already substantial body of work which supports the need for understanding both structures and stories to achieve reproductive health and justice (Ross et al., 2017; Ross & Solinger, 2017).

## **Methodological and Theoretical Contributions**

First, my project makes a methodological contribution to Communication research on narratives by introducing a Communication-based approach to Critical Narrative Analysis. Scholars like Harter (2009) have urged Communication researchers to study the relationships between everyday narratives, master narratives, power, control, and resistance and there have been several studies which successfully respond to this call (Basu & Dutta, 2007; Buzzanell & Ellingson, 2005; Harter, Kirby, Edwards, & McClanahan, 2005; Tullis et al., 2017). However, although approaches to CNA have been outlined in fields such as education (Souto-Manning, 2014) and psychology (Langdrige, 2007), I believe that my project is the first to explicitly outline a process for CNA grounded in Communication theory. By describing the steps I took to conduct CNA and by including the toolkit I developed to facilitate the CNA process, my thesis contributes a methodological tool that may be useful to future researchers.

My thesis project also contributes to Communication research in several theoretical areas. First, this project demonstrates the importance of applying a communication lens to the study of gendered-racist reproductive oppression. In April of 2019, a search of the Communication Abstracts database with the term “reproductive justice” yielded only fourteen results—none of the articles retrieved were published in a journal supported by the National Communication Association. In illustrating the ties between narratives and materiality in reproductive health, I hope my study will motivate further research in these areas. A Communication-oriented approach is also useful for integrating insights from Reproductive Justice, Narrative Medicine, Critical Race, Critical-Cultural, and Postcolonial theories on race, inequities, and health. By theorizing White supremacy, patriarchy, and colonialism as both master narratives and structures, and by understanding personal narratives as sites of agency negotiated within

particular structural and cultural locations, this thesis shows how these diverse (and often discrete) theories can be integrated into a cohesive framework, with communication as the central point of theoretical contact.

Next, while a significant body of academic research on reproductive health disparities has focused on understanding the experiences of patients (often with the goal of intervening to change patients' behaviors), comparatively little research has examined the experiences and perspectives of reproductive healthcare providers (Williams et al., 2015). Insofar as physicians continue to be associated with Whiteness, masculinity, and Western modernity in the U.S. (Essed, 2005), the sustained focus on patients' behaviors in health equity research may reflect colonialist master narratives which position Western White Men as the subjects and never the objects of knowledge (Yancy, 2008). Certainly, efforts to listen to and amplify the voices and stories of marginalized people are the key to advancing Reproductive Justice. With this said, I believe this project contributes to theorizing on reproductive oppression by reversing the traditional direction of the research gaze (Aguilar, 2012).

Additionally, most research on health disparities either eschews the idea that HPs may hold racist beliefs or has spoken about HP racism through evasive euphemisms (Bridges, 2011; Hoberman, 2007). Therefore, I hope that my efforts to direct the research gaze "up" and to link RHPs' sense-making with oppressive master narratives can disrupt the taken-for-granted notion that HPs are neutral, benevolent, and colorblind (Cunningham & Scarlato, 2018; Lupton, 2012; Monrouxe, 2009).

Finally, my project brings light to areas where counter-stories may be particularly effective in disrupting reproductive oppression. RHPs (especially physicians) in my study expressed a great deal of dissatisfaction with the current state of the U.S. healthcare system. I



have argued that this discontent is caused (at least in part) by master narratives about what it means to be a Good Doctor, which have provided unrealistic expectations and set physicians up for failure. I suggest, therefore, that the Good Doctor narrative is vulnerable to re-storying, as physicians may be open to constructing alternative identities which are more achievable, meaningful, and fulfilling.

Currently, the Good Doctor character reflects the values of Western modernity, White supremacy, and patriarchy (Essed, 2005). Re-storying the Good Doctor thus presents an opportunity to write new identity stories which reject oppressive norms and encourages a more just and equitable way of doctoring. Communication scholars, with our expertise in social construction of identity and discursive power, may be well-suited to partner in these efforts. For those interested in leading these conversations who are also committed to advancing social justice, it may be worth reflecting on questions like: What would an RHP identity based around affiliation and solidarity with patients look like (Charon, 2012; Doval, 2018)? What kind stories might help RHPs come to recognize political activism, as Eisenstein (2018) suggests, as an act of self-care? What kind of identity stories might help RHPs reconsider their allegiance to the White heteronormative bourgeois script? My thesis does not provide answers to these questions. However, by identifying an area where physicians may be receptive to change, this project contributes to social justice projects by identifying a new space for Communication-oriented activism.

### **Ethics and Reflexivity**

While I focused primarily on my participants' words in my analysis sections, I now wish to draw attention to my own role as story "coaxer" and co-creator (Plummer, 1995). First, my transcripts demonstrate multiple instances in which I drew on the same White supremacist and

colonialist master narratives as my participants. For instance, in my interview with Dr. Mary, when she first told me that there was a prison in her hospital during residency, I asked her, “Was that for if patients got violent?” Here, rather than recognizing the complicity between the prison industrial complex and biomedicine, my first reaction to Dr. Mary’s story was to draw upon White supremacist narratives which characterize Black people (especially Black men) as dangerous and violent (Oliver, 2003). This moment (and several others) in which I unintentionally drew on White supremacist master narratives during my conversations with participants reminds me that anti-racist solidarity is a process, not an identity (Leonardo & Zembylas, 2013). This project is not an effort to distinguish myself as a “good non-racist White” (Leonardo & Zembylas, 2013) and I do not wish to suggest that I am morally superior to my participants. I take examples of my own White supremacist speech in these transcripts as reminders to continuously develop reflexivity and critical thinking about my language and beliefs.

With this said, in retrospect, I feel even more disappointed in myself for nodding, smiling, and laughing with participants when they drew on White supremacist, colonialist, and/or gendered-racist master narratives. For instance, while I realized at the time that many of her comments drew on racist discourses, I never expressed this to Dr. Three when she spoke about the “Third World” and “Africa” in disparaging terms. At the time I conducted my thesis interviews, I felt hesitant to “call out” my participants, as I believed qualitative researchers should primarily listen during interviews and try to understand their participants’ perspectives rather than engage in debates with interviewees. In retrospect, I now view this stance as an excuse to protect my own White racial comfort (DiAngelo, 2011). First, I certainly could have probed further into participants’ White supremacist statements and offered alternative

perspectives, even if I did not wish to delve into a full-on debate. Additionally, I feel it is a coward's way out to critique my participants' words retrospectively without ever being willing to voice my concerns to their face. Thirdly, I now believe that research conventions which suggest that interviewers should avoid disagreeing with participants reinforce the status quo, at least in the context of research on members of powerful groups. Finally, I now regard it as an act of selfishness to prioritize my own needs for "uncontaminated" data over my ethical obligation to disrupt White supremacist and colonialist ideologies. I greatly regret my decision to say nothing (and even laugh, if uncomfortably) when I was confronted by White supremacist discourses.

A key tenet of Postcolonial scholarship is the move towards researcher reflexivity (Shome, 1996), a process which "returns the gaze on the researchers and the position of privilege that they occupy, continually questioning the ways in which they participate in the production of knowledge, the politics embodied in the production of such knowledge, and the specific instruments that they use to co-construct knowledge and to report it" (Dutta, 2014, p. 285). Thus far, I have attempted to demonstrate reflexivity by showing that, in drawing on White supremacist discourses and essentializing groups such as "Women" and "patients of color" during my research writing and processes, I have sometimes re-inscribed the oppressive power structures I've sought to critique (Broadfoot & Munshi, 2007). I would feel remiss, however, if I closed this thesis without discussing my own experiences as a patient and how these experiences have affected my approach to research.

When I was nineteen years old, I experienced what I can only term a "mental breakdown." I was hospitalized several times and eventually diagnosed with Borderline Personality Disorder. Since this time, I have been told by healthcare providers that I should never be a mother, I have been forced to undergo painful medical procedures I did not consent to, and I

have been held in an institution against my will. These experiences both inspired my interest in health communication and have led me to become acutely aware of the power imbalances that exist between patients and healthcare providers. While I was working on this project, when HPs would share their feelings of powerlessness, I would remember what it was like to be held down and forced by a team of doctors and nurses into a straightjacket. I would remember what it was like to be told by my doctor that if I tried to check myself out of the hospital, he would get a court order to prevent me from doing so, and that at that point I would “never be able to decide” when I could leave. I would remember what it was like to be too weak to fend off the hospital nurse who pierced my skin with the biggest needle he could find, again and again, and told me “it’s your own fault you’re here.”

Undoubtedly, then, I am oriented towards skepticism that HPs are truly helpless, and I tend to regard health care as a site of oppression for those who are marginalized by dominant narrative structures. I say all this to emphasize again that the story I tell in this thesis, like all other knowledge claims, is “partial, temporary, and contested” (Lindlof & Taylor, 2019, p. 193). The narrative world I construct is one which underscores the violent oppression enacted within healthcare systems, but there are many other stories which could be told and which co-exist alongside my narrative.

Finally, I have spent a great deal of time thinking about whether or not I have the right to solicit and share RHPs’ stories about patients as I have through this project. I cannot know how the patients in these stories would feel about the most personal and painful details of their lives being shared by their doctors, written about by a stranger, and published in academic literature. While I initially regarded stories about injustice as useful data, the more stories I heard the less comfortable I became with my role. For the past nine months, I have spent nearly every day

listening to RHPs recount stories of rape, imprisonment, government-sponsored child abduction, dead babies, and dying mothers. The large majority of the violent acts described in these stories targeted low-income women of color. I am reminded of Razack's (2007) article, "Stealing the Pain of Others," in which she argues that depictions of the suffering of Black people have become a popular source of moral authority and entertainment for Whites. Razack suggests that these depictions enable Whites to celebrate our own compassion and to position ourselves as non-violent, sympathetic, and benign on-lookers.

I am still unsure if I have the right to hear the stories of patients who have been abused and assaulted by White supremacist, colonialist, patriarchal biomedicine—particularly since none of the patients in question had the chance to refuse these tellings or voice their own story. Sontag (2003) writes: "Perhaps the only people with the right to look at images of suffering of this extreme order are those who could do something to alleviate it... or those who could learn from it. The rest of us are voyeurs, whether or not we mean to be" (42). Now that my stories have been "collected" and I can't give them back, I am reflecting about what I can do to make sure I and others learn from them. If I do not find some way to speak to the providers and voice the critiques I have developed back to them, I worry that this project will have ultimately been an exercise in voyeurism. I do not have a solution to these ethical concerns. I am considering where and how I could develop critiques of dominant depictions of Motherhood in a way that RHPs would hear. I am also questioning whether it would be useful to create a website which shares my data with a broader audience, contextualizing RHPs' stories within U.S. history and social/economic/political structures. In my implications section below, I also describe a number of future research projects I am interested in pursuing, which I hope will address some of the concerns I've raised. None of these projects would necessarily transform my research from a

project in voyeurism to a project in solidarity and allyship, but I am committed to continued reflection and to holding myself accountable for the consequences of my work.

## **Implications**

### **Implications for Medical Education**

My approach, by demonstrating the unique insights which can be developed by integrating narrative and critical approaches, carries implications for medical education. Specifically, it suggests that ongoing movements within medical education should become more integrated and collaborative to advance social justice and compassion in medicine. Over the past thirty years, there have been several movements to destabilize the dominance of the biomedical narrative in medical education (Hodges, Martimianakis, McNaughton, & Whitehead, 2014; Kidd et al., 2016; Marcum, 2008). Two such efforts have been the narrative medicine movement (Charon, 2006) and the introduction of courses in structural competency (Hansen & Metzl, 2017). Narrative medicine courses help students develop narrative competency (e.g., “the set of skills required to recognize, absorb, interpret, and be moved by the stories one hears or reads” (Charon, 2011, p. 211) by exposing students to literature and other arts and encouraging them to engage with texts through the techniques of close reading. One of the goals of narrative medicine is to encourage a culture of medicine which is characterized by humility, trustworthiness, and respect—values which are often left out of the biomedical narrative (Charon, 2006).

Structural competency is “an emerging paradigm in health care, [which] seeks to address medicine’s overemphasis on the individual (e.g., biology, behaviors, characteristics) while addressing the hierarchies that produce unjust health conditions” (Downey & Gómez, 2018, p. 213). Structural competency training is intended to help HPs understand the connections between the health inequities they see play out on a daily basis and larger structures, with a focus on

developing alliances with marginalized patients, learning from interdisciplinary scholarship, and encouraging participation in political movements (Metzl & Roberts, 2014).

Both of these movements in medical education are valuable and necessary. Yet, they have often played out in parallel. My project indicates that integrating these frameworks would be a more successful method for achieving the aims of each. Narratives (both master and resistive) and structures are deeply linked and mutually reinforcing (Dutta, 2011). Thus, to understand the oppressive structures that assault reproductive health, we must also understand the narratives which support and/or undermine these structures. At the same time, an exclusive focus on structures, systems, and macro perspectives could obfuscate the messiness, emotionality, and contradictions involved in patients' lived experiences of health and illness and providers' experiences of delivery care. I argue, then, that medical education strategies which combine these two approaches may be particularly effective for teaching RHPs about reproductive health—a topic which is both intimate and deeply personal for patients and, simultaneously, inherently relational and located within cultural, political, and economic structures.

To take an example, when RHPs learn about contraception counseling, they could learn about the various strategies that have been used to control poor Women of Color's reproduction across historical periods, review the evidence that teenage childbearing may have health benefits for low-income women of color, and reflect on how and where they (as future RHPs) fit within this history. They could then read or watch contemporary media by women of color who share how they have been affected by health policies and the practices of RHPs. If exposed to this kind of education (and afforded more time for reflection and rest), I doubt that Dr. Christine would

pressure a patient who wants to become pregnant into using a LARC or that Dr. Three would contend that younger moms and those without education are inherently worse parents.

Certainly, medical education is already intensely demanding and packed with important material. Still, of the 147 medical schools that participated in the Association of American Medical Colleges' annual survey in 2017, 144 and 125 schools reported they had courses which covered health disparities and medical humanities topics (respectively) (AAMC, 2019). As such, integrating coursework on narratives and social political structures would not necessarily involve *adding* new classes to medical curricula, but could entail changing how material is taught in time that is already allocated for such issues.

Additionally, experienced clinicians involved in medical education serve as role models to students and, many times, are among the most influential figures for students as they develop professional identities and skills (Maudsley, 2001; Passi et al., 2013). As such, educational interventions may be doubly effective if they are offered to more advanced providers, through Continuing Medical Education courses or faculty development programs. Columbia's College of Physicians and Surgeons developed a successful faculty development program based around the principles and processes of narrative medicine (Balmer & Richards, 2012). Courses which follow a similar design but incorporate materials to contextualize narrative texts within broader historical processes, cultural movements, and political structures may be a useful starting place for these efforts.

### **Implications for Structural Change and Policy**

Finally, based on this study, I argue that medical organizations should direct institutional resources towards re-storying physician identity. As discussed previously, creating a new image of the Good Doctor could potentially reduce physician burnout while also severing ties to White



supremacist, colonialist, and patriarchal master narratives. Thus, I argue that efforts should be made to stimulate conversation around this issue. Hospital Grand Rounds, resident didactic sessions, professional conferences, faculty development programs, and journal theme issues could all serve as spaces to stimulate this discussion. Leaders and organizers could ask participants to reflect on questions such as: What does it mean to be a doctor at this place and moment in time? How is this meaning changing? Who fits within this definition and who may be marginalized by it? How does our professional identity affect how we treat ourselves, our colleagues, and our patients? And, what values are embedded in physician identity and what values would we like to see embraced in this identity?

In addition to creating venues for conversations around physician identity, organizations (such as universities and hospitals) could encourage physicians to develop commitments to activism and social justice in a number of ways. The Yale School of Medicine provides an illustration of how this might be done. Yale holds a yearly “Power Day,” in which medical and nursing students, residents, and faculty come together to discuss issues such as racism and sexism in medicine and to celebrate nurses and residents who have used their power to build solidarity with less powerful community members (including patients) (Angoff, Duncan, Roxas, & Hansen, 2016). Universities could further support these behaviors by recognizing activism focused on improving community health (such as meeting with legislatures, running for office, serving on non-profit boards, organizing protests, etc.) as a form of service when CVs are reviewed for tenure and promotion. With initial steps such as these, institutional leaders may catalyze change to reduce burnout and advance reproductive justice.

## Conclusion

### Limitations

There are several limitations to this thesis study. First, the large majority of the data generated through for project was not analyzed or discussed in this thesis. Out of 816 pages of transcripts from 24 participants, I selected only eight stories from six participants for inclusion in my thesis. I made this choice intentionally, in the hope of providing a rich, detailed, and close analysis of the data I did share. However, as with all research projects, the account I provide in this thesis is a partial story which leaves much out. On a related note, I make no claims about generalizability or representativeness here, not merely because this was a qualitative project involving a small sample and small subsection of the data collected, but also because there was such diversity across and within participants' interviews. I believe that few inferences from this project could be representative of the dataset as a whole, not to mention of the perspectives of RHPs more broadly.

This project is also limited in terms of the perspectives included and excluded. While I noted at the beginning of each interview that I was interested in RHPs' experiences treating both cisgender and straight patients as well as their experiences treating LGBTQ+ patients, the large majority of my data is focused on straight, cisgender patients. This suggests that using non-exclusionary language does not necessarily lead to the development of an inclusive project (Ketheeswaran, 2019). To understand how RHPs make sense of race, reproductive health, and policy in the context of their interactions with LGBTQ+ patients and the implications of this for reproductive justice efforts, then, future studies may need to focus more explicitly on LGBTQ+ issues.

A final limitation I will note here is that my study enrolled a disproportionately high number of physicians and, to a lesser extent, nurse practitioners. Only two nurses participated in the study; one of these participants also held a research doctorate and the other was a manager at her workplace and performed little clinical work at this stage of her career. No medical assistants or administrative staff members participated in the study. While most of my recruitment was aimed at physicians, I also attempted to recruit participants by presenting my project at a staff meeting at a reproductive health clinic. There were roughly twenty medical assistants, nurses, and administrative staff members present at this event, but only one completed an interview. Medical assistants are disproportionately women of color (Chapman, Marks, & Chan, 2010) and other projects have found that ancillary medical staff at low-income clinics have unique and important insights into the processes of delivering reproductive health care, particularly because many of these staff share identities with patients they serve (Bridges, 2011). By failing to include the perspectives of the health professionals who are positioned at the bottom of the healthcare hierarchy in dominant narratives/structures, this thesis is limited in its exploration. In the future, research efforts should focus on enrolling ancillary medical staff to understand how they communicate about reproductive health, race, and policy, and how their perspectives and actions interact with those of physicians and nurse practitioners.

### **Future research**

In addition to future work which explores ancillary medical staff members' perspectives and RHPs' experiences with LGBTQ+ patients, there are several other directions for future research suggested by this project. First, because dominant narratives about the Good Doctor incorporate many White supremacist, patriarchal, and colonialist values, I am interested in understanding if there may be a statistical correlation between doctors' level of identification

with this identity and levels of racial and/or gender prejudice. Furthermore, as several of my participants felt burned out and disheartened because they felt powerless to help their patients, I am interested in finding out if doctors who participate in social activism may experience higher wellbeing and/or lower occupational burnout. In my next study, I hope to examine these questions through a survey of physicians.

Additionally, based on the ethical tensions and questions I engaged with during my interviews for this study, I am interested in developing an interviewing model which can help qualitative researchers engage in dialogue with study participants who draw on oppressive discourses during interviews. I believe Madison's (2005) work may be a helpful starting place for this project, as she explores in the importance of engaging in genuine dialogic exchanges with research participants. However, based on my experiences in this study with the challenges of engaging in these kind of interactions with participants, I believe a useful next step would be to develop a model which clearly outlines strategies and discursive methods for facilitating the kind of dialogue Madison describes.

Another area that warrants further research is the question of whether participating in interviews for this project influenced how RHPs make sense of issues of race, gender, and reproductive health (in)justice. My committee members pointed out that, by interrupting the medical norm of colorblindness and asking RHPs to reflect on these issues, participating in this thesis itself was an act of resisting dominant scripts in U.S. healthcare culture. Several participants shared with me that they enjoyed participating in an interview, because it provided them an opportunity to reflect on issues that matter to them. One physician, who had completed his residency only a few months earlier, said after his interview: "Maybe I should be more active and involved in these issues." Another participant told me that, after I interviewed a colleague of

hers some weeks before, this colleague had started a conversation with her co-workers about why racial minority patients were underrepresented in their organization.

Based on this feedback, I plan to do a follow-up project in which I interview a subset of my original study participants a second time. During these interviews, I will try to understand if (and how) RHPs' sensemaking around these issues has shifted since our first discussion and since reviewing stories shared by other RHPs and patients in the project. In other words, the next step for research here is trying to understand how narrating, sharing, and listening to stories about race and reproductive health may or may not disrupt dominant narratives among RHPs. From this perspective, sharing stories and listening itself could be an intervention for social change in reproductive health care.

### **Summary**

Race, gender, medicine, and politics have been inextricably linked with reproductive health since the founding of the United States (Gordon, 2007). The goal of my thesis was to understand how healthcare providers negotiate the meanings of these issues. To address this aim, I conducted semi-structured interviews with 24 reproductive healthcare providers. Ultimately, I recorded over 35 hours of interviews, resulting in 816 pages of transcripts. From this dataset, I selected eight narratives told by six participants for further analysis. I performed Critical Narrative Analysis—a novel communication-based approach to qualitative data analysis which incorporates insights from critical theories and narrative medicine—to generate my findings.

Based on my analysis, I argue that my participants communicated about reproductive health, race, and policy, by drawing on the dominant cultural narratives of White supremacy, Western imperialism, biomedicine, and neoliberalism. Participants engaged with these master narratives in a variety of ways. For instance, several participants challenged master narratives by

arguing against the current arrangement of healthcare resources in the U.S. and calling for health policy changes. At the same time, most participants upheld themes (such as meritocracy and colorblindness) and characters (such as the Good Mother and Bad (m)Other) derived from dominant narratives. Thus, even when they called for structural changes, participants tended to reify the narratives which perpetuate unjust, oppressive structures. I conclude that, to pursue reproductive justice in medical spaces, teaching approaches which engage with both narratives and sociopolitical contexts and structures affecting these narratives may be useful. Many of my participants spoke in their interviews about feelings of burnout, frustration, and sadness they experienced in relation to their work. Whether explicitly acknowledged or not, these feelings often arose when their lived experiences contradicted dominant narratives. By sharing my participants' stories and contextualizing them within master narratives and social structures, I hope to suggest future research and practice avenues for creating new stories about reproductive health and physician identity, stories which could simultaneously address burnout and suggest more equitable and just ways of doing reproductive health care.

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## APPENDIX A:

### INTERVIEW GUIDE

- This is a project focused on how healthcare providers make sense of reproductive health care and the current political climate specifically as it relates patients of color who are medically able to use hormonal contraception (such as patients of color who are cisgender woman, gender non-binary, or transgender female-to-male). Can you keep in mind that we are particularly interested in patients of color as you are answering these questions? If you haven't worked with transgender or non-binary patients of color, that's totally fine; we are just trying to be inclusive with our language. Just speak to your own experiences with the patients you have worked with.
- Just so you know, I'm interested in what you personally think about these topics. That means there is no right or wrong answer. I just want to hear about *your* own experiences in *your* own words. If you think of any topic which is relevant, feel free to bring it up! If you have any questions about me, the project, or something else about our interview, please ask. I'm more than happy to answer any questions you might have.
- How long have you been working in the field of reproductive healthcare?
  - (If they've been in this field for 5+ years) How have you seen reproductive health care change since you entered this field? How has medical care in general changed?
- Why did you decide to go into this career field? What kind of training do you have? Any training specifically on communication and/or contraception counseling?
- Tell me about your current job. (Probes: Job title?; Basic responsibilities?; Length of time in current position?)
- How would you describe the mission of the organization you work for?
- Walk me through an average day at work for you.
- Tell me about the age range, the sexual orientation, and ethnic make up of your patient population.
  - What sorts of patterns do you see with patients who fit into these different demographic categories?
  - Do you find patients in different categories have different medical needs and/or questions for you?
- What does reproductive health mean to you?
- In what ways do you typically interact/communicate with patients in your work?



- How do you talk about contraception with patients?
  - If you make recommendations to patients about birth control, what patient characteristics make you lean towards a particular method?
  - What do you think are the key issues for patients seek contraception or discontinuing or changing method?
  - Where do your patients get information about reproductive health? Do you think that patients are well informed about contraception before they come to see you?
- How do you talk about providing reproductive health with other providers and staff?
  - What tips/strategies do you share, or have others shared with you?
  - In what ways do you work with others to providers/staff to deliver care for patients?)
  - How do you talk about contraception with other providers and staff?
- What are the official guidelines for talking with patients about reproductive health in your organization? How do you feel about these guidelines? Is there any wiggle room?
- (If they see patients both at private and public practices) What differences have you noticed between your private and public practice patients? What are the similarities and differences with working in each of these contexts?
- What are your reproductive health and contraception-related goals for patients? How do you work to achieve these goals?
  - Can you give an example of a recent patient of color, your goals for that patient, and how you worked to achieve these goals?
- What is difficult about providing reproductive health care and advice about birth control? Are there any particular difficulties you face when providing care for patients of color? How do you work around these challenges?
  - Can you give an example of a recent case of a patient of color who was challenging to provide care for?
  - Can you give an example of a patient of color who you feel you weren't able to treat effectively, for whatever reason?
  - Are there any particular difficulties for patients of color based on their gender identity-- e.g. how are difficulties different for cisgender women vs. transgender men vs. non-binary patients?—Different strategies for patients based on gender identity?
- Looking in the previous literature, I've seen that patients of color don't have as much trust in their reproductive health providers, on average, as white patients. Is this something you have seen?
  - If you met with a patient you felt did not trust you because you are of a different race or gender than them, how would you approach a patient like that?
- Research literature has also documented that patients of color often do not receive the same level of patient-centered communication as white patients, or their providers may be more

likely to strongly recommend certain types of birth control for patients of color versus white patients. Is this something you've noticed with your patients of color?

- What do you enjoy about your work?
- Is there a connection between politics and reproductive health? What do you think about this?
- Do you think politics and/or policy affects your work and your patients? If so, how?
- Do you think patients are considering politics / the political climate when they making their decisions about contraception and family planning? If so, how?
- Do you or other providers you work with take the political climate into consideration when you interact with patients or provide them with advice? If so, how?
- Okay, now we're finishing up the interview. Now, if you feel comfortable, we would like to ask you to share a story from your experience that you would like policymakers, government officials, healthcare providers, patients, researchers, or other people making similar choices as you, to know. You do not have to share a story, if you would rather not. If you would like to share, you can write it down, or we can speak aloud and tell us.
- Is there anything else you'd like to share about your experiences providing reproductive health care to patients of color? Is there anything I've missed that you think is important for this conversation?
- What questions do you have for me? Feel free to ask anything about me, this research, how we will be using the interview, or anything else that may come to your mind.

Would you mind filling out this brief demographic form? You do not have to answer any questions that make you uncomfortable or share any information you wish to keep private.

What is your date of birth?	
What is your highest level of education?	
How long have you been working in the field of sexual/reproductive health care?	
How do you identify your gender?	
How do you identify your race?	

APPENDIX B:

CRITICAL NARRATIVE ANALYSIS TOOLKIT

Basics (plot, place, arc, time, moral, emotions, genre, mood)	
Characters (narrator, protagonist, antagonist, group membership, relationships, sympathy, blame, tropes)	
Construction (presence, absence, level of detail, role of narrator, world of story, emotions or embodied experiences described, I/you, uptalk, pauses, y'know)	
Critique (moral/values, ideology, Discourses, meta-narratives, interests served, goal, work done, effectiveness, silencing, colonialist practices)	
Reflexivity (noticing, feeling, interpreting, who do I become? Who am I made into?)	