REVISIONING REPRODUCTIVE HEALTH CARE PRACTICES WITHIN THE HEALTHCARE INDUSTRY: A STUDY IN CLINICAL AND ORGANIZATIONAL BIOETHICS

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CHAPTER 1

Revealing Reproductive Suffering

I have lots of concerns and fears with large corporations entering the Black maternal health space…While it is appreciated that corporations and large-scale businesses are wanting to take action to improve maternal and infant health outcomes, using racist, capitalistic tactics, that further perpetuate the notion of deficiency or cause more distrust between maternal health stakeholders who do this work on a daily basis does more harm than good. In their attempt to understand the complexities of the maternal mortality crisis in the U.S., they are actually adding to the system's problems that contribute to this issue (Angela Doyinsola Aina, Co-Founding Executive Director of Black Mammas Matter Alliance).[1]

1.1 Historical Context: Birth Equity as Sexy Suffering

Since the early 2010s, reproductive justice advocates have worked effectively to politically distance highly contentious conversations about abortion rights from conversations about inequitable birth outcomes. Their efforts to garner support across political and ideological divides shifted birth equity into what has been called a "policy window" ripe for collective response.[2] The framing of birth equity as a nonpartisan issued focused on maternal and infant mortality leveraged a concerted rhetorical strategy that situated Black pregnant Black women and infants as imminent tragedies.[3] In the wake of the SCOTUS judgment in Dobbs v. Jackson Women's Health Organization and the rising awareness of racial inequities

1. Kimberly Seals Allers, "Black Maternal Mortality Is Exploited By Corporations," Black Maternal Mortality Is Exploited by Corporations, November 19, 2020, https://www.refinery29.com/en-us/2020/11/10179076/black-women-maternal-mortality-racism-business-interest.

2. John W. Kingdon, *Agendas, Alternatives, and Public Policies*, 2nd ed., Longman Classics in Political Science (New York: Longman, 2003). Kingdon's policy model indicates that policy change emerges when a social problem aligns with the right political and policy context. He argues advocates be alert to the rare alignment of these three "streams" as they are always shifting and when an issue shifts from the policy window, it can take decades for the streams to realign.

3. Jennifer C. Nash, "Birthing Black Mothers: Birth Work and the Making of Black Maternal Political Subjects," *Women's Studies Quarterly* 47, no. 3/4 (2019): 29–50, https://doi.org/10.1353/wsq.2019.0054.

aligned with the COVID-19 pandemic, birth inequity was publicly acknowledged as a "crisis". The rhetorical framework of the birth inequity crisis resisted the construction of Black mothers as inherently suspect moral agents and instead constructed Black motherhood as a symbol of tragic suffering.[4]

Two seminal publications contributed to the development of the rhetorical framework of Black motherhood as a symbol of proximity and vulnerability to reproductive tragedy and death. The first publication was the 2010 publication of *Deadly Delivery: The Maternal Health Care Crisis in the U.S.,* Amnesty International. The report used the "Centers for Disease Control" data, evocative photos, and narratives of key actors and individuals in the movement detailing rising disparities in rates of maternal mortality. *Deadly Delivery* included pictographic statistical data, evocative black and white photos, and emotional vignettes to provide a systematic critique of the U.S. healthcare system. Amnesty International compared U. S. birth outcomes to those of the Global South to issue the first clarion call for clinicians, public health officials, and philanthropists to shift financial, social and political resources to address *the crisis* of race-based birth inequities. The 2017 documentary series *Lost Mothers: Maternal Mortality in The U.S.* further developed the strategy of rendering Black motherhood a crisis of perpetual vulnerability to suffering. The award-winning multimedia project was coproduced by Nina Martin at ProPublica and Renee Montagne at NPR. *Lost Mothers* intimately explored the impact of inequitable birth outcomes on families and clinicians. Martin and Montagne crafted birth equity as *an urgent crisis* that successfully influenced lawmakers and private funders to

4. Richard Besser, "RWJF Statement on Access to Safe and High-Quality Reproductive Medical Care," RWJF, June 24, 2022, https://www.rwjf.org/content/rwjf-web/us/en/about-rwjf/newsroom/2021/11/statement-from-richard-besser-on-access-to-safe-and-high-quality-reproductive-medical-care.html.

allocate attention and resources to address maternal mortality and inequitable birth outcomes.[5] As birth equity gained cultural currency, it became *a sexy virtue signaling cause*.[6] This cultural currency ignited apprehension from reproductive justice activists such as Angela Doyinsola Aina, who strategically deployed the crisis standard care framework to build momentum for reproductive justice. Advocates were worried about replicating harms they sought to address as corporations began coopting strategies and values of the reproductive justice movement.

1.2 Inattentive Silence as Epistemic Violence

During this same timeframe as birth and health equity broadly gained traction in healthcare bioethicists were disconcertingly silent. Although bioethics continued to be at the forefront of reproductive debates over abortion, scholars often wrestled internally on the appropriateness of addressing racism and whether racism was better aligned with the aims of critical health studies or sociology. Considering social and political analysis to be tangential to bioethics, the field effectively ignored how race and class influenced bioethics.[7] Bioethics began to move beyond its benign acknowledgement of antiblack biases in healthcare as the world turned its attention to how such biases prevail in healthcare during the COVID-19 pandemic and in "crisis standard of care" practices.[8] Bioethicists ignored racialized health

5. Nina Martin, "Lost Mothers," ProPublica, April 25, 2019, https://www.propublica.org/series/lost-mothers.

6. Deandre Miles-Hercules and Jamaal Muwwakkil, "Virtue Signaling and the Linguistic Repertoire of Anti-Blackness: Or, 'I Would Have Voted for Obama for a Third Term,'" *Journal of Linguistic Anthropology* 31, no. 2 (2021): 267–70, https://doi.org/10.1111/jola.12320.

7. Karla F. C. Holloway, *Private Bodies, Public Texts : Race, Gender, and a Cultural Bioethics*, E-Duke Books Scholarly Collection. (Durham, NC: Duke University Press, 2011).

8. George J. Annas and Sondra S. Crosby, "Standard Racism: Trying to Use 'Crisis Standards of Care' in the COVID-19 Pandemic," *American Journal of Bioethics* 21, no. 8 (2021): 1–3, https://doi.org/10.1080/15265161.2021.1941424.

inequities and positioned themselves as neutral mediators in the healthcare industry.[9] This inattentiveness to racial bias is especially curious given that bioethics emerged to mitigate the worst effects of the technological and scientific management of biomedicine, which played out along racial and class axes. Bioethics maintained legibility and legitimacy in healthcare by focusing on neutrality and carefully cordoning off critical analyses of health and healthcare.[10] Efforts to reclaim the role of critical analysis in bioethics led to siloed discourses including ethics of care and feminist approaches to bioethics, public health ethics, cultural bioethics, and organizational bioethics. In the wake of widespread attention to antiblackness in healthcare and other institutions, these discourses were rescued from the margins and quickly adopted into the larger bioethical discourse.[11]

The field of bioethics was built on the professional and ideological practices of biomedicine. Also called allopathic medicine, biomedicine emerged in the 1800s and represented an industrial approach to disease and injury. The biomedical model of healthcare was designed to guide physicians to the discovery of a *real disease* hidden inside the patient's symptoms of illness.

> Doctors pursue symptoms because of the belief that they are the direct manifestations of disease. Diseases are the "real" things – the things that count. Symptoms are a second-best access to the disease entity, the best being "direct" views such as x-rays, tissue examinations, electrocardiograms, and so on. From the same perspective, sick persons, as persons, are an agglomeration of "soft" data – feelings, emotions, values, and beliefs – in these terms, not as real as their diseases.[12]

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9. Michael A. Ashby and Bronwen Morrell, "To the Barricades or the Blackboard: Bioethical Activism and the 'Stance of Neutrality,'" *Journal of Bioethical Inquiry* 15, no. 4 (2018): 479–82, https://doi.org/10.1007/s11673-018-9887-0.

10. Tom Koch, *Thieves of Virtue: When Bioethics Stole Medicine*, Basic Bioethics (Cambridge, MA: MIT Press, 2012).

11. Camisha Russell, "Meeting the Moment: Bioethics in the Time of Black Lives Matter," *American Journal of Bioethics* 22, no. 3 (2022): 9–21, https://doi.org/10.1080/15265161.2021.2001093.

12. Eric J. Cassell, *The Nature of Suffering and the Goals of Medicine*, 2nd ed. (New York:

The interpretive method of biomedicine was built on the perspective of the body as a complex machine. In this way, the biomedical model effectively dismembered patients from their experience of suffering in the service to understanding and treating the disease. That is, sought to isolate the patient as a person, from the disease, as if the two were atomic entities.[13] This created distance between the experience of illness or injury and its interpretation in the clinical encounter. In my reading of Michel Foucault, the biomedical model was commensurate with colonial logics wielded by the clinician's authoritative reading of the body, called *the medical gaze*.[14] The medical gaze flattened subjective experiences of illness while turning a multidimensional person into a two-dimensional analyzable screen. In this way the medical gaze was designed to maintain the authoritative position of the biomedical model by bracketing the caring process in favor of objective diagnosis and treatment.

> Doctor and patient are caught up in an ever-greater proximity, bound together, the doctor by an ever-more attentive, more insistent, more penetrating gaze, the patient by all the silent, irreplaceable qualities that, in him, betray—that is, reveal and conceal—the clearly ordered forms of the disease. Between the nosological characters and terminal features to be read on the patient's face, the qualities have roamed freely over the body. The medical gaze need hardly dwell on this body for long, at least in its identities and functioning.[15]

In pursuit of efficiency, the biomedical model mirrored the factories of the industrial revolution and by alignment with technological and scientific advances oriented towards abstraction in the

Oxford University Press, 2004).

13. Michel Foucault and A. M. Sheridan, *The Birth of the Clinic : An Archaeology of Medical Perception; Translated from the French by A.M. Sheridan.*, Routledge Classics (London: Routledge, 1976), https://doi.org/10.4324/9780203406373.

14. Foucault and Sheridan.

15. Foucault and Sheridan, 15–16.

experience of illness. The medical gaze morphed into a penetrating gaze, built on Cartesian dualism, which created structured inattentiveness to the vulnerability of illness and the intimacy of the medical encounter.[16] This produced and reproduced racialized, gendered and classed social imaginations and material outcomes using phenotypical expressions as a proxy for assessing pain and health.[17]

Practitioners inside and outside the biomedical model unsuccessfully pushed towards shifting from the biomedical dismembering model of diagnosis and treatment. Medical historians such as Paul Starr have argued that biomedical practitioners in the U.S. used their sociopolitical power to ostracize osteopathic, homeopathic, ayurvedic, and Chinese traditional medicines that, by the mid-1950s, which biomedicine and its ideology were regarded as the only legitimate form of medical treatment. Neoliberal governance principles and capitalist financial structures catapulted biomedicine to social and political power so that by the second half of the twentieth century, biomedicine functionally marginalized other practices of medical care to become a hegemonic nosological model.[18]

This biomedical hegemony cemented the incorporation of the medical gaze as the focus of techno-scientific management. Health care providers have increasingly relied on abstract

16. Switankowsky, "Dualism and Its Importance for Medicine," *Theoretical Medicine and Bioethics* 21, no. 6 (2000): 571, https://doi.org/10.1023/A:1026570907667. In Switankowsky's systematic review of medical theorists including Mark Sullivan, James Gordon, Kay Toombs, and Eric Cassell, she argues that medical reductionism can be directly linked to the domination of Cartesian dualism that, "objectifies the patient and leads to diagnoses and treatments that fail to take the patient as a person seriously".

17. Nikolas S. Rose, *Politics of Life Itself Biomedicine, Power, and Subjectivity in the Twenty-First Century*, Information Series (Princeton: Princeton University Press, 2007); Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (London: Routledge, Taylor & Francis Group, 2008), https://doi.org/10.4324/9780203927076.

18. Colleen Derkatch, *Bounding Biomedicine: Evidence and Rhetoric in the New Science of Alternative Medicine*, Illustrated edition (Chicago: University of Chicago Press, 2016).

patients as data, screens, algorithms, artificial intelligence, and other intermediary technologies. A central claim of this dissertation is that this incorporation, the biomedical gaze, differentiates the medical gaze by way of its reliance on statistics, technologies, algorithms, treatment formulas, and other seemingly objective care guidelines that render the biomedical gaze omnipresent and omnipotent. These technologies restrict the patient's agency for expressing their own experience of pain and suffering in their clinical encounters, forming, as it were, what the American philosopher, John Lachs, called psychic distance.[19]

Lachs argues that there is an inverse relationship between moral agency and the techno-scientific administration of human services, including hospitality and health care:

> The longer and more extensive the chain of intermediaries, the less one retains the ability to understand the implications of actions. As power over our actions and conditions of our existence slips from our grasp, we begin to feel impotent or unimportant. The less we regulate the intermediaries, the less we control their actions on our behalf. And the more we lose command of these actions, the more difficult it becomes to view them as our own.[39]

Thus, the techno-scientific administration of care contributed to the efficiency of biomedicine in healthcare while dehumanizing care by psychic distance. Administrators of health care services were required to treat patients as just so many screens that limited the moral agency of patients in the *techno- structures of care*.[20] Using Lachs' account of psychic distance, created through the mediating structures of healthcare service delivery, shapes the moral imagination by abstracting experiences of illness, disease, and injury by dismembering the patient from healthcare as a service delivery.

1.3 Birth Injustice and Reproductive Suffering

19. John. Lachs, *Intermediate Man* (Indianapolis, Ind: Hackett, 1981).

20. Saif Khairat et al., "Association of Electronic Health Record Use With Physician Fatigue and Efficiency," *JAMA Health Forum* 3, no. 6 (2020): e207385, https://doi.org/10.1001/jamanetworkopen.2020.7385.

The biomedical model transformed the social imagination of birth *through the medicalization of birth*. The medicalization of birth and treatment as a disease state, rather than as a physiological and cultural process, has been widely identified as the root cause of poor birth outcomes in the western world. The techno-scientific abstractions undergirding the biomedical model of care ensure clinical efficiency and financial sustainability in reproductive biomedicine and produces reproductive suffering. Techno-scientific abstractions facilitate the division of billable reproductive care specialties. During pregnancy, a patient may be attended to by over twenty different individuals from specialties that include nurses, gynecologists, obstetricians, doulas, midwives, maternal-fetal specialists, chaplains, social workers, nurse practitioners, physicians, patient navigators, patient care technicians, and more.[21] Despite the billions of dollars invested in sophisticated care technologies, well-documented difficulties in coordinating the care practices of these actors exist. Reproductive justice scholars, care theorists, and critical bioethicists have argued that the disjointed nature of healthcare is antithetical to the kinds of health care practices that have been found to improve reproductive outcomes such as accessible, affordable, consistent and culturally congruent reproductive care.[22]

In these ways, the biomedical model systematically birthed reproductive injustice, which I refer to as *reproductive suffering*. The logics and tools used to facilitate the techno-

21. Emily P. Backes and Susan Scrimshaw, Birth Settings in America : Outcomes, Quality, Access, and Choice / Committee on Assessing Health Outcomes by Birth Settings, Consensus Study Report (Washington, DC: the National Academies Press, 2020).

22. Alicia D. Bonaparte, "'The Satisfactory Midwife Bag': Midwifery Regulation in South Carolina, Past and Present Considerations," Social Science History 38, no. 1–2 (2014): 155–82, https://doi.org/10.1017/ssh.2015.14; Lauren K. Hall, The Medicalization of Birth and Death Lauren K. Hall. (Baltimore: Johns Hopkins University Press, 2019); Brigette Courtot et al., "Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care," The Milbank Quarterly 98, no. 4 (2020): 1091–1113, https://doi.org/10.1111/1468-0009.12473.

scientific management of reproductive biomedical results in epistemic and existential violence. The well-studied systematic medicalization of birth results in poorer birth experiences and deadly outcomes especially for nonwhite patients.[23] Pervasive antiblack ideologies of the reproductive potential of Black people, their ability to feel pain, and make reasonable medical decisions are linked to maternal and infant morbidity rates.[24] Antiblack ideologies of the biological inferiority of Blacks has led to disastrous outcomes that include misdiagnosis, over- and under-treatment, and delayed or denied access to essential reproductive care.[25] Reproductive suffering results from these interlocked systems of abstraction and structured ignorance, which contributed, implicitly and explicitly, to eugenic-based sterilization policies and practices, environmentally-related infertility, disparate fertility treatment outcomes, disparate access to abortion care, obstetric violence, and inequitable infant/maternal morbidity.[26]

Reproductive suffering results from a spectrum of compounded gender and race-based oppressive mechanisms at interlocked levels: the micro-level (individual/internalized and

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23. Dorothy E. Roberts, *Killing the Black Body : Race, Reproduction, and the Meaning of Liberty*, 1st ed. (New York: Pantheon Books, 1997).

24. Lisa Rosenthal and Marci Lobel, "Gendered Racism and the Sexual and Reproductive Health of Black and Latina Women," *Ethnicity & Health* 25, no. 3 (2020): 367–92, https://doi.org/10.1080/13557858.2018.1439896.

25. Terri-ann Monique Thompson et al., "Racism Runs Through It: Examining The Sexual And Reproductive Health Experience Of Black Women In The South: Study Examines the Sexual and Reproductive Health Experiences of Black Women in the South," *Health Affairs* 41, no. 2 (2022): 195–202, https://doi.org/10.1377/hlthaff.2021.01422.

26. Loretta Ross and Rickie Solinger, *Reproductive Justice : An Introduction*, Reproductive Justice: A New Vision for the 21st Century ; 1 (Berkeley, CA: University of California Press, 2017), https://doi.org/10.1525/9780520963207; Loretta Ross et al., eds., *Radical Reproductive Justice : Foundations, Theory, Practice, Critique* (New York City: The Feminist Press at The City University of New York, 2017); Jamila Perritt and Natalia Eugene, "Inequity and Injustice: Recognizing Infertility as a Reproductive Justice Issue," *F&S Reports (Online)* 3, no. 2 (2022): 2–4, https://doi.org/10.1016/j.xfre.2021.08.007.

interpersonal oppression), the meso-level (institutional policies and community practices), and macro-level (ideologies, sociopolitical and national/global governance institutions).[27] The micro-level of suffering is the most commonly addressed aspect of reproductive suffering and includes clinicians' bias and patients' internalized bias that prevents the provision of appropriate clinical care during the perinatal period. Increasingly there is work to address meso-level mechanisms like hospital system policies and practices regarding risk calculations that include inherent racial biases and like the Vaginal Birth After Cesarean (VBAC) calculator. Macro-level reproductive suffering is related to the historical context as well as contemporary economic, social, and political policies that have contributed to generational poverty and barriers to accessing high quality, financially and geographically accessible primary and prenatal care. While most interventions designed to address reproductive suffering seek to address the micro-level because it is within the sphere of control of individual institution, increasingly there is collective action across sectors to address the ecosystem of reproductive suffering.

1.4 Risky Business: A Transdisciplinary Methodology

This dissertation investigates how two sets of nonclinical practitioners (applied bioethics and community-based birth workers) engage antiblack reproductive suffering for comparative analysis. It seeks to understand how these fields replicate and/or reject the logics controlling the biomedical gaze. Supporting this research is my training in theoretical and applied biomedical ethics in a university medical center and auto-ethnographic and community based participatory research with "Homeland Heart", which is a black-feminist based reproductive justice collaborative focused on training perinatal doulas.

27. Murray Levine, Douglas D. Perkins, and David V. Perkins, *Principles of Community Psychology : Perspectives and Applications*, 3rd ed. (New York: Oxford University Press, 2005).

My research is derived from over five years of reflexive field notes from training in theoretical and applied biomedical and public health ethics, which include shadowing clinical ethics consultations prior to and during the COVID-19 pandemic, rounding with ICU teams, and participating in organizational and clinical ethics forums. Further, my ethical observations in acute healthcare settings are balanced by extensive trainings in public health equity and ethics through volunteer service with "Healthy Nashville".[28] This experience links my research with Homeland Heart, which emerged from my lived experience as a potentially *at risk* pregnant Black woman living in a *targeted* zip code for its inequitable high maternal mortality rates.[29] The dissertation uses auto-ethnographic research collected during pregnancy and postpartum and womanist-based community based participatory research, which is modeled on womanist principles of ethnographic research.[30]

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28. Tracy Buck, "Healthy Nashville Leadership Council," Nashville.gov, 2002, https://www.nashville.gov/departments/health/boards/healthy-nashville-leadership-council. I have participated in Healthy Nashville Health Equity community and engaged in support of development of Community Health Improvement Plans for the Nashville Metropolitan statistical area as well as the larger Middle Tennessee region including the collar counties since 2017.

29. ProviderTrust, "Closing the Maternal Health Gap with Homeland Heart," *ProviderTrust* (blog), February 17, 2021, https://www.providertrust.com/blog/closing-the-maternal-health-gap/; Robert A. (Robert Alan) Aronowitz, *Risky Medicine : Our Quest to Cure Fear and Uncertainty* (Chicago: University of Chicago Press, 2015). Aronowitz suggests that allopathic medicine and the reliance on technoscientific management of care has contributed to the society wide obsession with risk-management leading to the adoption of disease risk management as a proxy for health. "Reducing risk is no longer a means to health but often its very definition. To comply with screening protocols, have acceptable numbers on blood tests or images on scans, and engage in behaviors believed to lower risk, is—despite the evident circularity—to be healthy. (p. 202) For women, particularly those socialized as black, the medical gaze constructs their bodies as always at risk and as such in need of constant surveillance and maintenance. Population health management uses statistical inference to abstract these obsessions to the meso- and macro-levels to collectively determine how best to manage and influence the public health risks related to individual attitudes and behaviors.

30. Phillis Isabella Sheppard, *Tilling Sacred Grounds : Interiority, Black Women, and Religious Experience*, Emerging Perspectives in Pastoral Theology and Care (Lanham: Lexington Books, 2022).

My methodology engages what Jennifer Nash calls the *feminist birth work industry*.[31] The feminist birth work industry includes perinatal doulas, lactation coaches, and childbirth educators among which doulas are the fastest growing among paraprofessional fields. For Nash the feminist birth work industry functions as an analytical framework that allows for the sociopolitical analysis of the economic context of reproductive health care:

> I develop the term feminist birth industry to describe how feminism has remade birthing in myriad ways, including the installation of the idea that birth is understood as a self-making event, one that can be crafted, tailored, and planned both to safeguard maternal health and to ensure an "experience" that meaningfully marks the transition to motherhood. It is not my contention that hospitals are now feminist spaces or that institutionalized medicine is a site of feminist practice. Indeed, the persistence of unwanted C-sections and obstetric violence reveals that birth remains a crucial site of the patriarchal control of women's bodies.[32]

The *remaking of birth,* under the feminist birth work industry, collides with persistent and unwanted inequities in reproductive outcomes. Despite the emergence of the *doula*, as a quality improvement tool in hospitals, *doulas* are largely regarded as noninstitutional or counter-institutional responses to the medicalization of birth.

The word *doula* is coined by medical anthropologist, Dana Raphael, and popularized through the founding of "Doulas of North America". Although the word is Greek for *slave or servant*, Raphael repurposes it as a benign definition for successful breastfeeding in postpartum.[33]

> I call this caring person a doula, someone who literally mothers the new mother and offers continuous encouragement. Too little mothering, and no doula, means not enough milk. Incidentally, the word doula comes from an ancient Greek word referring to the woman who comes to the home when a child is born, cares for the older children, cooks

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31. Jennifer C. Nash, "Birthing Black Mothers: Birth Work and the Making of Black Maternal Political Subjects."

32. Jennifer C. Nash.

33. Dana Raphael, "The Midwife as Doula: A Guide to Mothering the Mother," *Journal of Nurse-Midwifery* 26, no. 6 (1981): 13–15, https://doi.org/10.1016/0091-2182(81)90170-1.

> the dinner, bounces the fretting baby, and generally helps the new mother through the early postpartum period. [34]

Raphael skirts discussion of the socioeconomic implications of this work, including class differentials between *doula* and mother. Although *doulas* are popular resources for upper-middle class women, hospitals and community health organizations also engage *doulas* hoping to improve the quality of labor and deliver.[35] *Doulas* are a potential solution to disparate nulliparous term singleton vertex (NTSV) cesarean delivery rates for mothers *at risk* of poor outcomes due to their social, political, or economic barriers.[36] The current funding model for community-based *doulas* operates on the assumption that birth workers focused on supporting *risky* women, should be underpaid or unpaid. This logic uncritically mirrors the Greek usage of *doula*, as a servant committed to the provision of affectionate care without regard to or because of their constrained socioeconomic status.

To understand how the proliferation of low and no paid birth work in response to maternal mortality and the structured silence of bioethicists, I take a pragmatic womanist methodological approach. The field of applied bioethics and the para-professional field of birth work were both created to safeguard patient outcomes amid the complex web of structures in healthcare institutions by adding an external actor to counter the hegemonic power of the medical gaze. In my observation, the operating logic for the existence of both professions (bioethicists and *doulas*) is that non-clinical interpersonal relationships can mediate the most

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34. Raphael.

35. Donna J Sauls, "Effects of Labor Support on Mothers, Babies, and Birth Outcomes," *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 31, no. 6 (2002): 733–41, https://doi.org/10.1177/088421702129005380.

36. Carol Sakala, Candice Belanoff, and Eugene R Declercq, "Factors Associated with Unplanned Primary Cesarean Birth: Secondary Analysis of the Listening to Mothers in California Survey," *BMC Pregnancy and Childbirth* 20, no. 1 (2020): 462–462, https://doi.org/10.1186/s12884-020-03095-4.

detrimental effects of the biomedical gaze for patients and care givers. However, I also have observed that the responses of bioethics and *doulas* to reproductive suffering share the race and gender logics of reproductive biomedicine. To examine the complex relationships between the potential and perils of both fields, I examine and critique these logics, surrounding how Black maternal mortality, engages reproductive justice by drawing on womanist and pragmatic approaches to social ethics.

1.4.1 Womanist and Black Feminist Approaches to Bioethical Inquiry

Sociologist, Cheryl Townsend Gilkes, suggests that womanist approaches to social inquiry opens the *sociological imagination* because of its asset-based intersectional and holistic approaches to race and class analysis. For Gilkes, womanist methodological approaches represent, "a way of seeing, a vehicle for a holistic approach that centers African American women."[37] This is especially generative for demystifying the gender/race-based logics of the medical and biomedical gazes. I deploy womanist approaches to critique the moral messiness and complexity of actors operating in oppressive systems. I explore the constraints and complicity of actors in the healthcare system to provide a nuanced reading of moral agency, one that resists the lure of replicating reductive conceptions of blackness that ontologically prioritizes totality over difference.[38]

The dissertation engages interdisciplinary Black feminist and womanist methodologies of critical inquiry. This work draws from the theo-ethical approaches of Emilie M. Townes in *Breaking the Fine Rain of Death* and critical legal bioethical approaches of Karla F. C. Holloway in *Private Bodies, Public Texts.* In addition to theological reflection, Townes deploys

37. Cheryl Townsend Gilkes, "Womanist Ideals and the Sociological Imagination," *Journal of Feminist Studies in Religion* 8, no. 2 (1992): 147–51.

38. Victor Anderson, *Beyond Ontological Blackness : An Essay on African American Religious and Cultural Criticism.* (New York: Continuum, 1995).

theological, philosophical, and social analyses to make normative claims about collective moral responsibilities:

> Social ethics pays close attention to social contexts and how they shape and direct our sense of a moral self and moral action – our moralities. Social ethicists know that the social context influences the perspectives and incentives of the individuals acting within it. They explore issues of individual and collective moral responsibility and what is right action. So they look at what policies and practices institutions should follow and not only at how individuals should behave within the framework of existing policies and practices.[39]

Townes argues that a womanist approach to bioethical inquiry integrates theological and social methods. By integrating these approaches, Townes articulates a reading of collective moral agency at the meso and macro levels of analysis without exculpating individuals from addressing complicity in immoral actions. For Townes, contextual analyses of healthcare allow for a robust investigation of how institutional injustice shape sociomedical suffering.

In *Private Bodies, Public Texts*, Holloway advances a methodology of critical bioethics that draws from literature, legal studies, and bioethics to reveal and interrogate the multiplicities of patient stories rooted in biopolitical analysis. [40] Her model of cultural ethics is an interplay of legal theory, bioethics, and literature analysis that attempts to critique cultural complexity and subjectivity of bioethics. Holloway excavates how the discursive practices of bioethics produced the field. Bioethics, she argues, is not empty of cultural histories but attempts to create abstracted narratives of bodies neutralized of their histories. Holloway critiques narrative bioethics, which attempts to disrupt the hierarchy of knowledge in the biomedical encounter, because it does not go far enough towards creating a *prima facie* acknowledgement of the cultures that the field claims to be interested in investigating. Her

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39. Emilie Maureen Townes, *Breaking the Fine Rain of Death : African American Health Issues and a Womanist Ethic of Care* (Eugene, Or: Wipf & Stock Publishers, 2006).

40. Holloway, *Private Bodies, Public Texts : Race, Gender, and a Cultural Bioethics*.

advancement of cultural ethics examines how the constitution of subjects, patterns, and cultures makes bioethical failings *possible* or *probable* and resists the, "practiced objectification of patient stories" in bioethics and gives weight to sociohistorical and political analysis.[41] Following Foucault, Holloway engages legal, literature, and bioethics to interrogate the multiplicities of patients, who are often illegible in the privacy of the clinical encounter but publicly unveiled as the subjects of public health and other state sponsored surveillance mechanism. For Holloway, cultural bioethics allows for an examination of deeper terrains of ethical inquiry to reclaim the full personhood of the patient in bioethical inquiry.

1.4.2 Prophetic Pragmatism

This dissertation makes use of the pragmatic approaches of W. E. B. Du Bois and Cornel West. Both scholars advance culturally responsive and transdisciplinary methods that engage multi-level analysis of oppression. Du Bois engages anthropological, social, historical, humanistic, and ethical approaches to illuminate the sociohistorical context and implications of complex social problems.[42] This method is instructive for conducting transdisciplinary inquiry committed to community-based engagement and flourishing. I also draw on Cornel West's formulation of prophetic pragmatism. West argues that academics invested in social change must balance the tightrope between "critical temper as a way of struggle and democratic faith as a way of life" against the ever presence of "despair, dogmatism, and oppression" resulting from critical resistance to injustice.[43] For West, this balance allows for a generative pessimism

41. Holloway.

42. Leah Lomoki Lomotey-Nakon, "Du Bois's Decolonial Pragmatism: Teaching Community Psychology Toward Epistemological Liberation," *American Journal of Community Psychology* 62, no. 3–4 (2018): 364–73, https://doi.org/10.1002/ajcp.12289..

43. Cornel West, *Keeping Faith: Philosophy and Race in America* (Psychology Press, 1993), 126.

to endure seasons full of social and political suffering. West encourages rigorous inquiry paired with trust-based equitable partnership with community activists. He proffers that this model of scholarship provides avenues for productive exchange that honors the work of, "keep[ing] alive potent traditions of critique and resistance" against "death dealing forces" that compound suffering in institutions built as places of healing.[44]

1.4.3 Method

I also use discourse analysis to investigate how the medical and biomedical gazes contribute to reproductive suffering.[7] I engage critical race theory and science and technology studies to explore how actors and institutions in the "Medical Industrial Complex", (hereafter, the M.I.C) contend with the death-dealing effects of the biomedical gaze. I examine how bio-medicalization shape the material and epistemic circumstances driving reproductive suffering and the imagination of reproductive flourishing. I analyze collective and individual responsibility for addressing inequitable maternal morbidity rates (MMR). By focusing on a small aspect of reproductive suffering, inequitable pregnancy and birth outcomes, the dissertation investigates how mechanisms of moral meaning-making shape the trajectory of care of individuals made vulnerable by racial and gender-based socio-economic oppressions.

The dissertation is a practice and test of the methodology of a pragmatic womanist approach to cultural bioethics. I deploy an mixed-method approach to examine micro-level, meso-level, macro-level responses to *birth equity crisis discourse* surrounding maternal mortality.[45] I propose that this approach has the analytical and constructive potential to ecologically examine reproductive justice towards the expansion of ethically supportable

44. West, *Keeping Faith: Philosophy and Race in America*.

45. Jennifer C. Nash, "Birthing Black Mothers: Birth Work and the Making of Black Maternal Political Subjects."

responses to reproductive suffering in legal, social, political and economic structures.[46] I build on Holloway's imagining of the role of fiction as a mode of bioethical inquiry by engaging speculative fiction as a way to reconstruct healthcare narratives. I also turn to speculative fictions as pragmatic modes of epistemic resistance against the demonic logics of the medical and biomedical gazes. The dissertation illuminates possible pathways towards disrupting the dehumanizing effects of the M.I.C. and innovative ways of forwarding health care throughout the healthcare system.

1.5 Overview of Chapters

The dissertation begins with a genealogy of the biomedical gaze and how the techno-scientific management of biomedicine abstracts suffering in ways that lead to the dissociation of healthcare institutions from sociopolitical responsibility. In Chapter One, I track the intersection and transformation of multiple gazes that drive the contours of the biomedical gaze, including the Medical Gaze, the White Gaze, and its Normative Gaze to its residency in the U.S. M.I.C. Drawing on thinkers such as Frantz Fanon, Michel Foucault, W.E.B. Dubois, and Cornel West, and medical historians, such as Paul Starr, this chapter charts the ontological parity of *the gaze* throughout its four-fold manifestations: medical (Foucault), coloniality/white (Fanon, DuBois), normative (West), and the biomedical (Starr).

Chapters Three and Four investigate how two non-clinical fields in biomedicine, the field of applied bioethics and the feminist birth work industry, replicate and resist the logics governing the biomedical gaze. Chapter Two investigates applied bioethics, a field of inquiry and practice that has been embedded in the institutional infrastructure of the healthcare industry. This chapter also provides a historical analysis of bioethics as a function of the M.I.C

46. Abraham Schwab, "The ASBH Code of Ethics and the Limits of Professional Healthcare Ethics Consultations," *Journal of Medical Ethics* 42, no. 8 (2016): 504–9, https://doi.org/10.1136/medethics-2015-103074.

and its rhetorical posture towards antiblack reproductive suffering. The chapter uses discourse analysis to examine the structured silences surrounding maternal mortality. I use this analysis to hypothesize that the lack of engagement with race and reproduction is rooted in the inability of bioethics to wrest itself from the biomedical gaze.

Chapter Four looks outside of the acute care setting to the feminist birth industry and its approach to reproductive suffering. The chapter uses feminist and womanist ethics of care theorists, Virginia Held, Joan Tronto, and Emilie M. Townes to critique the feminist birth work's model of care ethics. I suggest that while the feminist birth industry has successfully positioned itself as an extra institutional or anti-institutional response to suffering, the field remains tied to the logics of the biomedical gaze in ways that advance and constrain the moral, social, and political decision-making of black feminist birth workers.

Chapter Five moves constructively towards investigating the potential of speculative fictions as a model of epistemic resistance to the biomedical gaze for both clinical ethics and birth work. I investigate the connections between bioethics and science fiction, a subset of speculative fictions and the ways that Black-identified authors used speculative fiction and Afrofuturism to refuse interlocking hegemonic gazes. I argue that this model can be transposed to the biomedical gaze as a model of epistemic resistance and refusal of its hegemony in the M.I.C. I wrestle with the legacy of narrative ethics and use the critical work of Ruha Benjamin to engage a neuroethical approach to moral reformation.[47]

47. J.F. Christensen and A. Gomila, "Moral Dilemmas in Cognitive Neuroscience of Moral Decision-Making: A Principled Review," *Neuroscience & Biobehavioral Reviews* 36, no. 4 (April 1, 2012): 1249–64, https://doi.org/10.1016/j.neubiorev.2012.02.008. Neuroethics refers to the study of the bioethical implications of neuroscience and how neuroscience can provide insights into moral-decision-making. In this work, I refer to the later definition and seek to provide exploratory conversation about the pedagogical implications of using speculative fiction in professional education.

Chapter six concludes by providing a framework for visionary bioethics. I scaffold on Chapter five to provide a pedagogical model of antiblack obstetric violence that resists the logics of the biomedical gaze. This chapter summarizes potential scholarly contributions of the dissertation and identifies future directions for empirical bioethics and medical humanities research providing pathways for addressing race and gender-based reproductive suffering.

CHAPTER 2

Residency: The Biomedical Gaze in the Medical Industrial Complex (M.I.C.)

2.1 Introduction

This chapter follows the morphology of the biomedical gaze from the Medical Gaze, the White Gaze, and its Normative Gaze to its residency in the U.S. medical industrial complex (hereafter, M.I.C.). I examine the episteme of the medical gaze, which especially undergirds modern medicalization of acute care settings where its hegemonic power manifests in the technoscientific management of care. The chapter also chronicles the emergence of the (M.I.C.) in the U. S., which encodes the biomedical gaze into technoscientific practices and the management of medicine. This genealogy of the biomedical gaze details its alliance with neoliberal demands that would transform the hospital as the center of residency for the biomedical gaze. Drawing on thinkers such as Frantz Fanon, Michel Foucault, W.E.B. Dubois, and Cornel West, and medical historians, this chapter charts the ontological parity of *THE GAZE* throughout its four-fold manifestations: medical (Foucault), coloniality/white (Fanon, DuBois), normative (West), and the biomedical. (Starr). The chapter concludes by considering how these presentations of the gaze have taken up residency and are replicated in healthcare management to reproduce reproductive suffering.

2.2 Part 1: The Force of the Gaze

2.2.1 The Medical Gaze (Michel Foucault)

Foucault coins the *medical gaze* through a genealogy of the physician/patient relation in *The Birth of the Clinic*. Educated in the French intellectual tradition and influenced by the existential phenomenology of Merleau-Ponty, Foucault critiques how clinicians analyze disease in clinical encounter. He is drawn to post-structuralist archeological methods to reveal how the

medical gaze produces and reproduces *biopower*.[48] Foucault named the method by which a physician interrogates, catalogues, and interprets the patient's suffering of disease, the *medical gaze*. The medical gaze relies on ethnocentric biological knowledge developed in the eighteenth century to classify and interpret disease by flattening the body to a two-dimensional model. This flattening, or neutralizing, obscures the patient as a person and reduces them to cartography:

> Classificatory thought gives itself an essential space, which it proceeds to efface at each moment. Disease exists only in that space, since that space constitutes it as nature; and yet it always appears rather out of phase in relation to that space, because it is manifested in a real patient, beneath the observing eye of a forearmed doctor. The fine two-dimensional space of the portrait is both the origin and the final result: that which makes possible, at the outset, a rational, well-founded body of medical knowledge, and that towards which it must constantly proceed through that which conceals it. One of the tasks of medicine, therefore, is to rejoin its own condition, but by a path in which it must efface each of its steps, because it attains its aim in a gradual neutralization of itself. The condition of its truth is the necessity that blurs its outlines. Hence the strange character of the medical gaze; it is caught up in an endless reciprocity. It is directed upon that which is visible in the disease—but on the basis of the patient, who hides this visible element even as he shows it; consequently, in order to know, he must recognize, while already being in possession of the knowledge that will lend support to his recognition. And, as it moves forward, this gaze is really retreating, since it reaches the truth of the disease only by allowing it to win the struggle and to fulfill, in all its phenomena, its true nature.[49]

The visual film imposed over the patient screens in the ocular orientation of the physician, but the medical gaze includes the full battery of physical senses. As the physician scans the patient by touching, smelling, and observing, the physician accesses a storage of medical knowledge in service of a discrete etiology. This nosologically (the classification

48. In my reading of Foucauldian biopower in *The Will to Knowledge*, modern sociopolitical powers enact authority through dispersed networks that functionally hide regulatory subjugation to control populations. Investigating the operations of these networks can provide models and pathways to resisting hegemonic power.

49. Foucault and Sheridan, *The Birth of the Clinic : An Archaeology of Medical Perception; Translated from the French by A.M. Sheridan.*

disease) focus inspection of the body to move from tactual experience of a patient towards the classification of the body. The physician's authority and professional status, Foucault suggests, emanates from the ability to efficiently and decisively wield this medical gaze to reveal the disease by recognition and categorization.

The medical gaze is an abstraction that validate the physician as the agent of biopower over the patient and the disease. As biopower, the medical gaze directs and constrains the patient's understanding of self and agency in the clinical encounter. It entangles both the seer and the seen in inextricable reciprocity:

> Doctor and patient are caught up in an ever-greater proximity, bound together, the doctor by an ever-more attentive, more insistent, more penetrating gaze, the patient by all the silent, irreplaceable qualities that, in him, betray—that is, reveal and conceal—the clearly ordered forms of the disease. Between the nosological characters and terminal features to be read on the patient's face, the qualities have roamed freely over the body. The medical gaze need hardly dwell on this body for long, at least in its identities and functioning.[50]

The more the medical gaze penetrates the body through, as simple a technology as the stethoscope, the more it abstracts the patient by means of categorizing disease. The patient, alien to this lexicon, allows their body to be read and cooperates with the interrogation so that their disease can be properly recognized and treated.

Foucault's archaeology of the medical gaze suggests that this infrastructure of knowledge is political and designed to maintain sociopolitical power. He argues that clinical knowledge, which emerged from the restructuring of hospitals and universities and the knowledge production system of these institutions created and reified the biological model of interpreting sickness and disease reified by medical and scientific elites. Thus, the medical gaze is a mechanism deployed for maintaining social and economic power. Foucault argues that the

50. Foucault and Sheridan, 15–16.

knowledge production mechanisms of the eighteenth century developed as an analog to the theological mythos that allies the physician to the clergy "with powers similar to those exercised by the clergy over men's souls."[51] Foucault's extension of the medical gaze to biopower and biopolitics, in his later works, locates the restrictive disciplinary force of the medical gaze in clinical space to the dialectics of the absolute knower and the compliant known.

2.2.2 Colonial/ White Gaze (Frantz Fanon and W.E.B. Du Bois)

Frantz Fanon was an Afro-Martinican born in 1925 to a middle-class family during French colonial rule of the island. His experience of antiblack racism during his medical residency in France and psychiatric practice in Algeria, bolstered by his background in philosophy shaped by Merleau-Ponty and Jean-Paul Sartre, contributed to his concern with the impact of colonization on the psyche of the colonized and colonizer.[52] *Black Skin, White Masks* was a rough attempt at a psychology and phenomenology of the internalization of colonialization. The work engages Marxism and the Négritude movement to provide a preliminary explanation of what he later calls, in *Wretched of the Earth*, "the racialization of thought."[53] Fanon suggests that the colonized speaking the language of the colonizer is inherent submission to the epistemological frame that, along with the self-perception of the colonized, permanently shapes the psyche of the colonized Black subject. His account is a fascinating mediation on agency, on the one hand, and on the other, a proposal that the agency of colonized is constrained by the sociogenetic imagination of the colonizer. Departing from Hegel's master/servant dialectic oriented towards recognition, he writes, "There is in fact a 'being for

51. Foucault and Sheridan, 33.

52. David Macey, *Frantz Fanon: A Biography*, 2nd ed. (London ; Verso Books, 2012).

53. Frantz Fanon, *The Wretched of the Earth* (Grove Press, 1965), 212.

other,' as described by Hegel, but any ontology is made impossible in a colonized and acculturated society."[54] For Fanon, the *colonial/white gaze* restricts any social ontology of resistance by the observed to the observer. This violence to the *Other* restricts and binds the observed to the colonizer's narcissistic consciousness, where the colonizer falls prey to sociogenetic forces forming their illusion of white supremacy.

Fanon's account of the *colonial*/*white gaze* begins with a vignette from his early experience of being observed by white child and her mother in France. Their white gaze upon his Black flesh distorted his own self imagination:

> In the white world, the man of color encounters difficulties in elaborating his body schema. The image of one's body is solely negating. It's an image in the third person. All around the body rains an atmosphere of certain uncertainty… It is not imposed on me; it is rather a definitive structuring of myself in the world – definitive because it creates a genuine dialectic between my body and the world …I was responsible not only for my body but also for my race and my ancestors. I cast an objective gaze over myself, discovered my blackness, my ethnic features…Disoriented, incapable of confronting the other, the white man, who had no scruples about imprisoning me, I transported myself on that particular day far, very far, from myself, and gave myself up as an object.[55]

Fanon illuminates the ongoing process by which his psyche is formed by *Othering* his Black skin. The sociogenesis of the white gaze locks the observer and the observed perversely into a relationship of oppression.

Should the colonized assimilate to the white gaze, this mimesis, imitation, only reinforces the Black inauthentic self-perception as the alienated Other. As David Hume long ago observed, the fete would be only a display of *parroting* by the *Other*.[56] Refuting Merleau-

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54. Frantz Fanon, *Black Skin, White Masks*, trans. Richard Philcox, Revised edition (New York : Berkeley, Calif.: Grove Press, 2008), 89.

55. Fanon, 90-93.

56David Hume, *Essays and Treatises on Several Subjects.*, Essays and Treatises (Edinburgh: Edinburgh Cengage Gale, 1793), 512.

Ponty's phenomenology of anti-black racism, Fanon proffers the Black body as the fundamental problem of racism and not the source of pre-reflective consciousness.[57] Fanon encounters with whiteness created permanent and situational sub-schemes that reshaped his self-consciousness. His account is paradoxical. It proposes the altered schema, that is, at once, a product of agency and control, and yet restricted by boundaries of the coloniality of being in white imaginations of and desires for mastery over the body:

> Beneath the body schema I had created a historical-racial schema. The data I used where provided not by "remnants of feelings and notions of the tactile, vestibular, kinesthetic, or visual nature" but of the other, the white man, who had woven me out of 1000 details, anecdotes, and stories. I thought I was being asked to construct a physiological self, to balance space and localize sensations, when all the time they were clamoring for more…I couldn't take it any longer, for I already knew there were legends, stories, history... As a result, the body schema, attacked in several places, collapsed, giving way to an epidermal racial schema.[58]

This race-based violence shaped by the white gaze triggers a collapsing of Fanon's bodily schema. The colonize is subjected to corporeal schema, rooted in normative standards of whiteness, that give shape to their preconscious, subconscious, and unconsciousness. For Fanon, the *body* discerns nothing *otherwise than being* beyond the coloniality of being, bound by its sociogenesis in cultural formations on colonized ground, constraining Black flesh by the omnipotent force of the white gaze.[59] Although Fanon's conception of the white gaze is rooted in perpetual violence, he would nevertheless find agency by the total overhauling of colonized consciousness by embracing a new revolutionary Black consciousness that would mark his last years in the Algerian liberation struggle.

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57. Dilan Mahendran, "The Facticity of Blackness: A Non-Conceptual Approach to the Study of Race and Racism in Fanon's and Merleau-Ponty's Phenomenology," *Human Architecture: Journal of the Sociology of Self-Knowledge* 5 (2007): 191+.

58. Fanon, 91-92.

59. Emmanuel. Lévinas, *Otherwise than Being, or, Beyond Essence*, trans. Alphonso Lingis, Martinus Nijhoff Philosophy Texts ; 3 (The Hague ; Martinus Nijhoff, 1981).

W.E.B. Du Bois' description of double consciousness and second sight also attempts to interrogate the ways that the Black psyche is impacted by the white gaze but rooted in the U.S. context. Developed nearly half a century before Fanon's work, Du Bois' construction of double consciousness retains the agency and dignity by the observed, which is foreclosed in Fanon's earliest account of the colonial/white gaze:

> After the Egyptian and Indian, the Greek and Roman, the Teuton and Mongolian, the Negro is a sort of seventh son, born with a veil, and gifted with second-sight in this American world, —a world which yields him no true self-consciousness, but only lets him see himself through the revelation of the other world. It is a peculiar sensation, this double-consciousness, this sense of always looking at one's self through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity. One ever feels his two-ness, —an American, a Negro; two souls, two thoughts, two unreconciled strivings; two warring ideals in one dark body, whose dogged strength alone keeps it from being torn asunder.[60]

Fanon and Du Bois hold that the making of colonized minds has its roots in the sociogenesis of the coloniality of being. Internalizing the white gaze is perceived as an inward two-way mirror that reflects the *Other* being simultaneously observed by the white gaze. One has but the imagine being placed in an interrogation room with a two-way mirror between the observed and observers, ever viewed by suspicious eyes on oneself. There is violence inherent in this perpetual adjustment felt by the observed but obscured from the observer. Fanon speaks of this feeling as an "[attack on] the body schema," and Du Bois as two "unreconciled strivings; two warring ideals"; the affect "[giving] oneself up as a subject" (Fanon); and "torn asunder" (Du Bois). An immediate distinction emerges in Fanon's colonized consciousness and DuBois' double consciousness. The distinction, in the one, is the futility of reconciling colonized gaze within Black self-consciousness (Fanon) and, in the other, an expressed pessimism in in reconciling Black self-consciousness against the mirror of the white gaze (DuBois).

60. W. E. B. Du Bois, *The Souls of Black Folk.* (New Haven, CT: Yale University Press, 2015), https://doi.org/10.12987/9780300213720, 5.

2.2.3 The Normative Gaze (Cornel West)

Cornel West extends this Du Boisean double consciousness in his genealogy of racism. In *Prophecy Deliverance*! *An Afro-American Revolutionary Christianity,* his treatment of the white gaze also bears a semblance to Fanon's account. [61] West constructs a "discourse that interprets, describes, and evaluates Afro-American life in order comprehensively to understand and effectively to transform it."[62] West provides a genealogy of Blackness in the European intellectual tradition to develop the notion of *the normative gaze* dependent on this history of knowledge. His now classic essay, "A Genealogy of Modern Racism" demystifies the "logic endemic to the very structure of modern discourse" and render, "the controlling metaphors, notions, and categories of modern discourse produce and prohibit, develop and delimit, specific conditions of truth and knowledge, beauty and character, so that certain ideas are rendered incomprehensible and unintelligible."[63] This discourse formed the basis of the cultural logic undergirding the canon of philosophical and scientific knowledge. The canon of knowledge emerging from the seventeenth- and eighteenth-century European Enlightenment was uncritically advanced as authoritative and so provided the "intellectual legitimacy of the idea of white supremacy.[64] His dissection of the *normative gaze*, analogous to Foucault's *medical gaze* and Fanon and DuBois's *white gaze,* unveils the authority of the observer and the internal eye of the observed.

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61. Cornel West, *Prophesy Deliverance!: An Afro-American Revolutionary Christianity* (Westminster John Knox Press, 2002), 16.

62. Cornel West, *Prophesy Deliverance!: An Afro-American Revolutionary Christianity* (Westminster John Knox Press, 2002), 16.

63. Cornel West, *46*.

64. Cornel West, 61.

West's genealogy begins with the methodological tools of the scientific revolution's advancement on observation and evidence. He reviews the contributions of philosophers Francis Bacon and René Descartes to suggest how their inductive empirical and deductive rationalist methodologies, respectively, prioritized observation and evidence as the new paradigm of experimental science.[65] This prioritization of observation and evidence was further shaped by the classical revival and resulting neoclassical movement from 1300-1750. This period cemented "Greek ocular metaphors and classical ideals of beauty, proportion, and moderation" into the structure of modern discourse in ways that created an "ideal value-free subject engaged in observing, comparing, ordering, and measuring in order to arrive at evidence sufficient to make valid inferences, confirms speculative hypothesis, deduce air proof conclusions and verify true representations of reality." [66] Drawing on Foucault's archaeology of scientific knowledge, West argues that the *normative gaze* identifies the authoritative power of cultural norms and aesthetics that were used to advance a model of natural history and develop a system to classify the natural world based on observable traits.[67] This system of classification undergirds the logics of white supremacy by creating an ideal Euro-centered form as the order of truth.

West identifies three stages of the emergence of modern racism that were scaffolded upon this structure of modern discourse. His review of the stages reveals, "the creative fusion of scientific investigation, Cartesian philosophy, and the classical aesthetic and cultural norms."[68] The first entailed the first scientific categorizations of humans by race using skin

65. Cornel West, 52.

66. Cornel West, 53.

67. Cornel West, 55.

68. Cornel West, 65.

color in the seventeenth and eighteenth centuries. These theorists included physician Francois Bernier, zoologist Carolus Linnaeus, and naturalist Georges-Louis Leclerc, Comte de Buffon. These men advanced into "evidence" that non-Europeans were subspecies of humans and Caucasians the apex of human development. The second and third stages included the disciplines of skull and face reading (phrenology and physiognomy). Anatomist Pieter Camper and physiognomist Johann Kaspar Lavater proffer that nature's ideal form of beauty was found ancient Greek facial features. Africans, they argued, had less symmetrical and disproportionate facial feature and were aberrations from the human ideal of beauty and intelligence.[69] The three stages of modern racism, West argues, contribute to "cultural attitudes and sensibilities, including alienating ideals of beauty"[70] that normalize the everyday exploitation of Black people.

This genealogical approach to understanding the power of the gaze is critical to understanding how perinatal care consistently delivers reproductive suffering. In the clinical encounter, the three gazes collide to constrain moral imagination of clinical teams, patients and their families. Foucault, Fanon, DuBois, and West critique the social and political disciplinary power of the medical, white, and normative gazes on the observer and the observed, l thereby locking in imaginative patterns that constrain possibilities for equitable and creative interpersonal and sociocultural relationships in reproductive health care. Fanon and Foucault suggest that the *hegemonic power* of the oppressor is an inescapable, totalizing force between the observer and observed. In the medical encounter, this force forecloses possibilities for nonwhite patient or colonized agency and resistance to the disciplinary forces of the physician or colonizer. Taken together, their reading of biopower in the clinical encounter suggests that

69. Cornel West, 59.

70. Cornel West, 65.

the provider's imagination of a patient of color is inextricable from racialized ontologies of inherent inferiority, which are reinforced by the epistemological model of biomedical disease.

2.3 Part II: The M.I.C. Residency of the Biomedical Gaze

2.3.1 The Medical Industrial Complex

Part I charts three forces of *the gaze* in relation to dialectics of biopower over the patient (medical gaze), the colonized (white gaze) and the sociogenesis of both in modern racism (normative gaze). The biomedical gaze includes these three into its contour and technoscientific practices prevailing in the M.I.C. The trajectory of medical technoscience practiced in the confines of healthcare systems has reinforced the ways that the biomedical gaze neutralizes and renders invisible the patient's subjective experiences of illness and care. Through managerial science, the management of medicine has increased the pace of the clinic and its reliance on clinical meaning-making through evidence-based medicine and algorithms using *objective data* turned on the patient's body to produce disease etiologies and calculate risk-benefit ratios.[71] Despite efforts to democratize evidence-based medicine, empirical studies suggest that medical trainees increasingly rely on these *black boxes* to guide their early practice. [72] For providers trained in the biomedical model, relevant data can be seen and viewed on screens where haptic or tactile examination of the patient is secondary data, a less

71. David L. Sackett, "Evidence-Based Medicine," *Seminars in Perinatology*, Fatal and Neonatal Hematology for the 21st Century, 21, no. 1 (February 1, 1997): 3–5, https://doi.org/10.1016/S0146-0005(97)80013-4.

72 Alex John London, "Artificial Intelligence and Black-Box Medical Decisions: Accuracy versus Explainability," *The Hastings Center Report* 49, no. 1 (2019): 15–21, https://doi.org/10.1002/hast.973.

efficient way of knowing.[73] This reliance on technoscience is a direct outgrowth of the commodification of medicine and cooptation of neoliberal ideologies of care.

As medical technology rapidly developed, the commodification of medicine began in the mid-twentieth century and reinforced the structure of the biomedical model developed in the previous century. By the early 1970s, critics of the corporatization of healthcare in the U.S. coined the term, *the medical industrial complex* to refer to the increasingly complex privatized system of healthcare.[2] The M.I.C. refers to the commodification of care and the development of market economy for healthcare services. The system was not a coordinated system but comprised of a complicated financial relationship between pharmaceutical companies, health insurance payers, hospitals, and post-acute care settings.

Bolstered by neoliberal logics of the market's adequately to distribute care, healthcare administrators quickly adopted the tools of industrialism and managerial science to secure higher profits and greater efficiency in clinical care while ostensibly improving care.[3] Investigating the commodification of care and the industrialization of managing care resources reveals that the abstractions of patients and employees embodied biomedical and neoliberal logics curated over the course of the last century. The biomedical model is rooted in the cultural logics of the postindustrial age, which treats the patient's body as a machine with increasingly interchangeable parts and the doctor as mechanical engineer. This model sanitizes provisions of healing and caring for unwell persons into a perfunctory process of interrogation and interpretation.

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73. Joey Nicholson et al., "Understanding Medical Student Evidence-Based Medicine Information Seeking in an Authentic Clinical Simulation," *Journal of the Medical Library Association : JMLA* 108, no. 2 (April 2020): 219–28, https://doi.org/10.5195/jmla.2020.875.

The confluent epistemological power of the biomedical model and medical gaze have been solidified by medical technology. The healthcare industry, thus, mimetically developed the process of *McDonaldization*, or the scientific management of industries towards increasing predictability, calculability, efficiently and control. This has led to the proliferation of diagnostic, administrative, and treatment technologies, buttressed by neoliberal ideology that supported the exponential rise of health care administration roles in the 1970s and 1980s. Although these technologies are represented as objective and authoritative sources, their operations mask the subjective aspects of the medical, colonial/white, and normative gazes undergirding the practice and administration of medicine. *This confluence of technology, neoliberal ideology, and biopower in the clinical encounter, I call, the biomedical gaze.*

The biomedical gaze is internalized by health care providers, administrators, and patients and collapses the imagination over disease etiology and treatment pathways, especially for patients already vulnerable by mechanism of socioeconomic or political inequity. The biomedical gaze includes the administrative rhythms and technoscientific algorithms of the M.I.C., the contributary to the hegemonic power of the medical gaze. These mechanisms strengthen the hegemonic power of the medical gaze and white gaze because they have long been assumed to be neutral policies, practices, and programs. The operations of the biomedical gaze can clearly be observed in reproductive health practices such as a trial of labor after cesarean section (TOLAC). Race was encoded into the Vaginal Birth After Cesarean (VBAC) calculator as a correction to disqualify Black women from a TOLAC and increased disparities in cesarean section rates. Although this assessment was advanced as a *neutral* assessment of risk, maternal race only appeared in risk calculations in the U.S. The biomedical gaze functions to ensure that inequitable outcomes are standardized within the organizational structures which limits the agency of clinicians and patients.

2.3.2 Hospital Residency

The encoding of the biomedical gaze into the management of medicine is an outgrowth of the centralization of medical care in hospitals. Since World War II, hospitals rapidly morphed into places of acute medical care, managed by physicians and healthcare administrators. Modern hospitals strive to serve as beacons of medical training, providing scientific cure and innovative treatments. The major shift in the sociopolitical role of hospitals was tied to the social evolution of American medicine in ways that led to increased profitability of care and ultimately contributed to the rise of the M.I.C. As historian Paul Starr reveals in his research, this transformation is distinctive in the history of social institutions and results from careful guidance by the medical profession:

> Few institutions have undergone as radical a metamorphosis as have hospitals in their modern history. In developing from places of dreaded impurity and exiled human wreckage into awesome citadels of science and bureaucratic order, they acquired a new moral identity, as well as new purposes and patients of higher status. The hospital is perhaps distinctive among social organizations in having first been built primarily for the poor and only later entered in significant numbers and an entirely different state of mind by the more respectable classes.[74]

As an institution, the hospital has been a marvel of stakeholder stewardship – first by civic and religious leaders, then by physicians and politicians, and increasingly in the modern era by corporate and industry stakeholders. Hospitals are uniquely situated as social institutions and have aided community leaders in their bids to consolidate and display civic, political, and economic influence.

The hospital was shaped by changing technology, demography, and ideologies of care that changed the shape of communities, reframed attitudes towards health and healing, and restructured the core function of the hospital as a sociopolitical institution. Thus, the trajectory of the hospital was influenced by "changing definitions of health and illness, shifts in the

74. Paul Starr, *The Social Transformation of American Medicine [Electronic Resource] / Paul Starr.*, ACLS Humanities E-Book (Series) (New York: Basic Books, 1982), 145.

ecology of disease, the role of religion, and the fluctuating sense of responsibility for welfare and health care" and, "developments in the modern science and the practice of medicine."[4] Risse suggests that hospital operations have always been distinctive in large part since their missions have been driven by their economic model, moving from personal benefactors, state taxes, to the current domination of insurance reimbursements. However, he notes that every hospital throughout history linked its establishment to a sense of civic responsibility for the health of the population.

While tracking the birth of the hospital from ancient to modernity, Risse finds in the seventeenth- and eighteenth-century European Enlightenments a growth in the hospital, as a site for acute care, and the growth of medicine, as a ritualized science with daily checks and body scans to track and record bodily functions became routine aspects of care. This set the stage for the birth of the early modern European hospital and the medicalization of hospitals so by the 1800s, hospitals became "houses of teaching and research."[75] Just decades later, with the rapid progression of the biomedical model and sciences, the hospital became a "house of dissection" that prioritized physical exams and body knowledge.[76]

For Starr, the story of the hospital's transformation from a charitable almshouse to the center of technoscience is connected to the rise of industrialization and capitalism. Until the industrial era, the hospital had largely operated as a place of refuge rather than administration of medical treatment or practice of medicine. However, by the Civil War, access to anesthesia and antiseptics led to the creation of modern surgery and hospitals as *houses of surgery* and the advent of the American general hospital. The modern hospital is an outgrowth of the

75. Guenter B Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (Cary: Oxford University Press, Incorporated, 1999), 676.

76. Risse, 646.

industrialization of society, which contributed to the full shift in the function of the hospital from a place of respite for the ill to an "efficient and rational organization" that administered specific curative treatments toward the "production of health."[77] This rapid succession of technology, bolstered by a growing class of physicians who desired to increase their social standing, turned hospitals into *the house of science* by the 1950s. This development prioritized the *mission of medical treatment* over *humanistic missions* so that the modern hospital serves as a "house of high technology" prioritizing acute care and medical science leaving "the cure of souls" to ancillary services.[78]

Starr highlights the importance of understanding the unique economic and administrative structure of the American system of care. Unlike their European counterparts, American physicians managed to maintain professional authority and sovereignty through the largely private nature of the hospital.[79] Not only were hospitals physically structured to promote private care, but they were also largely privately funded rather than institutions of the state. Furthermore, American hospitals were designed economically, politically, and structurally for privacy and followed the general conceptualization of the physician as an autonomous agent and the hospital as a non-governmental entity.[12] The transformation of medical care and the industrialization of the hospital complicated the moral landscape of medical practice, says Risse:

> New management techniques and the commodification of medicine are forcing an American hospital system notorious for its bloated finances and decentralization to streamline services and correct notable inefficiencies. This may contribute to desirable institutional reforms, but business values can easily jeopardize the technical quality and humanitarianism inextricably linked to hospital services. The logic of financial gain is already threatening to undermine the hospital's ability to function as a house of healing,

77. Risse, 259.

78. Risse, 677.

79. Starr, *The Social Transformation of American Medicine [Electronic Resource] / Paul Starr.*, 21–22.

prompting calls for a new institutional ethic that could guide caregivers in assisting a "wounded humanity".[80]

The moral landscape of this *new medicine* contributed to increased religious and political scrutiny of hospitals and their treatment of patients that would lead to the development of bioethics, an independent field of applied medical ethics. Theological ethicists were the first to wade into the complex moral landscape of this new medicine and wrestle with the impact of rapidly advancing technology and science on the moral boundaries of the practice and administration of care. Early theological approaches to the changing moral landscape of health care varied widely across and among denominations but overwhelmingly concentrated on the role of individual physicians and their sense of moral commitment to the care of persons in the midst of increasing economic and professional pressures of the clinic.[81]

The current iteration of the biomedical model is an extension of the authority of both biomedical and neoliberal logics of the body, logics that have been carefully curated over the course of the last century. The biomedical model is rooted in the logic of the postindustrial age and treats the patient's body as a machine with interchangeable parts and the doctor as an engineer. This model sanitizes the provision of healing and caring for unwell person into a perfunctory process of interrogation and interpretation. Despite persistent challenges to the epistemological dominance of the biomedical model by other cultural approaches to disease etiology and treatment, practitioners of biomedicine in the U. S. worked diligently to preserve its authority.[82] The ascendance of the profession into a higher-class status hinged on the

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80 Risse, *Mending Bodies, Saving Souls: A History of Hospitals*, 685.

81 Albert R. Jonsen, *The Birth of Bioethics*, 1st edition (New York, NY: Oxford University Press, 1998).

82. Starr, *The Social Transformation of American Medicine [Electronic Resource] / Paul Starr.*, 48.

development of mystified knowledge and specialized languages that created a hierarchy between provider and patients.

2.4 In Good Fellowship: Demonic Operations of the Biomedical Gaze

The mechanisms and practices the biomedical gaze in the M.I.C embrace neoliberal values, which is disturbing to critics, especially to the political theologian, Adam Kotsko. Kotsko suggests that neoliberalism, which surfaced in the 1970s, represented a new economic order that has shaped, what womanist social ethicist, Emilie M. Townes, calls *the Fantastic Hegemonic Imagination*.[83] Neoliberalism was adopted as a mechanism of guaranteeing socioeconomic freedom through the marketplace. The marketplace is the moral arbiter providing "an account of the source of legitimacy for our social institutions and of the moral order of the world."[84] That, says Kotsko, places all in the marketplace of competitive advantage where winners and losers find position. He describes the logic of neoliberalism as demonic:

> Neoliberalism makes demons of us all, confronting us with forced choices that serve to redirect the blame for social problems on to the extensible poor decision-making of individuals. This strategy attempts to deal legitimate protest – and ultimately even political debate as such –in advance by claiming that the current state of things is what we have all collectively chosen.[85]

As Foucault above saw analogies between the medical gaze and clericism, so Kotsko finds in the embrace of neoliberal values by the biomedical gaze a political theology where what is of ultimate concern is ones' standing in the arena of monetary competition as the highest aspiration and human ideal.[86] Proponents of neoliberalism advanced the idea that the

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83. Emilie Maureen Townes, "Womanist Ethics and the Cultural Production of Evil. Black Religion, Womanist Thought," *Social Justice. New York: Palgrave Macmillan*, 2006.

84 Adam Kotsko, *Neoliberalism's Demons : On the Political Theology of Late Capital* (Stanford, CA: Stanford University Press, 2020), 33, https://doi.org/10.1515/9781503607132.

85 Kotsko, 2.

86 Kotsko, 7.

market, left alone, could solve problems that the State could not. The ideology of neoliberalism is upheld through its competitive market ethos, which coerce individuals and institutions into participating in marketplaces. By naming the operations of neoliberalism a political theology, Kotsko hopes to contrast the authority of neoliberal's market morality, as West calls it, to modes of legitimacy and authority invested in counter moral institutions to "maintain their explanatory power and justify the loyalty of their adherents."[87] His argument extends Peter Berger's observation of religion as a world structuring ideology to suggests that neoliberalism is a secular theology.[88]

Neoliberalism restricts expressions of freedom to competitive positioning and as a result restricts the individual and social flourishing of the least advantaged. Kotsko argues that healthcare, specifically the creation of the Affordable Care Act (ACA) and its focus on the creation of a marketplace for health insurance is a direct product of this secular theology. He suggests that a commercial marketplace is the appropriate mechanism for distributing medical care is a prime example of neoliberalism's demonic power to constrain human flourishing. The ACA's explicit goal is to refrain from directing the flow of resources by neutrally developing and supporting competition among independent insurance marketplaces.[89] This idea contributes to the idea that competition could drive equity and access to health care. In this framework, those who do not receive adequate care are responsible for their poor decision-making in the seemingly neutral marketplace:

> Overall, then, in neoliberalism an account of human nature where economic competition is the highest value leads to a political theory where the prime duty of the state is to enable, and indeed mandate, such competition, and the result is a world wherein individuals, firms, and states are all continually constrained to express

87. Kotsko, 8.

88. Peter L. Berger, *The Sacred Canopy; Elements of a Sociological Theory of Religion, by Peter L. Berger.*, [1st. ed.] (Garden City, N.Y: Doubleday, 1967).

89. Kotsko, *Neoliberalism's Demons : On the Political Theology of Late Capital*, 37.

> themselves via economic competition. This means that neoliberalism tends to create a world in which neoliberalism is "true." A more coherent and self-reinforcing political theology can scarcely be imagined…[20]

Neoliberalism self-legitimatizes itself by constructing freedom as individual choice and market competition as "the highest actualization of human liberty."[90] Kotsko's treatment of neoliberalism as a political theology illuminates how biopolitical power lies invisibly embedded in the collective psyche of U.S. citizens and how structured ignorance of its power aids adherence to its ideals.

The focus on autonomy as a goal of medical care as a principle of bioethics illuminates the *demonic* operations of the biomedical gaze undergirding modern healthcare. The primacy of autonomy in bioethics has been long criticized by ethics of care theorists for its underlying assertion that those at the most vulnerable stages of life ought to function as autonomous agents. In a neoliberal sociopolitical structure, health is considered the outcome of morally defensible individual choices. The autonomous and economically productive citizen, deserving good health, is the rational actor choosing health promoting behaviors, pursuing education to become a health literate consumer, participating in high quality health insurance plans through employment, and selecting the best doctors and health care options among competitors. Neoliberalism suggests that one's health status is result of individual choices that require individual risk management rather than social or collective response to structural inequity.[91] The biomedical gaze's emergence out of neoliberal structures leads it to wield hegemonic power over medical decision-making options, and this bodes poisonous consequences for those who are least socioeconomically advantaged in the "competition" for equitable health

90. Kotsko, 10.

91. Kotsko, 95.

outcomes. Dismantling the hegemony of the gaze begins with demystification and consciousness-raising among those most benefiting its interpretive power, says Jessica Young, et al.[92]

2.5 Fully Attending to the Biomedical Gaze

This chapter began with a mandate of demystifying and consciousness raising concerning the socially poisonous and death dealing effects of the biomedical gaze and its hold over the M.I.C. Undoing its damage began with its morphology in the sociogenesis of the medical gaze (Foucault), the colonial/white gaze (Fanon and Du Bois), and the normative gaze (West), each shaping the contour of the biomedical gaze. Foucault's conceptualization of the medical gaze provided a perspective into how the practice of medicine abstracts suffering in ways that generate biopower by constraining the range of etiological possibilities within and beyond the clinical encounter. The colonial/white gaze offered by Fanon and Du Bois, respectively, extracted the violent mechanics of racialized biopower and the impact on moral agency. Their works excavated how the colonial/white gaze was cemented within the psyche of the colonized and colonizer and bifurcated the sense of the self among the oppressed. This bifurcated sense of self is maintained through the mechanics of what West called the normative gaze – or the deep encoding of Eurocentric norms and aesthetics into sociocultural productions including science, medicine, and art.

In this chapter I traced how the ontological parity of these gazes have taken up residency within the M.I.C. and further encoded as the biomedical gaze through the development of the technoscientific management of medicine and healthcare administration. I suggest that the four iterations of the gaze shape the contour of the biomedical gaze and are

92. Jessica Young et al., "The Valuing of 'good Care' within Neoliberal Times: The Importance of Relationship Activities," *New Zealand Sociology* 32, no. 2 (2017): 81.

crucial for demystifying racially inequitable reproductive suffering and identifying generative pathways towards reproductive flourishing. At stake for the oppressed and the oppressor is acknowledging the totalizing, dehumanizing effects and affects that the biomedical gaze poses for providers and patients. This recognition urges the quest for innovative ways of humanizing the clinical encounter. Chapter 3, then, explores the field of clinical ethics as a response to the biomedical gaze.

CHAPTER 3

The Biomedical Gaze and the Clinical Ethics Encounter

1. 30-year-old Somali woman G2P1000 at 21w4d by 19wk US. Bright red vaginal bleeding started on 9/27. Subsequent had imaging demonstrating complete placenta previa. MRI as an inpatient further suggested placenta accreta in the left lower uterine segment.

2. Ethical issues arose when the patient refused recommended surgery needed to save her life. She will not be able to carry the baby to term reportedly and since she lost her first baby after 3 days, this is a very wanted pregnancy. Team has tried on multiple occasions, with other family present, to explain, using the language line. This has been difficult because of cultural norms-often the translators are other men. Nevertheless, they appear to understand what has been said to her/them, they have just refused the surgery. They have agreed to transfusion and large bore IV lines.

3. Case reviewed and discussed with team and nurses. Also consulted with translation services about their experience with family and discussion. Team has done everything ethically appropriate to work towards the best outcome for mom and the family. We will honor her wishes to refuse lifesaving treatment as long as the team believes she is able to make decisions and understands the consequences of her choices.

4. Team felt/experienced that patient and spouse were understanding well. Patient agreed to continue hospitalization to carry the baby for as long as possible. Got him just past 22 weeks Cesarean hysterectomy 10/21. Baby boy taken to NICU. Suffered severe intracranial bleed, GI problems. DNR 11/13 for imminent death. He was just too small to survive.[93]

3.1 Introduction

The above case was my first exposure to the discursive practices of bioethics centered on cultural and reproductive ethics. The case provides a clear example of how ethical dilemmas often emerge from structural and institutional inequities and how bioethicists deploy the biomedical gaze in ways that frame the scope of which concerns are *bioethical*. The write-up provides a clear sense that the bioethical issue was refusal of treatment by a woman acting as an agent over her reproductive health care and conditions under the medical team to accept the

93. VUMC Center for Biomedical Ethics Case Review, September 2017

patient's refusal. As the team considered whether the ethical management of this case maximized the best possibilities of outcomes for the clinical team, the patient, and her family, I ruminated on the role of bioethicists as mediators. Clinical bioethicists are like social workers in acute care settings as hospital-employed providers tasked with problem solving individual cases that emerge from conflicting interests of inter-and intra-institutional structures and policies and interpersonal concerns.

The case is the discursive form of bioethics that is paradoxically an intimate and impersonal encounter with suffering. Bioethicists in hospitals navigate this space as insider-outsiders with varying levels of legibility and credibility to address and advocate for equitable individual and institutional practices. This chapter examines the history of bioethics under the gaze of the bioethical model that ubiquitously shape disciplinary boundaries and practices of applied ethics. I apply critical discourse analysis to understand how clinical ethics addresses antiblack obstetric violence, assess what possibilities exist for reproductive bioethics to address systemic suffering within the M.I.C. Critiques of bioethics from within and outside of the field understate the complicated relationships between bioethics and the M.I.C. by prioritizing historical or contemporary analyses of the field. In this chapter, I integrate the two approaches by examining the sociopolitical milieu undergirding the emergence and growth of the field in relation to reproductive ethics and the contemporary posture of reproductive ethics focused on Black families. I attend to how their disciplinary practices and postures rely on the biomedical gaze and mimics the neoliberal values embedded in the M.I.C.

3.2 Historical Overview

Bioethics emerged as hospitals transitioned from serving as theological houses of care designed to provide comfort to suffering souls to complex centers of technology and innovation designed to treat and produce medical research and health as quantifiable commodity, the

M.I.C. It developed concurrently as a discursive formation and inter-professional practice in the mid-twentieth century in direct response to sweeping technological, social, and political changes in the practice and administration of medicine.[94] The field was established to help administrators and clinicians make ethically and legally defensible choices as they navigated the increasingly complex moral landscape of biomedicine. Doctors, lawyers, theologians, and philosophers wrestled to find common ground as the landscape of healthcare and meanings of life, death, cure, and care shifted beneath them.

As medical technology rapidly reshaped healthcare practices, treatment options, and the very meaning of life and death in the 1950s, there was simultaneously a rise in reported human rights violations in research ethics and clinical practice. Politicians and physicians invited moral, religious, and legal experts to provide guiderails pointing to boundaries of appropriate medical practice in light of technology reshaping the definitions of life, death, and the role of medicine.[95] By the 1970s, symposiums and conferences focused on theological and philosophical issues in medicine, which morphed into an independent field of discourse. The 1980s and 1990s saw this growing discourse developed into a medical profession called *clinical ethics* and an academic discipline called *bioethics*. In a generation, bioethics and bioethicists became linchpins in the sociopolitical governance of biomedicine and biotechnology.[96]

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94. Lopez, Jose. "How Sociology Can Save Bioethics . . . Maybe." *Sociology of Health & Illness* 26, no. 7 (2004): 875–96.

95. David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*, 2nd pbk. ed., Social Institutions and Social Change (London: Routledge, 2017); Jonsen, *The Birth of Bioethics*.

96. David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*, 2nd pbk. ed., Social Institutions and Social Change (London: Routledge, 2017)

3.2.1 Shifting Power Relations in Biomedicine

As with biomedicine, bioethics emerged from a series of professional negotiations concerning the boundaries of moral authority and decision-making power.[97] Through the development and consolidation of power in an institution such as the American Medical Association (AMA), physicians were able to develop professional solidarity, respectability, and develop a lucrative marketplace for their services.[98] While this increasing reliance on institutions facilitated the consolidation of professional and financial power for physicians, it also contributed to the steady decline of moral standing. The growth of bureaucratic healthcare institutions ultimately served to curtail physician's authority by constraining their clinical, administrative, and financial autonomy.[99] As medical care was centralized and "practically every development in medicine in the post-World War I1 period distanced the physician and the hospital from the patient and the community, disrupting personal connections and severing bonds of trust," decision-making authority and governance of appropriate medical practice transferred from practicing physicians to administrators.[100] Choices concerning the allocation and limitations of appropriate medical care were now matters of institutional reputation and industry-level resource negotiations.

The consolidation of smaller hospitals into larger regional centers in the following decades resulted in an increased pace of acute care that further anonymized the context of

97. Jonsen, *The Birth of Bioethics*, 4.

98. Starr, *The Social Transformation of American Medicine [Electronic Resource] / Paul Starr.*, 21–22.

99. Starr, *25.*

100. Rothman, *127.*

medical care.[101] As hospitals invested in complex technology and deployed scientific management practices, they were able to focus institutional resources on the most acute and emergent illnesses and injuries.[102] The uses of statistics and screens were foregrounded over engaging the voice and body of the patient so that "pausing by the bedside has come closer to being, diagnostically speaking, an indulgence, for the patient is frequently far less interesting and less revealing about symptoms than the technology."[103] As hospitals became sites for the most acute types of medical care, administrators sought to regulate the flow of non-staff caregivers and families to not disturb the rhythm of care. The adoption of electronic medical records, digital note taking, centralized vital monitoring tools, and other technologies contributed to the standardization of healthcare practices. Simultaneously, technology created social and physical isolation through an increasingly sanitized clinical environment and instituted structural barriers to the connection between physicians and patients.

3.2.2 Changing Public Opinions about Biomedicine

The public ethos of doctors and healthcare shifted in relation to changes of the nature of the doctor-patient relationship. While the Nuremburg Trails of the 1940s exposed the connections between the racist logics of the American eugenics movement and the atrocities committed during the Holocaust, the steady progression of medical technology was accompanied by a general sense of optimism about medicine leading up to the mid-century.[104]

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101. Rothman, 131.

102. Starr, 430-435. "In 1961 there were only five consolidations of hospitals in the United States; by the early 197os, the number had grown to about fifty a year. In its 1980 survey of multihospital systems, the trade journal Modern Healthcare found 176 systems owning or managing 294,199 beds. Another survey, conducted under the auspices of the American Hospital Association, found 245 multihospital systems with 301,894 beds."

103. Rothman, *132*.

104. Albert R. Jonsen, *The Birth of Bioethics*, 1st edition (New York, NY: Oxford

Medicine and technoscience produced: the discovery of Penicillin in 1928, the discovery of the usefulness of streptomycin for tuberculosis in1946, the rollout of the polio vaccine in1950s, invention of the pacemaker, the successful completion of a heart valve replacement and open heart surgery the 1952, and the invention of the electronic defibrillator in 1958. However, optimism about the swift advance of medical technology throughout the 1950s began to wane precipitously as insiders (clinicians and scientists) and outsiders (journalists and politicians) began publicly to reveal practices regarded as unethical in medical research. Spurred by public investments during the World II era and private investments in the post-war period, from the 1940s to 1970s biomedicine experienced exponential growth in its "Golden Age" of research and development.[105] Signed into law by Harry Truman in 1946, the Hospital Survey and Construction Act (Hill-Burton Act) provided over $3.7 billion for the development of over 6,8000 hospitals, long term and ambulatory care facilities from 1947-1971.[106]

The Hill-Burton Act contributed to ongoing structural inequity in the distribution of medical care. Due to lobbying the Commission on Hospital Care, a coalition that included the American Hospital Association, and the Kellogg and Commonwealth Foundations, there was overwhelming concentration of hospitals in middle-income communities.[107] Furthermore, until 1963, when the U.S. Supreme Court decision in Simkins v Moses H. Cone Memorial Hospital led to the ruling that racial segregation of public hospitals violated the equal protection clause, the majority of these hospitals refused to treat nonwhite patients.[108] While the provisions of the

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University Press, 1998), 12.

105. Franco Malerba and Luigi Orsenigo, "The Evolution of the Pharmaceutical Industry," *Business History* 57, no. 5 (July 4, 2015): 664–87, https://doi.org/10.1080/00076791.2014.975119.

106. Starr, *348-50.*

107. Starr 350.

108. P. P. Reynolds, "Hospitals and Civil Rights, 1945-1963: The Case of Simkins v Moses H.

Hill-Burton Act limited federal and state oversight in the buildout of the healthcare infrastructure, investments in healthcare insurance contributed to the *de jure* and *de facto* desegregation of hospitals. The massive expenditure of dollars in Medicare and Medicaid was accompanied by careful regulation to manage uncertainty concerning the ability of administering health insurance at the national level.[109]

The Blue Cross health insurance plans were created in the prewar period and by 1940 boasted over 6 million subscribers. However, a health insurance industry emerged in earnest with the rise of employer-based health insurance plans in the 1950s.[110] Catalyzed by the commodification of medical services by Medicaid and Medicare, employer and government sponsored health insurance provided stable sources of financing as well as the basis for an integrated medical economy. [111] By 1971, critics had deemed this growingly complex and lucrative network of hospitals, healthcare facilities, insurance and pharmaceutical companies, the Medical Industrial Complex (M.I.C.). The growth of and maturation of the M.I.C led to increased public and political pressure to have independent oversight over ethical boundaries of clinical medicine and medical research:

> In the decades after World War II, medical ethics took a turn as medical science advanced and medical interventions became increasingly technical. The decorum was challenged by impersonal machines that intervened between doctor and patient. Traditional duties were challenged because it was no longer clear what is benefit and what is harm…The social ethics was challenged by the growing intricacy of medicine with government, commerce, and the producers of new technologies. Medicine grew so technical it became expensive; who assumes the duty of caring for those who cannot pay? Cultural and religious changes led to doubts about the authority that had been the

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Cone Memorial Hospital," *Annals of Internal Medicine* 126, no. 11 (June 1, 1997): 898–906, https://doi.org/10.7326/0003-4819-126-11-199706010-00009.

109. Jonsen, *388.*

110. Starr, 428-429

111. Starr, 428-429.

> privilege of the professional. The untroubled medical conscience began to feel some qualms.[112]

Questions covering clinical practice began to surface concerning the role, allocation, and cost of new technologies. The AMA's *Code* of professional ethics did not account for concerns presented by the "new medicine" of the post-World War II era.

The erosion of public trust and confidence in physicians was also a consequence of the medicalization of society. [113] Largely shaped by media, the public imagination of medicine contributed to changes in patients' attitudes and expectations of the clinical encounter. The exposure of medical foul play by insiders such as Henry Beecher and outsiders such as journalists and activists, changed the public perception of the medical practice and physicians. Beecher's 1966 exposure of research violations intensified suspicions about the role of providers and about increasing technologizing of the medical encounter. The increasing general public pessimism regarding healthcare lagged behind that of nonwhites rendered nonhuman by the logics of medical, white, and normative gazes operative in biomedicine and white women treated as inferior facsimiles of the male body. Thus, the activism of the Freedom and Feminist Movements in the early and mid-1900s only publicly exposed what minoritized populations had experienced in biomedical treatment for at least a century.

In addition, the most complicated bioethical cases were often news spectacles, and coverage often maximized the dramatic effects. "The AMA [American Medical Association] was a powerful trade lobby and the doctor, a rapacious businessman."[114] Healthcare was

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112. Jonsen, 12.

113. Peter Conrad, *The Medicalization of Society on the Transformation of Human Conditions into Treatable Disorders* (Baltimore: Johns Hopkins University Press, 2007).

114. Rothman, 141

increasingly viewed as a marketplace and the physician, a commission-driven vender in an economic marketplace.[115] Reporting of specific controversial cases and healthcare as a general industry thus increased legitimacy of bioethics practitioners by portraying bioethicists as value and industry neutral moral adjudicators providing expertise and objectivity.[116] As advances in medical technology led to continued public outcry and contemplation of the boundaries and meanings of life and death and increasing agreement that these neutral outsiders ought to be responsible for regulating the profession.[117]

Professional, political, and public concern about the changing landscape of biomedicine led to a series of conferences in the 1960s devoted to interprofessional and interdisciplinary wrangling over how physicians might ethically use new medical technologies that were changing the definitions of life and the expectations for physicians preserving and prolonging it.[118] Nonmedical professionals including theologians, philosophers, and lawyers generated a set of robust research agendas and a corollary demand for academic institutions to house these agendas. By the 1970s, bioethics was well on its way to becoming an independent academic field led by non-clinicians who served in independent research institutes such as the Hastings Center and academic centers such as Georgetown's Kennedy Institute.[119]

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115. Rothman, 4

116. Jonsen, 372

117. G O Ginn, "Strategic Change in Hospitals: An Examination of the Response of the Acute Care Hospital to the Turbulent Environment of the 1980s.," *Health Services Research* 25, no. 4 (October 1990): 565–91.

118. Jonsen, 18.

119. Jonsen, 19-20. "The discourse of the conferences was now fitted into a general framework of research fostered by several new permanent centers: the Institute of Society, Ethics and the Life Sciences (The Hastings Center) and the Kennedy Institute of Ethics at Georgetown University. A third organization, The Society for Health and Human Values, also encouraged interdisciplinary activity. These organizations were the culmination of the decade of conferences: they gave permanent homes to the discourse of bioethical concern."

The development of bioethics supported the transition from individual, informal decision-making by physicians to collective and formal processes dominated by written documentation and aligned to value-neutral normative principles:

> Whether drawing on a tradition of predictability (in the law) or of first principles (in philosophy or religion), they [outsiders to medicine] joined together to create a new formality and impose it on medicine, insisting on guidelines, regulations, and collective decision making. They concurred on the need to reduce physicians' discretion and enhance patients' autonomy.[120]

These outside moral experts were largely non-clinicians who lacked the technical context to appropriately understand and respond to the intricacies of the dilemmas facing the medical community. Thus the *armchair ethics* presented by the early progenitors of bioethics in the 1970s and 1980s insufficiently addressed the complicated nature of the clinical encounter. However, within a decade, armchair bioethicists, such as Richard Zaner, made their way into the clinic and used their insider-outsider status to advocate for inter-professional clinical training for the next generation of bioethicists. This need was warranted since by 1992, the Joint Commission on Accreditation of Healthcare Organizations mandated that health care organizations "have in place a mechanism for the consideration of ethical issues arising in the care of patients, and…provide education to caregivers and patients on ethical issues in health care."[121]

The uniquely American field of bioethics thus emerged as a regulatory solution to ethical complexities raised by rapidly advancing technologies post World-War II and concurrent rise of healthcare as an economic industry with political power. The rapid rise of life-prolonging treatments in the second half of the century alongside increasing media

120. Rothman, 5.

121. Pat Milmoe McCarrick, "Ethics Committees in Hospitals," *Kennedy Institute of Ethics Journal* 2, no. 3 (1992): 285–306, https://doi.org/10.1353/ken.0.0041.

attention to the failures of medicine, led to changing concepts of the sanctity of life and the cost and equitable distribution of scarce medical resources. The field of bioethics served as a tool for addressing the gap between medical ethics as a professional code and public/political angst over revelations that medical practice was embedded in economic, social, and political inequities.

3.3 From Medical Ethics to Bioethics

While the first generation of bioethicists were hyper focused on the clinical encounter, the 1980s saw academicians, who were increasingly engaging in clinical ethics practice, suggesting that there was a moral responsibility to shift medical practices. Recognizing that institutional constraints to practicing patient-centered medicine were outside the control of the individual doctor and well entrenched in the structures of health care, these bioethicists were looking to develop more holistic approaches to applied bioethics:

> To read some of the [bioethics] critiques, one would think the problem is mostly a matter of educating medical students by emphasizing communication skills (so doctors learn better how to interview and how to listen) and incorporating the humanities into the curriculum (on the theory that studying the classics will increase empathy). But however worthwhile these efforts, a reliance on the education of the future practitioner as the vehicle for change minimizes the structural barriers to recasting the doctor-patient relationship. The organization and delivery of medical care almost guarantees that at a time of crisis patients will be treated by strangers in a strange environment. This circumstance has transformed many patients' behavior, encouraging a style closer to that of a wary consumer than a grateful supplicant. Moreover, this distancing helps explain why a cadre of outsiders felt compelled to enter the medical arena and promote a commitment to a more formal and collective type of medical decision making, including regulatory guidelines and committee oversight.[122]

Scholars like Rothman articulates the failure of bioethics to socio-politically situate the interactions between physicians and misunderstand the appropriate locus of change in

122. Rothman, *Strangers at the Bedside*, 128.

healthcare. He suggests that bioethicists fundamentally misunderstand the very social and economic structures of biomedicine that made room for their ascendance in the field.

This story of the rise of bioethics, including the dominance of its normative principles, is also bound to the culture of academia in the U.S. and the prominence of American liberalism. While Jonson suggests that neither the philosophers nor theologians entered the realm of bioethics with a set of canonical or methodological commitments, *logical positivism* was a favored method of analysis.[123] Indeed the discursive practices of bioethics are uncontestably tied to the influence of moral philosophy, theology, and legal studies. Johnson suggests that originators of bioethics "reinvented", in an unconscious atavism, the style of public philosophy that William James and John Dewey had invented decades before. Bioethics engaged the facts of the case, explored alternative solutions, tested these against the opinions of many participants and worked to turn these principles into practice." [124] Despite common methodological roots in pragmatism, theological and philosophical bioethics developed on parallel tracks with clearly articulated and divergent ends that compartmentalized early exchanges between theological and philosophical bioethics.

Jonson suggests that a *trinity of theologians*, which included Joseph Fletcher, Paul Ramsey, and Thomas McCormick, were driven by practical and ministerial ends while philosophers focused on theory. "Above all, they differed profoundly in their purposes: theologians studied ethics in order to educate their congregations in the moral life; philosophers pondered ethics in order to unravel conceptual puzzles and probe theoretical foundations. They

123. Jonsen, *The Birth of Bioethics*, 88. "I believe that bioethics inherited from its distant and almost forgotten forebearers, the American philosophers (pragmatists), some of its most distinctive traits."

124. Jonsen, 83.

did not easily learn to converse." [125] After a decade spent resolving their divergent ends and discursive practices, these theologians, philosophers, clinicians, and lawyers, quickly realized the need to coalesce as their discourses developed into an authentic profession with the growth of independent, governmental, and academic institutes for bioethics. Encouraged by the growth of the legitimacy of bioethics as a professional identity, theologians and philosophers developed a common disciplinary language and merged their distinctive identities into one professional identify of the *bioethicist*:

> The theologians came out of their churches and into the conferences, bringing a tradition of reflection on the moral life and a rich vocabulary. Academic philosophers, segregated from public philosophy by the arcane terminology of analytic philosophy, arrived at the conversation, eager to instill logic into arguments. Philosophers and theologians quickly realized that they needed not only to familiarize themselves with the world of science and medicine but also how to phrase arguments that the other conversants could understand and answer.[126]

In this way, common discursive practices of these fields contributed to the reliance of bioethics on, "formalistic, procedural, disembodied and universalist way(s) of identifying and solving bioethical dilemmas."[127]Although the recent internal urge to further legitimize the field through certification has been controversial and as a result, placed greater scrutiny on the diversity of the field, bioethics continues, without much public controversy, to be a highly interdisciplinary field with trainees hailing from the fields of law, medicine, philosophy, religion, and the medical humanities.[128]

125. Jonsen, 83.

126. Jonsen, 352.

127. Jose Lopez, "How Sociology Can Save Bioethics . . . Maybe," *Sociology of Health & Illness* 26, no. 7 (2004): 879, https://doi.org/10.1111/j.0141-9889.2004.00421.x.

128. Mark Siegler, "The ASBH Approach to Certify Clinical Ethics Consultants Is Both Premature and Inadequate," *The Journal of Clinical Ethics* 30, no. 2 (2019): 109–16.

3.4 Principlism as a Hegemonic Discourse

In these disciplinary negotiations, the bioethical principle framework quickly became the hegemonic discourse of applied bioethics. Principlism advances a value-neutral approach to applied ethics rooted in four principles: autonomy, beneficence, non-maleficence, and justice. This approach was developed in 1979 by Tom Beauchamp and James Childress and advanced the idea that biomedical ethics ought to be rooted in: *Respect for autonomy* – the decision-making ability of autonomous persons; *Nonmaleficence* – avoiding harm; *beneficence* – providing benefits and balancing risks; and *Justice*- fairly distributing risks and costs of medical care. Designed to address the prevalence of medical paternalism, principlism essentially posits that physician responsibility ought to be understood as limited service-based function that ensures patients are able to flow efficiently through the hospital. Although the concept of justice, as a principle includes equitable access to care, it is typically construed as interpersonal responsibility concerning the distribution of resources among patients.[13]

Autonomy operates explicitly as the leading principle among principles. This principle has been consistently attacked because of its latent ethnocentrism and lack of connection to the reality that the care of patients is connected to a social web with existing power dynamics. Autonomy focuses on ensuring that patients are able to pursue, "self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding that prevent meaningful choice."[129] The assumption of individual autonomy renders race, gender, class, and power invisible which averts the realities of medical practice, and indeed the very rationale behind the existence of bioethics as a regulatory force designed to prevent the exploitation of socio-politically vulnerable persons. The prevalence of principles as a

129. Robert Zussman, "Sociological Perspectives on Medical Ethics and Decision-Making," *Annual Review of Sociology* 23, no. 1 (1997): 171, https://doi.org/10.1146/annurev.soc.23.1.171.

framework and autonomy as the pinnacle of those principles, assumes a power-neutral social and moral landscape in which autonomous action is something that "doctors or other healthcare professionals can unproblematically grant their patients."[130]

The bioethical principles have been criticized most substantively by virtue ethicists and ethics of care theorists for their reliance on the primacy of autonomy and the construction of bioethics as a "check-list" to adjudicate medical conflicts. Virtue ethicists suggest that the overreliance on principles minimizes the role of practical wisdom in the clinical setting and diminishes the ability for physicians to engage in moral reflection. Feminist bioethicists argue that the dominance of autonomy in the principles does not reflect the realities of social, political, and economic interdependence. Similarly, ethics of care theorists criticize the principles for the abstract and impersonal method of addressing the particularities of intimate interpersonal relationships necessary in the delivery of medical care.

3.4.1 Principlism in Bioethics

Scholars have explained the continued dominance of principlism and related reticence to engage racism in three primary ways, 1) as a function of the field's multi-disciplinary origins, 2) as a result of its power dynamic in relationship to biomedicine, and 3) as a result of its overall entrenchment in logics of whiteness. One set of scholarship looks to the disciplinary bounds of bioethics as an inhibiting set of forces. Scholars such as José Lopez argue that bioethics, as an interdisciplinary field of inquiry and practice might be understood and examined as a discursive formation structured by rules concerning the formation of objects of knowledge, enunciative modalities related to knowledge production, methodological concepts,

130. Lopez, "How Sociology Can Save Bioethics . . . Maybe." Though narrative, feminist, and a growing field of black feminist and womanist bioethicists have argued for a theory and practice of bioethics rooted in storytelling in applied bioethics the framework of principlism has reigned supreme in the everyday practice of applied bioethics.

and thematic strategies.[131]

These four fields (medicine, law, theology, and philosophy), which contributed to the development of bioethics as a discursive formation, have highly formal discursive practices, although many scholars attribute bioethics' "selectivity towards a formalistic, procedural, disembodied, and universalistic way of identifying and resolving bioethical dilemmas" to moral and analytical philosophy.[132] The demographic makeup of medicine and three fields undergirding bioethics match the academy writ large. However, philosophy, which has had an outsized impact on the disciplinary boundaries of bioethics, continues to be dominated by cisgender heterosexual white males:

> Whatever the success, adequacy or cognitive validity of bioethics as a knowledge – producing discourse which might be called to analyze and mediate the relationship between a doctor and a patient, or a particular technology and a defined cultural community, its legitimacy and authority are in part secured through the way it is embedded in an ecology of socially sanctioned knowledges…[133]

When bioethics is viewed as a constellation of disciplines vying for collective dominance and relevance in the M.I.C., it is easier to assess how principlism emerged as the hegemonic discursive framework of bioethical inquiry. By advancing the principles, seemingly neutral framing easily recognizable across disciplines and actionable in applied settings, bioethics cleared a path to sustained legitimacy and independence from any one field of academic inquiry.[134] Approaches to naming and analyzing bioethical dilemmas that recognize

131. Lopez. Lopez argues following Foucault that bioethics might be best studied as a discursive formation to understand the possibilities of disrupting hegemonic practices

132. Lopez, 878.

133. Lopez, 886.

134. Evans, John H. "A Sociological Account of the Growth of Principlism." *The Hastings Center Report* 30, no. 5 (2000): 31–39. https://doi.org/10.2307/3527886.

sociocultural or political differences have been marginalized or considered to exist beyond the disciplinary scope of the field because this aligns with the culture founding disciplines.[135]

Bioethics, by way of its philosophical routes, has been accused of devoting undue attention to the separation of the ethical and political, which can be understood as a particular type of privilege for those, "who most closely approximate the rational, autonomous individual at which much of bioethics thus far has been aimed".[136] This eschewing of the role of biomedicine in the creation and maintenance of racial inequity in the name of disciplinary boundary policing has served to marginalize the contributions of nonwhite bioethicists as navel gazing at best, and academic inferiority at worst.[137] This conceptualization of standpoint theories within bioethics is a function of epistemological injustice, which naturalizes whiteness and biomedicine as a universal standard rather than particular cultural and epistemological frames:

> Doctors and other healthcare workers must recognize that, even if they occupy a privileged social position, they, too, have cultures–they have morals, hold values, and make judgments that are not universal. Moreover, health care itself has an institutional culture, which reflects the dominant culture in which it evolved–one which Ikemoto describes as racist, ethnocentric, and nativist. Indeed, even science, which is typically presented in contrast to religion or culture, has its own set of assumptions and articles of faith, and sees the world through a particular lens which filters out a good deal of 'subjective' information in favor of data it regards as 'objective'. The scientific worldview produces what Ikemoto calls the medical gaze, a way of assessing patients that prizes time and efficiency, effectively stripping patients of much of their social and lived experience. Even bioethics, in its critical examination of clinical practice and other biomedical issues, reflects the culture of its first and most dominant practitioners, selecting which issues are most critical, which values should be protected

135. Russell, Camisha A. "Questions of Race in Bioethics: Deceit, Disregard, Disparity, and the Work of Decentering: Questions of Race in Bioethics." *Philosophy Compass* 11, no. 1 (2016): 43–55. https://doi.org/10.1111/phc3.12302. p. 44

136. Russell, p. 49

137. Ray, "Blog - Black Bioethics and How the Failures of the Profession Paved the Way for Its Existence," Bioethics Today, November 7, 2022, https://bioethicstoday.org/blog/black-bioethics-and-how-the-failures-of-the-profession-paved-the-way-for-its-existence/.

> and promoted, and which sort of interventions are most valid and useful. Unless those in privileged positions take account of their own biases and operating assumptions, they will never be 'competent' to take into account those of marginalized others.[138]

As science and technology studies scholars and sociologists have noted, the role of medicine as a social order provides ample space to explore the shift of *healthiness* to a secular religion. Health has become the preeminent paradigm of social regulation in Western societies. In collusion with neoliberal frameworks, healthism has contributed to the medicalization, or the transformation of human functions into "objects of medical scrutiny to be fixed by medical solutions."[139] This framework suggests that people can be *treated* for society's diseases. Programs such as food prescriptions, which allow doctors to provide *orders* for patients to receive subsidized nutritious foods that help manage disease have proliferated as solutions to address the social determinants of health. Even the social determinants of health framework might be understood as a way to connect wicked social to collective health outcomes.

Healthiness has replaced *Godliness* as a yardstick of accomplishment and proper living. Public health and health promotion, then, may be viewed as contributing to the moral regulation of society, focusing as they do upon ethics and moral practices of the self.[140] Health and healthism are world ordering forces that bioethicists have widely ignored. The discourse of bioethics tends to treat medicine as a neutral ground on which bioethical concerns are raised as aberrations from the norm. This stance conceptualizes the biomedical gaze as a window rather

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138. Camisha A. Russell, "Questions of Race in Bioethics: Deceit, Disregard, Disparity, and the Work of Decentering: Questions of Race in Bioethics," *Philosophy Compass* 11, no. 1 (2016): 43–55, https://doi.org/10.1111/phc3.12302.

139. Cristina S. Richie, "Not Sick: Liberal, Trans, and Crip Feminist Critiques of Medicalization," *Journal of Bioethical Inquiry* 16, no. 3 (2019): 375–87, https://doi.org/10.1007/s11673-019-09922-4.

140. Deborah. Lupton, *The Imperative of Health : Public Health and the Regulated Body* (London ; Sage Publications, 1995), 4.

than a tinted and medicated lens that warps what makes for an ethical dilemma, discourse and analysis of cases, and the ultimate resolution of issues.[141]

Critical bioethicist Christopher Mayes and colleagues propose, following Carmisha Russell, that bioethics uncritically engages the biomedical gaze in ways that circumvents considerations of racism from the scope of inquiry and engagement:

> …these positions operate to constrain how things may be thought about, they have both epistemic and ethical costs… in the case of race, by obscuring an examination of the very concept of race and the way it operates in social and political landscapes. Epistemic scientism has mostly delivered us back into the clutches of medicalization, where the reproduction of social inequalities is shaped by a representational politics of reductive individualism.[142]

This uncritical approach is often attributed to how the field established and maintained its legitimacy in the M.I.C.'s structures. Following in the footsteps of biomedicine, bioethics instilled professional status and legitimacy by creating disciplinary authority.

The mechanisms by which bioethics legitimizes the subject and objects of bioethical inquiry reinforces the hegemony of the biomedical gaze. By establishing and policing what and how bioethics is done, bioethics stretched its scope of practice towards being a valid knowledge and governing force. Its authority rested in its ability to, "define problems as 'ethical' (and not structural) and solve them 'ethically' (and not necessarily equitably)."[143] Thus the discursive practices function to reinforce and reify neoliberal ideologies that advance autonomy and individualism as the highest human ideals, which work to legitimate bioethics as

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141. Camisha A. Russell, *The Assisted Reproduction of Race* (Bloomington, Indiana: Indiana University Press, 2018).

142. Christopher Mayes, Claire Hooker, and Ian Kerridge, "Bioethics and Epistemic Scientism," *Journal of Bioethical Inquiry* 12, no. 4 (2015): 565–67, https://doi.org/10.1007/s11673-015-9667-z.

143. Lopez, "How Sociology Can Save Bioethics . . . Maybe," 882.

a regulatory force for biomedicine:

> The object of bioethics is inseparable from the historical emergence of its enunciative modalities in the arena of public policy and the governance of technological change in liberal societies. Consequently, the cognitive claims of bioethics are, in part, sustained by their convertibility into relatively straightforward and efficient principles of bureaucratic regulation and calculation which are congruent with political liberalism, the modern rationalized state and the contemporary demand for 'transparency' associated with the audit culture. [144]

Reiterating Lopez, as a discursive formation embedded in the M.I.C., the discourse of bioethics is dependent on mechanisms undergirding biomedical gaze. This indebtedness narrows the focus on bioethics to the interpersonal encounter to the detriment of comprehensive ethical evaluation.

The reign of principlism and related marginalization of socio-politically conscious approaches within bioethics scholarship has also been explicitly attributed to the ideologies of white supremacy. These scholars suggest that whiteness functions as an *ethos* or *relational category* contributing to continued epistemic injustice in the scholarship and practice of biomedicine.[145] Indeed, many critiques of bioethics such as those from Warwick Anderson and Catherine Myser, "call for diversity in bioethics or more empathy among its (assumed white) practitioners". [146] Myser suggests that the ignorance of racism is a structured epistemology of ignorance and the "seeming invisibility of white epistemologies and performance"[147] in the discursive formations of bioethics. Warwick Anderson, an Australia-based bioethicist, suggests

144. Lopez, 882.

145. Warwick Anderson, "The Whiteness of Bioethics," *Journal of Bioethical Inquiry* 18, no. 1 (2021): 93, https://doi.org/10.1007/s11673-020-10075-y.

146. Catherine Myser, "Differences from Somewhere: The Normativity of Whiteness in Bioethics in the United States," *American Journal of Bioethics* 3, no. 2 (2003): 2, https://doi.org/10.1162/152651603766436072.

147. Anderson, "The Whiteness of Bioethics," 2.

that whiteness "becomes a strategy of authority—admittedly, a relatively benign one, and certainly well intentioned, but nonetheless a strategy of authority."[148]

Though Anderson suggests that whiteness is benign, counter to other non-white identified bioethicists, his engagement is part of a global conversation about colonialism and white supremacy within bioethics led by white-identified bioethicists outside the U.S. This sustained discourse exemplified in journals such as *Journal of Bioethical Inquiry, Canadian Journal of Bioethics,* and *Journal of Global Bioethics,* suggests that indeed the ignorance of race might be a structured erasure in the U.S. bioethical discourse.

3.5 Bioethics and Its Critics

The 1997 merger of the Society for Health and Human Values, the American Association for Bioethics, and the Society for Bioethics Consultation into the American Society of Bioethics and Humanities (ASBH) spurred a small burst of reflective work on the discursive formations and professional practices of bioethics including reluctance to engage inequity within medicine. In 2000, the newly elected fourth president of ASBH, Laurie Zoloth, issued a "call to arms" for bioethics to attend to the sociopolitical context that shaped the context of clinical ethics in the U.S., including the lack of access to universal healthcare. In response, the *Hastings Center Report*, editor Gregory Kaebnick and colleagues noted the "risk" involved in addressing race, but nevertheless attempted to sketch out a research agenda to shift the lens of bioethics.

> "Bioethics is still mostly about the kinds of questions that arise in individual cases. How should *this* doctor respond in *this* case? How can *this* patient's concern best be met? Increasingly, however, bioethicists are turning their attention toward broader, societal concerns, especially toward concerns about disparities in health and equitable access to health care." [149]

148. Anderson, "The Whiteness of Bioethics."

149. Gregory Kaebnick, "Bioethics and Race," *The Hastings Center Report* 31, no. 5

Fifteen years later, John Hoberman mused about the continued lack of research addressing race and racism in bioethics asking, "Why does our empathetic imagination fail us – bioethicists – when we confront racial difference, and especially why in the medical culture, which has an obligation to mitigate human suffering?[150] While rooted in white normativity, his question provided a methodical review of the field's continued reluctance to engage in the "risky" practice of engaging race and racism. His review of the literature suggested that intersectional approaches to bioethics written by nonwhites tended to exist outside of the disciplinary bounds of bioethics and were concentrated in books that were rarely engaged as the "real" work of bioethics. Hoberman argued that part of the reticence of bioethics to engage racism is that bioethics is part of a larger academic culture that eschews "being mobilized on behalf of catalyzing social or institutional transformations".[151] Others have argued that following the whiteness of philosophy, bioethics has historically deemed engagement with race to be shallow and uninteresting compared to other, more sophisticated bioethical inquiries such as the future of genetics and other technoscientific advances.[152]

(2001): 3–3.

150. John Hoberman, "Why Bioethics Has a Race Problem," *The Hastings Center Report* 46, no. 2 (2016): 16, https://doi.org/10.1002/hast.542.

151. Hoberman, "Why Bioethics Has a Race Problem."

152. Howard Brody, "Economism and the Commercialization of Health Care," *Journal of Law, Medicine & Ethics*, 2014, Gale General OneFile.

3.5.1 Structured Invisibility-Critical Approaches

In this section, I explore the discursive practices of bioethics related to antiblack obstetric violence by conducting an integrative literature review focused on the major peer reviewed journals in bioethics. By reviewing the primary discourse focused on race and class in relation to reproductive ethics, I examine the relationships between bioethics and the biomedical gaze.[153] I posit that the key issue is not related to the culture of the academy or medicine, but that bioethics, like the broader American culture, is fundamentally enmeshed in the logics of white supremacy manifested in the biomedical gaze in healthcare and biomedical research. This comprehensive literature search of the major U.S. journals focused on bioethics confirms what scholars have informally inferred, that the bioethics literature has overwhelmingly ignored racism within healthcare, especially relating to reproduction, instead limiting engagement of racism to discussions of genetic screening, selection of genetic traits, and mistakes in transplanting embryos leading to the birth of genetically unrelated children.

The first inflection point of engagement with racism in bioethics emerged in 2000, after Laurie Zoloth, then president of the American Society for Bioethics, exhorted the field to become more conscious. The following in 2001, Gregory Kaebnick, editor of the *Hastings Center Report* exhorted colleagues to engage the "risky territory" of race. [154] The second inflection point was in response to the cultural panic that ensuing around the 2016 U.S.

153. Please see Appendix A. I exclude articles published outside of the US and manuscript-length works to capture the active discourse of what is policed as the boundaries of bioethics and the professional culture of the field. The following US published peer reviewed journals are included in this analysis: Ethics, The Hastings Center Report, Journal of Medical Ethics, The Journal of Law, Medicine and Ethics, Theoretical Medicine and Bioethics, Bioethics, The Journal of Clinical Ethics, Kennedy Institute Ethics Journal, Cambridge Quarterly of Healthcare Ethics, Christian Bioethics, Medicine, Health Care and Philosophy, The American Journal of Bioethics, International Journal of Feminist Approaches to Bioethics, The American Journal of Empirical Bioethics, HEC Forum, and the AMA Journal of Ethics.

154. Hoberman, "Why Bioethics Has a Race Problem."

presidential election**.** The April issue of the *American Journal of Bioethics* focused on the role of race in the practice and theoretical discursive formations of bioethics. Kayhan Parsi, now the elected president of the American Society of Bioethics, argued that the *unbearable whiteness of bioethics* was particularly disconcerting given that bioethicists were uniquely situated, as an interprofessional field of theologians, clinicians, theologians, and legal scholars to address social inequities.[155] Comparing the strides of public health in addressing structural racism, Parsi notes, following Paul Farmer, how social inequities "are not the product of accident or random events. Rather they are the fruits of an ideology…"[156] This ideology is embedded in the scholarship and practices of bioethics and pushes the responsibility to address racism from the collective to the individuals. Relying on thinkers impacted by racism or allies of those impacted to address racism puts them at risk of social or professional isolation. This is one of the strange fruits of this ideology.

The language of risk in relation to addressing race in bioethics is a clue to understanding the operations of the biomedical gaze. Since the 1960s, African American physicians and historians of medicine have worked to link bioethics and racial inequity to little measurable success at changing the culture of the field. [157] Medical historians created what John Hoberman calls "Bioethical Literature" that opened up analytical space to address the relationships between bioethical analysis and critical race studies.[158] These works provide

155. Kayhan Parsi, "The Unbearable Whiteness of Bioethics: Exhorting Bioethicists to Address Racism," *American Journal of Bioethics* 16, no. 4 (2016): 1–2, https://doi.org/10.1080/15265161.2016.1159076.

156. Parsi, 1.

157. Hoberman, "Why Bioethics Has a Race Problem," 14.

74. William H. Grier and Price M. Cobbs, *Black Rage* (New York: Basic Books, 1968); Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans*

ample evidence of the complex relationship between contemporary practice of medicine and the social production of race and inequality.

In bioethics, there was also a sustained yet largely ignored effort by nonwhite scholars and white allies to ensure that the field addressed race and racism outside the fantastical obsession with Tuskegee that simultaneously raised the status of the field and established bioethicists as "public intellectuals".[159] However, these critics remained marginal to the actual discourse working through predominant journals.[160] Prior to 2020, articles by nonwhites were limited in the major journals of bioethics. Despite their absence in the discourse, there were sustained efforts in the field to address this being spurred by the *African American Perspectives on Biomedical Ethics Projec*t, which is a series of think tanks and conferences from the late 1980s through the early 2000s and led to two published anthologies.[161] While many comprehensive explorations of race-conscience approaches to bioethics have been published, these publications by Blacks have had limited uptake in the field of bioethics.
Feminist bioethicists have long shifted from individual rights to an understanding of the "conditions under which rights can be exercised."[162] Feminist bioethics literature, however, has often made "white heterosexual males the norm against which alternative bodies find

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from Colonial Times to the Present (Knopf Doubleday Publishing Group, 2008); Roberts, *Killing the Black Body : Race, Reproduction, and the Meaning of Liberty*.

159. Hoberman, "Why Bioethics Has a Race Problem," 16.

160. See Appendix A

161. Harley. Flack and Edmund D. Pellegrino, *African-American Perspectives on Biomedical Ethics* (Washington, D.C: Georgetown University Press, 1992); Lawrence. Prograis and Edmund D. Pellegrino, eds., *African American Bioethics : Culture, Race, and Identity* (Washington, D.C: Georgetown University Press, 2007).

162. Alexis Shotwell, "Aspirational Solidarity as Bioethical Norm: The Case of Reproductive Justice," *International Journal of Feminist Approaches to Bioethics* 6, no. 1 (2013): 106, https://doi.org/10.3138/ijfab.6.1.103.

themselves publicly visible" in ways that tie flourishing to assimilation or imitation.[163]

Structural inequities are rarely engaged in clinical or theoretical bioethical considerations, particularly in the clinical setting, although structural and institutional barriers are typically the root cause of bioethical consultations. As bioethicists have publicly acknowledged in the wake of the 2020 pandemic and global movement against state-sanctioned antiblack violence, the longstanding loyalty of bioethics to the biomedical gaze is frustrating given the sociopolitical and institutional power of bioethics. Ignorance of structural inequities has become untenable as the field wrestles with how healthcare and biomedical technoscience shape the range of possibilities for individual dignity and autonomy and constructions of what counts as bioethical considerations. The dominant focus on autonomy and appropriate interactions between administrators/providers/researchers and families/patients/subjects and their rights by bioethics ignores biopolitical analysis that demystifies the produced and reproductive forces of the biomedical gaze in the research and practice of biomedicine.[164] Bioethics has long shirked critical responsibility to interrogate, i.e. police, its reliance on the biomedical gaze in the M.I.C. Its prioritizing the virtues of liberal principlism and the dogmatism of market forces may sacrifice for the field any possibility of rescue from public irrelevance. [165]

163. Holloway, *Private Bodies, Public Texts : Race, Gender, and a Cultural Bioethics*, 14.

164. Russell, *The Assisted Reproduction of Race*.

165. Christopher Mayes, "Race, Reproduction, and Biopolitics: A Review Essay," *Journal of Bioethical Inquiry* 18, no. 1 (2021): 99–107, https://doi.org/10.1007/s11673-020-10071-2.

3.6 Conclusion

In this chapter, I surveyed the forms and culture of bioethics as a product of the logics and logistics of the M.I.C. in ethical inquiry. I began the chapter with a historical analysis of the emergence of bioethics alongside the development of healthcare as an economic industry that increased the power of institutions and administrators in moral decision-making and authority. Using the rise of principlism within clinical bioethics, I examined the operations of the biomedical gaze and the structured invisibility and ignorance of critical and biopolitical approaches to bioethical inquiry. I deployed critical digital discourse analysis to illustrate the intellectual trajectory of U.S. bioethics and key epistemological junctures in the field. In the next chapter, I examine how the biomedical gaze has taken up residency outside of the clinic in the logics and logistics of the feminist birth industry's response to reproductive suffering and management of reproductive health care.

CHAPTER 4

Black Doulas' Demonic Grounds

4.1 Introduction

Black women were essential to the development of reproductive biomedical sciences as willing and unwilling participants in medical experimentations and practitioners.[166] Prior to the abolition of slavery, midwifery allowed enslaved Black women a limited measure of autonomy over their fertility and provided enslaved women with culturally congruent care amid an inhumane system dependent on their physical and reproductive labor.[167] Historians provide ample evidence of physicians in the mid-to late nineteenth century, such as J. Marion Sims, who performed countless painful procedures on enslaved girls and women like Anarcha, Lucy, and Betsey who suffered from fistulas because of their multiple births in their role as reproductive technologies of the socioeconomic institution of slavery.[168] The temptation of traditional bioethical approaches to reproductive suffering is its focus on the clinician-patient encounter and the supportability of Sims providing unanesthetized procedures. The focus on interaction between clinician and patient obscures the sociopolitical context for women and Black enslaved women producing more chattel to sustain the economic, social, and political structures of the antebellum South. As detailed in Chapter 3, the apolitical framing of bioethical inquiry circumvents consideration of how physicians such as Sims and others used scientific

166 Roberts, *Killing the Black Body : Race, Reproduction, and the Meaning of Liberty*.

167 Bonaparte, "'The Satisfactory Midwife Bag': Midwifery Regulation in South Carolina, Past and Present Considerations."

168 L L Wall, "The Medical Ethics of Dr J Marion Sims: A Fresh Look at the Historical Record," *Journal of Medical Ethics* 32, no. 6 (2006): 346–50, https://doi.org/10.1136/jme.2005.012559.

knowledge to subjugate competing practices of reproductive health care rooted in African and Indigenous knowledges that included midwifery.

This chapter builds on prior ones that analyze biomedical ethics to explore how the technologies designed to mitigate the ill-effects of the M.I.C. can reproduce injustice in reproductive biomedicine. This chapter situates *birth work* in the ethics of care discourse on women's labor and engages feminist and womanist theorists, Virginia Held, Joan Tronto, and Emilie M. Townes to evaluate the ethics of care in Black feminist birth work. I begin by investigating how reproductive biomedicine contributed to reproductive suffering and how the Black feminist birth work industry has been rhetorically positioned as a noninstitutional response to *the Crisis Standard* of care discourse surrounding Black maternal mortality. Using qualitative data collected in a two-year ethnographic study with a Black feminist led reproductive justice collective in Nashville, Tennessee, I examine how the burgeoning Black feminist birth work industry resists yet replicates hegemonic logics of the biomedical gaze. Engaging Katherine McKittrick's usage of demonic grounds as a generative heuristic, I delineate the ways in which Black feminist birth work operates in liminal spaces of the M.I.C. to offer *infinite possibilities* for informed refusal of the biomedical gaze toward reproductive justice.[169] I conclude with an analysis of how this work, however, compounds Black women's reproductive suffering by commodifying and undervaluing reproductive care labor.

4.2 Black Women in the Folds of Biopower

The colonial project in the U.S. required a high investment in women's reproductivity as a means of sustaining the economic and social survival of settler colonization. From the founding of the American colonies to the rise of chattel slavery, Black reproduction was a

169. For more on Fanon's use of *infinite possibilities* following Sartre see: Fanon, *Black Skin, White Masks*.

matter of regulation.[170] Slavers had a vital interest in managing birth to ensured physical and psychological control over reproduction among slaves after the passage of the 1807 Act Prohibiting Importation of Slaves. While there was vital interest in the fertility and reproductive capacity, the perinatal period for enslaved women was often filled with a surplus of physical suffering related to the need for uninterrupted manual labor during pregnancy and shortly after birthing. Fueled by the latest biomedical research, which touted that Black women had a *natural propensity* for birth, slavers routinely engaged in sexual and emotional exploitation of their reproductive capacity leading to lifelong suffering owing to malnutrition and maltreatment.[171] High infant and maternal mortality rates ensuing from these dire conditions were blamed not on enslavement but on the *inherent inferiority* of Black women's bodies and maternal care practices.[172]

Despite the close surveillance over the products of reproductive exploitation, the actual process of childbirth went until the early twentieth century largely unnoticed by the white male gaze. This is because birth was seen as *women's work* managed by the free or the cheap labor of Black granny midwives, also known as, *grannies*.[173] In some regions, grannies often

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170. Roberts, *Killing the Black Body : Race, Reproduction, and the Meaning of Liberty*.

171. Roberts.

172 British historian, Olivette Otele, however, argues that the notion of the *inferiority* of the African woman's body was a later determination following medieval assessments of Africa women's bodily advantages over European women in lactating and providing sexual pleasure; "Thirteenth-century Europe became interested in the bodies of black women and their alleged abilities to produce higher quality milk and to give pleasure. Drawing on Aristotle's observations about the links between menstrual blood and heat, thirstiest-century medical scholars alleged that the milk of black women had more nutrition," thereby rendering their milk "more digestible and of better quality for the child" and "black women had a greater desire to have intercourse because they came from hotter climates, while white women had more capabilities for intercourse because of their alleged excessive menstrual blood. Albert the Great 's lecture of 1258 in Cologne was about pleasure and appetite. It was stated, for example, that the shape of a black women's vulva provided greater pleasure to men. *African Europeans: An Untold History* (New York: NY, Basic Books, 2021), pp. 27-28.

173. Alicia D Bonaparte, "Physicians' Discourse for Establishing Authoritative Knowledge in Birthing Work and Reducing the Presence of the Granny Midwife," *Journal of Historical Sociology* 28,

managed the labor and deliveries for white women and were highly respected for their deep herbal and spiritual healing knowledge. Granny midwives were older women heeding a spiritual or vocational call to heal. They were revered not only for their skills in managing the physiological process of childbirth but also for their stewardship of traditional cultural and healing knowledges:

> [G]rannies garnered respect due to their age, life experiences, and an interdependent relationship between healer and community members that oftentimes lasted from birth into adulthood. Grannies also used food (e.g. teas for colicky children) therapeutic agents for illness and maintained the passing of knowledge about the medicinal properties of particular foods and plants from mothers to young female children. This transmission of knowledge also fostered cultural reproduction and rebelling against dominant Western medical practices.[174]

While grannies were the primary managers of birth in the plantation economy, their healing wisdom was extensive and included folk and herb remedies and care practices not limited to childbirth. Indeed, their work extended throughout the lifespan of enslaved and free Black persons and sometimes white clientele to the chagrin of physicians. [175]

Now largely romanticized in contemporary accounts by a classic movie such as *Gone with the Wind*, the history of Black reproductive midwifery before emancipation was but one wide ranging aspect of labor-intensive care duties heaped on aging Black women.[176] Their roles, however, were revered. Historical evidence indicates grannies trained in indigenous and African healing modalities were often trusted more than their physician counterparts in the

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no. 2 (2015): 168, https://doi.org/10.1111/johs.12045.

174. Alicia D. Bonaparte, "The Persecution and Prosecution of Granny Midwives in South Carolina, 1900-1940" (Thesis (Ph. D. in Sociology)--Vanderbilt University, Aug. 2007., 2007).

175. Bonaparte.

176. Sharla M. Fett, *Working Cures: Healing, Health, and Power on Southern Slave Plantations*, Gender & American Culture (Chapel Hill: University of North Carolina Press, 2002).

nineteenth century so much that the burgeoning field of biomedicine had to engage in structured public and professional campaigns to turn Americans from reliance on other etiological models.[177] Despite the work it entailed, during the early twentieth century, physicians successfully wrested the management of birth from midwives by infantilizing and ridiculing their professional knowledge and practices. This slowly but effectively shifted birth discourse so that by the early-twentieth century, grannies are no longer represented as socio-spiritual healers. Instead, they were demonized as *superstitious hacks* unfit to manage the *complex* medical process of birth.[178]

Often referred to as the medicalization of birth, this process required epistemic and economic violence in the deployment of economic and political power to shift public opinion concerning ritual framings of birth and to regard it as a pathological condition to be managed best by technoscience. While physicians were *advancing* reproductive technoscience by torturing and mutilating Black women, they filled medical journals with arguments discrediting the adequacy and legitimacy of midwifery in efforts to relegate Black midwifery.[179] Sociologist, Alicia Bonaparte says that in efforts to curtail Black midwifery, that while "nuanced and often contradictory", rhetoric focused on infantilizing Black midwives:

> First, their opinions encompassed advocacy for better educating the general populace about the dangers of midwife-assisted births. Second, physicians opined that midwives required more in-depth obstetrical training to counter their contribution to maternal and infant mortality. Third, physicians argued for midwifery supervision to more effectively

177. Deborah A. Sullivan and Rose Weitz, *Labor Pains : Modern Midwives and Home Birth* (New Haven: Yale University Press, 1988).

178. Barbara. Ehrenreich and Deirdre. English, *Witches, Midwives & Nurses : A History of Women Healers*, 2nd ed., Contemporary Classics (New York: Feminist Press at the City University of New York, 2010); Richard W. Wertz and Dorothy C. Wertz, *Lying-in : A History of Childbirth in America*, Studies in the Life of Women (New York: Schocken Books, 1979).

179. Judith Walzer. Leavitt, *Brought to Bed : Childbearing in America, 1750 to 1950* (New York: Oxford University Press, 1986); Jessica Mitford, *The American Way of Birth* (New York, N.Y: Dutton, 1992).

> deal with the inadequacy of midwifery care. And fourth, some physicians saw that educational and supervisory efforts would achieve the ultimate goal of eliminating the midwife or at the very least, reduce her presence in birthing work because she was a "necessary evil".[180]

These strategies depended on the burgeoning of the biomedical gaze. Technoscience and market capitalism rendered pregnancy as a pathology and birth a manageable product. Biomedical practitioners saw that subsuming birth under the biomedical model would render the knowledge of midwives obsolete. And they were right.

In their bid to ascend and cement their professional and economic power, physicians created an "antagonistic and highly competitive environment," which included targeted policies and public health campaigns deploying racial and gendered stereotypes to instill fear into the public about midwives. They also presented home births attended by midwives were obsolete, poverty-driven, and unsafe.[181] Furthermore, the structure of medical education, which barred women and Blacks from entry, ensured that white and Black midwives would be erased from the birthing process. This process was so effective that by the mid-twentieth century when then Hill Burton Act passed, the biomedical gaze calcified the M.I.C.'s structural geography:

> The floor plans for new regional hospitals under the Hill-Burton Act in 1946 calcified existing obstetrics practices such as isolation of laboring women from support networks, movement of women from room to room during labor, and separation of mothers and infants by working these practices into the very design of labor and delivery wards. Changing hospital practice or individualizing care became impractical since the design of the hospital emphasized medical control. The large scale of these new modern hospitals, in turn, increased the need to efficiently coordinate the activities of many different providers and many different patients. Maternity care became increasingly impersonal and increasingly standardized, seen most clearly in the "assembly line" maternity wards of the 1960s.[182]

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180. Bonaparte, "Physicians' Discourse for Establishing Authoritative Knowledge in Birthing Work and Reducing the Presence of the Granny Midwife."

181. Wertz and Wertz, *Lying-in : A History of Childbirth in America*.

182. Hall, *The Medicalization of Birth and Death Lauren K. Hall.*, 29.

As political scientist, Lauren Hall details, "assembly line birthing" marked the culmination of a half-century of strategies to garner professional authority and dominance. Hall contends that the culmination of the medicalization of birth into "assembly line birthing" represents the hegemony of the biomedical gaze and its influence on the physical, social, economic, and political structures in and beyond the M.I.C. Assembly line birthing turned an obstetrician into a "foreman… managing the uterus as a machine that produces the baby and the woman as laborer who produces the baby."[183]

What was once a socio-physiological event overseen ritually by midwives and other women is now a pathological crisis managed by clinicians to control medical risks. Although the ideological and physical structures of the M.I.C. were not designed to provide care during pregnancy and birth, labor and delivery continue to challenge the biomedical model. The processes involved in birth resists temporal epistemes rationalizing the M.I.C. Birthing processes often unfold nonlinearly. Scholar-practitioner, Paulomi Niles terms this nonlinear process *Kairos timelines*, to indicate the liminal space of birthing that is best marked by human rituals of care. Niles notes that the hospital management of labor and delivery occurs along *Chronos timelines*, measured by linear outcomes and binary progress indicators:

> Where Chronos is quantitative, Kairos is qualitative. Chronos values are empirically rooted in measures of time, linear progress, risk calculations, and technologically generated information— as operationalized through Bishop's scores (an algorithm used to assess the appropriate induction method) and acuity scores. These are in stark contrast to the inherently 'Kairotic' process of pregnancy, labor, and birth – which is often recounted by midwives and laboring people as the slow, gradual change over time, measured by interactions, moments, intimacies, and transitions.[184]

183. Emily. Martin, *The Woman in the Body : A Cultural Analysis of Reproduction : With a New Introduction*, [2001 ed.]. (Boston: Beacon Press, 2001).

184. Paulomi Mimi Niles et al., "Kairos Care in a Chronos World: Midwifery Care as Model of Resistance and Accountability in Public Health Settings," *Birth (Berkeley, Calif.)* 48, no. 4 (2021): 480–92, https://doi.org/10.1111/birt.12565.

Hospital administrators have tried to address this tension while maintaining control of childbirth by building spa-like birthing suites, employing midwives and *doulas*, or acquiring free-standing birthing centers.[185] Despite efforts to borrow language and strategies from the feminist birthing industry, hospitals continue to struggle to find technological solutions to better manage the flow of labor (staffing) and labor (birth).[186] This management abstracts the individual patient from the *Kairos* process of birth in favor of the *Chronos* process of labor and delivery. Labor and delivery minimized patients and staff as individuals and maximize labor and delivery to represent statistical units, bed counts, and resources analyzable by algorithms.

The competition between *Chronos* care (driven by technoscientific management) and *Kairos* care (responsive to the needs of communities, families and individuals) has been well studied. Anthropologist, Sharon Kaufman studies the influence of hospital structures and policies on the agential power of clinical staff, administrators, and patients. Tracking "how hospital procedures and the bureaucratic mandate of the health care system and how they produce the conditions for death," Kaufman argues that healthcare studies underestimated the influence of structural constraints on the actions of individuals in the systems. [187] Kaufman examines the relationship between organizational processes and the M.I.C. Patients and providers were constrained by systems of classification in healthcare administration leading to predetermined pathways. These pathways aligned with the ultimate aims of the M.I.C. to "move things along" through the development of "policies, care plans, and medical

185. Backes and Scrimshaw, *Birth Settings in America : Outcomes, Quality, Access, and Choice / Committee on Assessing Health Outcomes by Birth Settings*.

186. Avery Plough et al., "Common Challenges Managing Bed and Staff Availability on Labor and Delivery Units in the United States: A Qualitative Analysis," *Birth (Berkeley, Calif.)* 45, no. 3 (2018): 303–10, https://doi.org/10.1111/birt.12342.

187. Sharon R. Kaufman, --*And a Time to Die: How American Hospitals Shape the End of Life* (New York: Scribner, 2005), 95.

algorithms…to move the patient on routinized tracks of diagnosis and treatments that categorize, ameliorate, and manage disease."[188] Kaufman observes that the technoscientific management of medical treatment pathways restricts moral and clinical agency:

> Doctors and other hospital staff learn to see treatment and care in terms of where patients are going in the system as well as in term of payment schemes, institutional regulations, and treatment logics, all of which enable patients to pass through that system in a manner considered timely by hospital staff.[189]

Hospital administrative requirements makes end of life care limited to the *zone of indistinction* experienced and inhabited by that those on the brink of death. This concern over the ambiguity of death lead to two primary pathways for managing the flow of resources for these patients, namely, the revolving door pathway and the heroic pathway. While the heroic pathway gets most attention in media portrayals of healthcare, the revolving door tends to be the primary way patients and families experience projected deaths. The two logics that govern these pathways are as distinct as they are effective:

> Once a patient and the family are placed on one [path], its logic is more powerful, at least initially, than any individual voice, lay or medical. Everyone is stuck there – doctors, patients, and families…. Defiance of the compelling trajectories of these choices is not typical and requires a strong sense of conviction, clarity about what should be done.[190]

Kaufman argues that public debates about good and bad deaths miss the constraints that families and patient's face in hospital. It also places the burden of good outcomes on individuals who have the financial, personal, or cultural capacities to engage in defiance and act on their strong senses of conviction. It is fallacious, Kaufman insists, that autonomous decision-making can occur independently of the constraints of the technoscientific regime of

188. Kaufman, 96.

189. Kaufman, 97.

190. Kaufman, 100.

the M.I.C.[191] The process of dying, much like the process of birthing, unfolds in a *Kairos timeline* resistant to the *Chronos* logics of market capitalism upon which the M.I.C. is built.

4.3 The Demonic Grounds of Racialized Care Burdens

Kaufman offers a helpful entry into understanding how the M.I.C. shapes the possibilities of both clinical and ethical decision-making through the technoscientific management of care within the acute care landscape. Under the biomedical gaze in clinical and acute care spaces, Black patients oscillate between the categories of invisibility, illegitimacy, and illegibility. In labor and delivery units, clinicians navigate the pressures of *Chronos* time by simultaneously supporting the progress of multiple births through the use of tools such as, labor accelerants, remote fetal heart monitoring, cesarean risk-management calculators that have been shown to increase the likelihood of inequitable outcomes for Black patients.[192] Without romanticizing preindustrial medicine and the importance that scientific advancement have played in the improvement of birth and infant outcomes, I argue the technoscience undergirding the biomedical gaze obscures as much as it reveals, especially in the perinatal period. Reproductive technoscience fundamentally changes the possibilities and practices of reproductive health care resulting in the meso-level and macro-level institutionalization of persistent racial inequalities that are unresponsive to what are seen as microlevel socioeconomic protective factors such as income, education, and marital status.[193]

191. Kaufman, 103–4.

192. "ACOG Committee Opinion No. 766 Summary: Approaches to Limit Intervention During Labor and Birth," *Obstetrics and Gynecology (New York. 1953)* 133, no. 2 (2019): 406–8, https://doi.org/10.1097/AOG.0000000000003081.

193. Samuel H. Fishman et al., "Race/Ethnicity, Maternal Educational Attainment, and Infant Mortality in the United States," *Biodemography and Social Biology* 66, no. 1 (2021): 1–26, https://doi.org/10.1080/19485565.2020.1793659.

Katherine McKittrick's heuristic of *demonic grounds* reveals how the operations of biomedical gaze in the *physical location* of reproductive healthcare settings contributes to "racial-sexual domination [a]s an ongoing spatial project."[194] Drawing from Sylvia Wynter's transdisciplinary conceptualizations of the creation of human geographies, McKittrick argues that the socio-political production of space, creates three processes that contribute epistemic violence and the erasure of Black women's geographies:

> First, ideas, about black femininity, racial superiority, and difference are spatialized, consequently curtailing subaltern geographic desires and opportunities. In this case, the historical and historically present body is at stake, frequently returning us to questions of geographic captivity, ownership, and dispossession as they are connected to corporeal schemas. Second, black women's unique geographic concerns are concealed by racial, sexual, and economic processes. That is, the dispossessed black female body is often equated with the ungeographic and black women's spatial knowledges are rendered either inadequate or impossible. While dispossession and the ungeographic are certainly not guaranteed, traditional social paradigms, such as implementation of transparent space and the geographic manifestation of racial-sexual classificatory systems, shape how we see, or do not see, black women's geographies. Finally, these real and discursive sociospatial processes evidence struggles—over the soil, the body, theory, history, and saying and expressing a sense of place. Importantly, the real and imaginary geo-graphic processes important to black women are not just about limitations, captivities, and erasures; they are also about everyday contestations, philosophical demands, and the possibilities the production of space can engender for subaltern subjects.[195]

For McKittrick, *demonic grounds* refers to mechanisms reproducing *geographic nonexistence* of Black femininity in ways that make Black women denied and deniable, illegitimate and illegible in the logics of Man/human geographies. McKittrick distinguishes *demonic grounds* from other Black feminist theoretical approaches that construct Black femininity as a "marginal special-partial vantage point."[196] *Demonic grounds* instead refers to how the instability and

194. Katherine. McKittrick, *Demonic Grounds : Black Women and the Cartographies of Struggle* (Minneapolis: University of Minnesota Press, 2006), 126.

195. McKittrick, *Demonic Grounds : Black Women and the Cartographies of Struggle*.

196. McKittrick engages Wynter's analysis of the Invention of Man1 and Man2 and the ways in which European encounter with the Other created core "sociointellectual ruptures" that required theological, scientific, secular and biological reclassifications to maintain and naturalize human

liminality of Black femininity provide fertile grounds for the discovery of "the ways in which human normalcy is spatialized and resisted."[197] The instability of Black women's geographies is the invention of Man yet provides opportunities for diverging from the hegemony of biopolitical power.

McKittrick's demonic grounds is a useful heuristic for understanding the tensions inherent in Black feminist birth workers contemporary responses to reproductive suffering. The demonic grounds of Black women's reproductive suffering have been forming over the course of centuries making reproductive justice a devastatingly deadly problem that requires coordinated and consistent efforts at the micro-, meso-, and macro-levels of sociopolitical action.[198] The biomedical gaze, which is socio-politically productive of Black and nonwhite women's reproductive sufferings, burdens the individual with solving problems rooted in and perpetuated by M.I.C. beyond their direct control. [199]

The logistics of reproductive care operating in the M.I.C. reveal its alignment with the spatial projects of dispossession. While the *doula* profession was created to nominally rectify inequalities created by the collision of *Chronos* and *Kairos* birthing care timelines, the response of providing mirco-level solutions to sociopolitical suffering ensured reproduction was

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subjugation. For more on McKittrrick's use of Winter see Chapter 5 in *Demonic Grounds: Black Women and the Cartographies of Struggle.*

197. McKittrick, *Demonic Grounds : Black Women and the Cartographies of Struggle*, 146.

198. See chapter 1 for a discussion of the framework of wicked problems and multi-level sociopolitical analysis.

199. Chantel L Martin et al., "Understanding Health Inequalities Through the Lens of Social Epigenetics," *Annual Review of Public Health* 43, no. 1 (2022): 235–54, https://doi.org/10.1146/annurev-publhealth-052020-105613; Shannon Sullivan, "Inheriting Racist Disparities in Health," *Critical Philosophy of Race* 1, no. 2 (2013): 190–218, https://doi.org/10.5325/critphilrace.1.2.0190.

maintained as a sphere of the biomedical gaze.[200] Through the creation of *doulas* and birth workers, the M.I.C. shifted responsibility for reproductive suffering to individuals most impacted by injustice in ways that maintain the *naturalization* of racial-sexual domination. However perilous, I argue that *the liminality of demonic grounds* of Black feminist birth work are also sacred because they offer models for liberation for Black and nonwhite women through the inbreaking of transformative hope into sustainable actualities.[201]

While *doulas* are conventionally regarded as counter-institutional cultural actors in biomedicine, the profession itself was crafted and scaled by physicians. The term *doula* was coined in 1982 in a collective effort between physicians and birth advocates to address tensions between the medicalization of birth and the 1970s home birth movement among middle class white women.[202] In the 1960s and 1970s, Case Western Reserve University physician-researchers Marshall Klaus and John Kennell studied maternal bonding and "the benefits of continuous emotional and physical support from another person in labor."[203] Their findings led them to engage external partners to develop training programs for individuals to support laboring women. Together with birth advocate, Anne Kennedy, social worker, Phyllis Klaus, and physical therapist, Penny Simkin, the *Doulas of North America*, now known as DONA

200. Katharine McCabe, "Mothercraft: Birth Work and the Making of Neoliberal Mothers," *Social Science & Medicine (1982)* 162 (2016): 177–84, https://doi.org/10.1016/j.socscimed.2016.06.021.

201. For more information on the ways in which African Americans create and maintain sacred grounds for epistemic and sociopolitical resistance see the work of Vorris Nunley: Vorris. Nunley, *Keepin' It Hushed : The Barbershop and African American Hush Harbor Rhetoric*, African American Life Series (Detroit: Wayne State University Press, 2011).

202. Bonnie B. O'Connor, "The Home Birth Movement in the United States," *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 18, no. 2 (April 1, 1993): 147–74, https://doi.org/10.1093/jmp/18.2.147.

203. "History of DONA International," accessed February 16, 2023, https://www.dona.org/the-dona-advantage/about/history/.

International, was established. Founders chose the term *doula* because, as a Greek term denoting a woman servant and they, "wanted to rediscover the essential ingredient of support in labor and post-partum."[204]

Thirty years later *doulas* are at the forefront of what Jennifer Nash has called the feminist birth industry, which includes lactation consultants and childbirth educators. The feminist birth industry denotes the ways feminism and the M.I.C. rear-ended to remake birth a "self-making event, one that can be crafted, tailored, and planned both to safeguard maternal health and to ensure an "experience" that meaningfully marks the transition to motherhood." [205] Curiously, however, the feminist birth industry, as does the M.I.C., embraces neoliberal market values by commodifying or coopting traditional and indigenous reproductive health care rituals, materials, and practices that transformed birth into a marketable experience.[206]

Sociologist, Katharine McCabe contends that birth workers such as *doulas* contribute to hegemonic biopower by encouraging the internalization of the biomedical gaze.[207] She argues that the proliferation of *doulas*, child birth educators, and lactation consultants, function as biopolitical tools to drive mothers towards investing in neoliberal health governance. Thereby, they serve as biopolitical tools to ensure that clients perceive and manage their perinatal health that shift ultimate responsibility for health outcomes from the healthcare industry to the individual. Under the guise of women's empowerment, patient autonomy, and consumer rights,

204. "History of DONA International."

205. Jennifer C. Nash, "Birthing Black Mothers: Birth Work and the Making of Black Maternal Political Subjects," 21.

206. Rosalynn Adeline Vega, "Commodifying Indigeneity: How the Humanization of Birth Reinforces Racialized Inequality in Mexico," *Medical Anthropology Quarterly* 31, no. 4 (2017): 499–518, https://doi.org/10.1111/maq.12343.

207. McCabe, "Mothercraft: Birth Work and the Making of Neoliberal Mothers."

the feminist birth industry sells services that ensure effective individual management of the reproductive experiences. It transforms traditional care roles into a profitable *gig-economy* by commodifying cultural health capital.[208]

McCabe advances the term *mothercraft* to refer to the pedagogical process by which birth workers deploy the empowerment model to attune clients to the biomedical gaze and prime them for the accumulation of products and care services. McCabe, however, does not provide demographic data about research participants but references identify patients as overwhelmingly white women. Birth workers, McCabe argues, promote an *Eurocentric* birth ideal:[209]

> Women without the social or financial supports to "choose" or who cannot shoulder the burden of the taxing regimes associated with value laden "natural" birth ideals are marginalized within care models that prescribe individualized and consumerist notions of choice and self-control, marking the limit of the field of possibility that enables predominantly white, economically privileged women to claim a moralized maternal identity.[210]

208. Alex de Ruyter and Martyn Brown, *The Gig Economy*, Economy (Newcastle Upon Tyne: Agenda Publishing, 2019). I use the term gig economy following the work of Alex De Ruyter who argues that the gig economy emerged in the "context of globalization, market-led re-regulation of the employment relationship, and technological change" (32). Rutyer argues that contrary to the levity of the terminology, "gig work is precarious, infrequent, badly paid, unstable and fortuitous, while the gig–work relationship is seen as transactional but unequal" (7).

209. Karen Elise Fields and Barbara Jeanne Fields, *Racecraft : The Soul of Inequality in American Life* (London ; Verso, 2012). Though McCabe does not reference the work of Karen and Barbara Jean Fields in Racecraft: The Soul of Inequality in American Life, her argument concerning the ways in which social roles in the United States are produced and reproduced biopolitically map neatly alongside the work of Racecraft. "The ideas of racecraft are pieced together in the ordinary course of everyday doing. Along the way, they intertwine with ideas that shape other aspects of American social life. Those of racecraft govern what goes with what and whom (sumptuary codes), how different people must deal with each other (rituals of deference and dominance), where human kinship begins and ends (blood), and how Americans look at themselves and each other (the gaze)."

210. McCabe, "Mothercraft: Birth Work and the Making of Neoliberal Mothers," 178.

Through *mothercraft*, the feminist birth industry shapes perinatal health expectations along neoliberal frames that ultimately lays responsibility for reproductive suffering on "failed consumers."[211]

When the ethics of care is applied to the lived experiences of Black and other nonwhite identified women, careful attention needs to be paid to the particulars in which Black womanhood has been constructed on demonic grounds since their colonial encounter, which contributed to their reproductive suffering. Womanist approaches to the ethics of care provide correctives to the work of feminist-identified ethics of care theorists by explicitly engaging racialized suffering related to the burdens of care carried by nonwhite women. As a standpoint theory, womanist social ethics focuses on the realities of those at the social, political, and economic margins of society and the mechanisms by which society displays the banality of their suffering.[212] Although having benefited from Black liberation theology, feminist theology, and critical race theory, progenitors of womanism, nevertheless, argued that these fields under assessed the experiences of nonwhite women regarding their spirituality, survival, resiliency, and quality of life concerns.

Theological approaches addressing racialized suffering demystify ideological sources that fuel sociopolitical apathy toward suffering. They critique the moral geography of Black women as a counter narrative challenging gendered and racialized assumptions that Black women lack rationality and moral reasoning.[213] By engaging the lived experiences of Black women, womanist theories reconfigure collective responsibility for suffering and how social

211. McCabe, 181.

212. Katie G. Cannon, *Black Womanist Ethics*, American Academy of Religion Academy Series 60 (Atlanta, Ga: Scholars Press, 1988).

213. Cannon.

systems restrict the agency and possibilities for Black and nonwhite women thriving even as they honor their resiliency. Womanist ethics excavates and exposes the moral landscape of Black women. From the insight of womanist ethicists, critical race theorists, and practical theologians on demonic grounds, Black women's moral geographies uncover sacred modes of resistance that allow for the recovery of the *Imago Dei* and discovery of models for reproductive thriving in and beyond the M.I.C.[214]

4.4 Black Birth Workers Between a Rock and a Hard Place

My qualitative research with Black feminist birth workers focused on a small birth worker collective in a midsized city in the southern U.S. called the Homeland Heart Collective. The collective is designed for "Mamas, Birth Workers, and Wellness Professionals of Color, and their Allies." The organization was founded in 2019 with a mission to provide free and reduced cost reproductive health care management services to Black families most at risk for poor birth outcomes. The collective receives funding from individuals and public and private funders. The collective also participates in a number of research projects in collaboration with academic medical centers. While the collective is fully engaged with multiple stakeholders, leaders and trainees often express a pessimistic view of these relationships and the possibilities that these relationships will ultimately contribute to nonwhite reproductive thriving within the M.I.C. and the boundaries of the biomedical gaze. Maternal mortality, activists often remark, is currently *sexy* to funders and politicians, who love bringing people to see and research poor Black women in *the latest zoo*. By encouraging families *to think and act like white people*, *doulas* train patients to regard healthcare resources as something one deserves and patients once at risk now fortunate now offered services. Birth workers train clients to identify and

214. Phillis Isabella Sheppard, *Self, Culture, and Others in Womanist Practical Theology*, 1st ed., Black Religion/Womanist Thought/Social Justice (New York: Palgrave Macmillan, 2011).

demand access to services and to hold the M.I.C. accountable for Black and nonwhite women's reproductive suffering. In other words, *doulas* were encouraged to identify the biomedical gaze and strategically deploy it in the making of demonic grounds.

In my study, birth workers providing for low-income clients often navigate tensions between their moral imperative to cultivate sacred grounds on the demonic grounds of reproductive medicine and the economic drive towards sustainable living wages from birth work. This tension is pronounced for birth workers in Black-led community *doula* programs, which are underfunded, despite increased interest in addressing Black maternal mortality.[215] The Homeland Heart leadership team participates on committees working on institutional and political policy. They are critical in pushing for TennCare reimbursement for *doula* services, and their *doula* training programs are funded by federal and state grants.[216]

Birth workers often articulate a vision of *return* to homebirth through the *rebirth* of the Black midwife movement. In explaining their calling to Black feminist, community-based birth work, birth workers ubiquitously identified Black feminist or Afrocentric approaches to reproductive care a moral imperative. Black feminist birth workers often argue that Afrocentric

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215. There are two other types of doulas – hospital based and private. Private *doulas* provide boutique perinatal services to middle- and high-income women such as stylized birth plans and on-demand access to pregnancy and labor emotional support. Hospital-based doula services operate like patient navigation and are used by health care systems to target services to those deemed at-risk of poor outcomes due to a lack of social supports. While there is legislation drafted in many states attempting to allow doula services to be covered under Medicaid, community-based programs currently rely on philanthropic and governmental support. For more information see: Robbie. Davis-Floyd, ed., *Birth Models That Work* (Berkeley: University of California Press, 2009), https://doi.org/10.1525/9780520943339.

216. Assistant Secretary for Public Affairs (ASPA), "Health Resources and Services Administration Announces Availability of New Funding to Support Community-Based Doulas," Text, HHS.gov, April 1, 2022, https://www.hhs.gov/about/news/2022/04/01/hrsa-announced-the-availability-of-4-million-for-hiring-training-certifying-compensating-community-based-doulas.html; "TennCare Increases Health Care Benefits for Pregnant and Postpartum Women," accessed February 16, 2023, https://www.tn.gov/tenncare/news/2022/3/31/tenncare-increases-health-care-benefits-for-pregnant-and-postpartum-women.html.

birth work is uniquely positioned to counter reproductive suffering building on the legacy of *granny midwifery.* At least one time per training session, trainers repeat a version of the refrain, "We know they [healthcare systems] don't really care about *us.*" Building on models of Afrocentric private birth work practices, community-based programs articulate *doula* care as a form of resistance to the medicalization of birth and capitalist notions of reproductive care management. Black feminist birth work, they argue, especially honors a holistic model of family and Black motherhood. In the latent and overt curriculum, *doulas* are socialized to actively train patients to identify and resist racism at the interpersonal level through Afrocentric *mothercraft* or by mimicking the socioeconomic posture of middle-class white families, understanding that there are no institutional or structural mechanisms for reproductive justice. This spatially locates *doulas* on demonic grounds caught and between a rock and a hard place.

Although funding for *doula* training programs has exponentially increased, Homeland Heart does not garner enough funding to pay living wages to *doulas*.[217] *Doulas* at Homeland Heart, who are not part of federal grant funded programs, are volunteers who receive an honorarium of $150.00 to attend a birth after attending three unpaid births. Perinatal support can take 20-30 hours over the course of pregnancy, labor, and delivery. This places trainees, primarily 25-35-year-old mothers working in low-wage positions, in a conundrum as many engage *doula* work as a *gig* that could "help bring in some coins while helping my sisters." Commonly Black feminist birth workers are supplementing their incomes as solo-entrepreneurs with side hustles related to Afrocentric practices such as selling waist beads, making herbal tinctures, placenta ceremony services, and other non-Western medical, spiritual and cultural

217. "TennCare Increases Health Care Benefits for Pregnant and Postpartum Women." www.tn.gov. https://www.tn.gov/tenncare/news/2022/3/31/tenncare-increases-health-care-benefits-for-pregnant-and-postpartum-women.html.

practices. Birth workers also sold supplemental herbal products, somatic services, and facilitation services for ritual practice and express a desire to work with clients who would serve as consumers for the products and services filling the pregnancy, postpartum, and postnatal needs of their clients. For many, this supplemental income, gained from birth work and the future earning potential of working with middle- and upper-income private clients, is a primary draw to the work.

Black feminist birth work navigates similar tensions as do clinical ethicists in their complicity and constraints under the biomedical gaze. They articulate a desire for a new reproductive equity imaginary while driven by financial advantages offered by the M.I.C. Birth workers at Homeland Heart often spoke of their desire to engage in counter institutional moves that would remove women from the biomedical gaze of healthcare by returning to home birthing. But this moral aspiration is compromised by their need for earning a living wage through their work. As care theorists have long argued, the inequitable distribution of care along racial and gender lines located on demonic grounds naturalizes financial burdens on care providers. However, I draw on the ethics of care to chart how Black feminist birth work, constrained on demonic grounds, resist the biomedical gaze.

4.5 Ethics of Care: A Feminist Bioethical Geography

Ethics of Care emerged in the early 1980s through seminal feminist works by Carol Gilligan and Nel Nodding.[218] These works sparked a transformative shift in approaches to patriarchal centered ethical theories that made rationality an ontological priority over relationality, considering the latter inferior to psychological and intellectual approaches to

218. Carol Gilligan, *In a Different Voice : Psychological Theory and Women's Development* (Cambridge, Mass: Harvard University Press, 1982); Nel. Noddings, *Caring, a Feminine Approach to Ethics and Moral Education* (Berkeley: University of California Press, 1984).

moral reasoning. Emphasis on relationality and its centering sociopolitical analysis on gender relations distinguished care theorists from moral utilitarian and duty-based approaches to biomedical ethics. Further, ethics of care is distinctly interdisciplinary.[219] Political theorist, Joan Tronto and philosopher, Virginia Held advanced the clearest articulations of the relationship between the practices of care and sociopolitical structures to gendered labor and medical care.[220]

Tronto analyzes the marginalization of care in the public and political contexts. She holds that there is a moral boundary marker in public policy that is rooted in the neoliberal ideology that political structures must be "distant and disinterested." 221 To maintain neutrality, policymakers evade sociocultural contexts of care that materially expand human flourishing. Tronto ties this evasion to Enlightenment epistemologies that asserts biological not accidents differentiate race and gender and in some instances class status.[222] Policies circularly reinforce this ideology, namely, that there are categories of people naturally deserving and undeserving of care and protection. Others are better suited by their *natural disposition* or diminished economic potential to deliver undercompensated care.[223]

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219. Rosemarie Tong, "The Ethics of Care: A Feminist Virtue Ethics of Care for Healthcare Practitioners," *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 23, no. 2 (January 1, 1998): 131–52, https://doi.org/10.1076/jmep.23.2.131.8921.

220. Joan C. Tronto, *Moral Boundaries : A Political Argument for an Ethic of Care / Joan C. Tronto.* (New York: Routledge, 1993).

221. Tronto, 9–13.

222. Tronto, *Moral Boundaries*, 50–57; 123.

223. Allan Laine Kagedan, "The Politics of Race in the United States and Canada," in *The Politics of Othering in the United States and Canada*, ed. Allan Laine Kagedan (Cham: Springer International Publishing, 2020), 105–24, https://doi.org/10.1007/978-3-030-52444-9_7.

Ethics of care shifts responsibility for the care of the least advantaged to interdependence from the liberal emphasis on individual autonomy.[224] Neoliberalism, she argues, fills the social imaginary with the view that society is constituted by *independent men*, where citizenship is validated by police powers and loyal to, what Cornel West calls, the *three dogmas of market forces*.[225] The three dogmas include: free-market fundamentalism that glorifies markets as idols or fetish; aggressive militarism or excessive policing policies; and escalating authoritarianism resistant to too many liberties due to deep rooted distrust among people.[226] Freedom, Tronto counters, is ultimately tied to "our capacity to care and to make commitments to what we care about."[227] But in the public health crisis of the 2020 pandemic, dubbed *essential workers* suffered and died in higher proportions than other healthcare workers falling outside zones of high skilled, technological, and professional agents of care.[228] Sadly, given their subjection to demise, housekeeping and environmental services and technicians who were pre-pandemic disposable low wage earners, hospitals in 2022 are now offering

224. Tronto, *Moral Boundaries*, 129; 162.

225. Joan C. Tronto, *Caring Democracy: Markets, Equality, and Justice* (New York, NY: New York University Press, 2013), 86, https://doi.org/10.18574/9780814770450; Cornel. West, *Democracy Matters : Winning the Fight against Imperialism* (New York: Penguin Press, 2004).

226 Cornel West, *DEMOCRACY MATTER: Winning the fight Against Imperialism* (New York: The Penguin Press, 2004), pp. 3-11; See Victor Anderson's discussion of West's dogmas in "Mimetic Reflections: The Religious Critic between the Church and Empire" in *Mission for Diversity: Exploring Christian Mission in the Contemporary World, Interreligious Studies Volume 8*, Elochukwu E. Uzukwu, editor (Zurich: Centre for World Christianity and Interreligious Studies, 2015), pp. 46-47.

227. Tronto, *Moral Boundaries*, 95.

228. Kim Parker and Juliana Menasce Horowitz, "Majority of Workers Who Quit a Job in 2021 Cite Low Pay, No Opportunities for Advancement, Feeling Disrespected," *Pew Research Center* (blog), accessed February 16, 2023, https://www.pewresearch.org/fact-tank/2022/03/09/majority-of-workers-who-quit-a-job-in-2021-cite-low-pay-no-opportunities-for-advancement-feeling-disrespected/.

signing bonuses for these roles ranging from $500-$6,000 to maintain the pipeline of low-wage labor.[229]

Held argues that the liberal value of autonomy can be a core value only if "developed and sustained within a framework of relations of trust."[230] Held posits *mutual autonomy* as a process of reciprocity. It displaces "benevolent domination" and "proportional caregiving" for people occupying levels of socioeconomic power. [231] Care is seen as a preferable moral value to autonomy by "replacing the hierarchies and dominations of gender, class, race, and ethnicity" and transforming relationships between sociopolitical domains.[232] Held suggests that this transformation opens the possibilities of accelerating the material thriving of the most marginalized members of society. The ethics of care requires decision makers at all levels of society to focus on the actual lived experiences of individual care rather than relying on cases derived from hypothetical or statistical persons.[233] Held conceptualizes care as a cluster of practices and values that depicts a caring person as one who has appropriate motivations to care for others and who participates adeptly in effective caring practices.[234]

Held and Tronto provide conceptions of interpersonal and institutional transformation of political systems that deconstruct imbalances of gender and class power rooted on neoliberal logics of "desert". Their works expose the collusion of neoliberal ideology and policy that

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229. Suzanne Rose, Josette Hartnett, and Seema Pillai, "Healthcare Worker's Emotions, Perceived Stressors and Coping Mechanisms during the COVID-19 Pandemic," *PloS One* 16, no. 7 (2021): e0254252–e0254252, https://doi.org/10.1371/journal.pone.0254252.

230. Virginia Held, *The Ethics of Care: Personal, Political, and Global* (Oxford ; Oxford University Press, 2006), 72.

231. Held, 56.

232. Held, 160.

233. Held, 160.

234. Held, 45.

creates a self-perpetuating feedback loop circulating between interventions of health care into reproductive suffering and its abdication of the M.I.C. in favor of neoliberal loyalty to market forces. Black women serving as birth workers are tasked with flipping the *death worlds* of biomedicine to create sacred space. As noted, the care birth workers provide is often treated with hostility by nurses and physicians regardless of the racial identity of the birth worker or birthing person, but this hostility is often compounded towards Black women.[235] Much like the role of the antebellum granny midwife, Black birth work is a *naturalized calling* required by community-based birth work.

4.6 Womanist Ethics: Excavating Demonic Grounds

Womanist ethicist Emilie M. Townes has called this naturalized calling, the "everydayness" of social suffering. 236 Townes; is referencing the material and epistemic consequences of socially constructed evil, which "involves patterns of relationships that are directed toward the denial of the human dignity and value of some human beings for the benefit of other human beings."[237] From these patterns of relationships, a Black woman is an enduring symbol of suffering.[238] In reproductive biomedicine, there is a correlation and increasing evidence of causation between psychological suffering and physical suffering of Black women.

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235. Laura Lucas and Erin Wright, "Attitudes of Physicians, Midwives, and Nurses About Doulas: A Scoping Review," *MCN, the American Journal of Maternal Child Nursing* 44, no. 1 (2019): 33–39, https://doi.org/10.1097/NMC.0000000000000488; Cyleste C. Collins et al., "'I Felt like It Would've Been Perfect, If They Hadn't Been Rushing': Black Women's Childbirth Experiences with Medical Providers When Accompanied by Perinatal Support Professionals," *Journal of Advanced Nursing* 77, no. 10 (2021): 4131–41, https://doi.org/10.1111/jan.14941.

236. Emilie Maureen Townes, ed., *A Troubling in My Soul* (Mayknoll, N.Y: Orbis Books, 1993); Rob Nixon, *Slow Violence and the Environmentalism of the Poor [Electronic Resource] / Rob Nixon.* (Cambridge, MA: Harvard University Press, 2011), https://doi.org/10.4159/harvard.9780674061194.;

237. Townes, *A Troubling in My Soul*, 48.

238. Townes, 49.

White coat hypertension, a phenomenon in which person's blood pressure measures significantly higher in the clinical encounter than in a nonclinical setting due to stressors of the clinical encounter, which includes experiences of obstetric racism emanating from the internalization of the biomedical gaze.[239] The presence of hypertension may also trigger in professionals, what Lauren Hall calls, the "cascade" of interventions to manage perceived medical risk.[240] Similarly in delivery, researchers find that when Black women engage in *mothercraft* as health care consumers during labor and delivery and voice their intentions to engage in informed refusal of procedures ["intravenous analgesia, no epidural, breastfeeding only (i.e. no formula supplementation), delayed cord clamping, intermittent (rather than continuous) fetal monitoring, and no episiotomy Hepatitis B vaccine, and formula supplementation"], they experience an increase in perceived discrimination and are more likely to be perceived as uncooperative by the medical team.[241] In this way the biomedical gaze contributes to the cycle of psychological and physical suffering and the banality of socially constructed evil within reproductive biomedicine.

Seeing the operations and outgrowths of the biomedical gaze as moral evil provides a critical lens into how inequitably distributed suffering is encoded in institutional and social policy as tool of oppression.[242] In reproductive medicine, this most often shows up where

239. Sonia Johnson et al., "Maternal and Perinatal Outcomes of White Coat Hypertension During Pregnancy: A Systematic Review and Meta-Analysis," *Hypertension (Dallas, Tex. 1979)* 76, no. 1 (2020): 157–66, https://doi.org/10.1161/HYPERTENSIONAHA.119.14627.

240. Hall, *The Medicalization of Birth and Death Lauren K. Hall.*

241. Laura B. Attanasio and Rachel R. Hardeman, "Declined Care and Discrimination during the Childbirth Hospitalization," *Social Science & Medicine (1982)* 232 (2019): 270–77, https://doi.org/10.1016/j.socscimed.2019.05.008.

242. Townes, *A Troubling in My Soul*, 78.

maternal mortality is looked upon as being outside the professional scope of the moral responsibility of providers and policy makers. The problem of maternal mortality inequities in the U.S. has been varyingly referred to *a wicked problem*. Public policy scholars, Horst Rittel and Melvin Webber, coined the term *wicked problem* to refer to the difficulty of ensuring equity in a pluralistic society.[243] The theoretical construction of wicked problems was an attempt to acknowledge the difficulty of describing and interrupting mechanisms contributing to social suffering in a complex society committed to scientism and the technoscientific management and measurement of efficiency. Their work suggested that collective responsibility towards addressing social suffering included a participatory engagement of those outside of the "wise and knowledgeable" professional experts and politicians. [244]

Arguments made by decision makers like Louisiana senator and physician Dr. Bill Cassidy often are rooted in ontological arguments about the bodies of Black persons. In a 2022 interview with the Harvard Chan School of Public Health, Senator Cassidy proposed that the large population of Black women in Louisiana was the reason why maternal mortality rates seem disproportionate high for his state, proposing that "about a third of our population is African American; African Americans have a higher incidence of maternal mortality. So, if you correct our population for race, we're not as much of an outlier as it'd otherwise appear."[245] Accounting for the demography of Black women in the state, statistical masking covers over the magnitude of reproductive suffering experienced by Black women in the state by *blaming*

243. Horst W. J. Rittel and Melvin M. Webber, "Dilemmas in a General Theory of Planning," *Policy Sciences* 4, no. 2 (1973): 155–69, https://doi.org/10.1007/BF01405730.

244. Horst W. J. Rittel and Webber.

245. Sarah Owermohle, "Why Louisiana's Maternal Mortality Rates Are so High," *Politico,* 2022..

the victims for their suffering. Maternal mortality is constructed as *the group problem* rather than reflecting institutional and political decision making.

Womanist approaches begin with moral outrage, or what Townes calls lament over suffering and commitment to its eradication. This outrage, Phelps and Townes suggest, is generative because oppressed peoples are often asked to suppress their outrage and to refrain from acknowledging mechanisms that enable and maintain their pain and suffering. Building on the work of Audre Lorde, Townes differentiates pain and suffering noting that "suffering is un-scrutinized and unmetabolized pain."[246] Townes urges mobilizing strategies of justice rather than settling for immobilized stunned reactions. One's ascribing suffering as courageous or an act of divine will are tools of oppression. While experienced on demonic ground, pain has the potential to transform victimhood by allowing the oppressed to dually examine "her or his situation and make a plan for a healthy future" and "the past and the recovery of the truth" because pain, unlike suffering, can serve as a generative "tool for liberation and wholeness." It bestows the power of questioning the narratives and half-truths of what has been written about Black womanhood.[247] Metabolizing suffering, by naming it, transforms suffering into pain, which is a pathway towards agency and social action.

For Townes, pain also generates skills for surviving and transforming oppression through critical reflection of oppressive conditions. Townes differentiates types of authority in the Christian mission - domination requiring subjugation of others instead of partnership reflecting community and justice. The way out of this domination is justice, which is taking responsibility to discover and discern God's will and implement it in the world. This is an act of

246. Townes, *A Troubling in My Soul*, 84.

247. Townes, 85.

obedience and a "religious decision versus…mindless submission."[248] Among the types of mindless submission that womanist ethics eschews are "mindless violence, conditional justice, destructive life-styles, or complement inertia."[249] Thus womanist ethics uses pain to interrogate systemic injustice. The pain that spurs such honest interrogation finally leads to a new horizon for society, or a new Jerusalem. Justice, Townes suggests, moves the horizon further towards, "a society that respects the rights and humanity of all peoples and nature."[250] Townes leaves readers with this affirmation:

> Suffering is outrageous. Suffering does not ennoble, enable, or equip this generation or future generations of Black people. A life based on survival and reaction does not produce healthy minds, bodies, or souls. The fragmentation of the spirit and the witness prevents the Black church from living in the New Jerusalem. Rather than rest on counterfeit virtues, womanist ethics challenges the African-American community and the Black church to be the true people of God and hang together.[251]

Pain triggers the senses and spurs individuals and communities to take progressive action towards social liberation, while suffering is senseless and dulls the ability to respond. Townes warns that ethicists must be wary of conversations about virtue that slip over into oppressive well-worn stereotypes and attempt to make sense out the outrageous. The biomedical gaze leads to solutions that make social care transactional. Womanist ethics of care attempts to make sense out of senseless structures of inequity in healthcare and provide restrained relief to the severity of Black women's suffering.

4.7 Aesthetics of Care and its Statistical Liturgies

The crisis discourse surrounding Black birth "make[s] visible Black maternal suffering

248. Townes, 88.

249. Townes, 88.

250. Townes, 89.

251. Townes, 91.

and death and to make apparent the myriad ways that hospitals can be death-worlds for Black mothers and their children". [252] However, over the past decade an inverse relationship exists between the value of Black maternal mortality as a political currency and maternal mortality and morbidity rates. Epidemiological and quality improvement scholars find evidence that structural inequity has more impact on maternal and infant morbidity outcomes than individual barriers to health. Though The Joint Commission organization publicly reports hospitals with higher-than-average cesarean rates and newborn complications, much of the response deemed *the crisis in birth inequity* focuses on interpersonal solutions that align with neoliberal logics of labor and responsibility for social suffering. [253]

The crisis discourse surrounding Black maternal mortality equates Black woman to the *tragic* and *synonymous with pain*.[254] This rhetorical shift, read as *Black Maternal Politics*, is also a strategic move leveraged by Black feminist activists to wrest Black women from the folds of power and to name mechanisms of reproductive suffering. For Nash, Black Maternal Politics transforms the *everydayness* of reproductive suffering into an emergent disaster demanding response:

> [T]he long- standing conditions of the ordinary have been newly framed as a crisis and where Black mother-hood itself has become a site of cultural interest, empathy, fascination, sup-port, and seemingly benign regulation both by the biopolitical state and by Black feminists as they have collaborated to figure Black mothers as living in

252. Jennifer C. Nash, "Birthing Black Mothers: Birth Work and the Making of Black Maternal Political Subjects," 16.

253. "The Joint Commission Begins Public Reporting for Two Hospital Perinatal Care Measures in 2021 | The Joint Commission," accessed February 16, 2023, https://www.jointcommission.org/resources/news-and-multimedia/news/2021/02/the-joint-commission-begins-public-reporting-for-two-hospital-perinatal-care-measures-in-2021#.Y-784nbMKUk; Mohana Biswas et al., "1040 Doula Support Impact on Maternal Health Outcomes for Minority Women: A Meta-Analysis of Observational Studies," *American Journal of Obstetrics and Gynecology* 224, no. 2 (2021): S645–S645, https://doi.org/10.1016/j.ajog.2020.12.1065.

254. Jennifer C. Nash, "Birthing Black Mothers: Birth Work and the Making of Black Maternal Political Subjects."

> crisis…Black mothers in the United States have become spectacularly and dangerously visible through the frame of crisis, one that insists on their spatial and temporal location in a death-world that is described as reminiscent of the nation's imagined past, even as it is consistent with the conditions of the unfolding pre sent. While crisis has made the precarity of Black mothering newly visible— if not remediable—it has also tethered Black maternal flesh to disorder, even if it is not the disorder of earlier eras, namely pathology and poverty. It is precisely because Black motherhood is now cast as suffering rather than pathological, as tragic rather than self- destructive, as traumatized rather than deviant, that the crisis frame can be both deeply seductive and rhetorically effective. Yet the rhetoric of crisis is part of an enduring and troubling tradition of rendering Black women generally, and Black mothers specifically, into symbols, even if now Black mothers are symbols of tragic heroism rather than deviance. [255]

This frame is an incredibly powerful rhetorical tool that has redirected social and political resources while failing to lead to measurable improvements in outcomes for Black women.[256] While Black maternal politics effectively shifts attention to the everydayness of suffering, the scope of attention collapses into what is visible in the biomedical gaze. It is the gaze, which abstracts suffering for statistics and other tools of technoscientific management and renders Black women's suffering symbolic.

The world ordering power of the biomedical gaze upholds reproductive suffering while symbolizing responsiveness identified in the ritual recitation of what is "the statistical liturgy of black reproductive suffering."[257] Statistical liturgies of Black death activate the collective imagination and signal community membership by strategically deploying the tools of the biomedical gaze towards mapping individual suffering. Statistical liturgies are recited at the beginning of every gathering, workshop, and lecture focused on reproductive justice and ubiquitously paired with a specific, often viscerally detailed, examples of Black suffering

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255. Jennifer C. Nash, 5.

256. "Maternal Mortality Rates in the United States, 2020," November 7, 2022, https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm.

257. James K. A Smith, "Secular Liturgies and the Prospects for a 'Post Secular' Sociology of Religion" (NYU Press, 2012), 159.

foregrounding key players, victims and victors, in the crisis of Black birth. Statistical liturgies identify the M.I.C., also variously known as *the system* or *structural racism*, against which reproductive justice activists and families wrestle. This menacing demonic ground haunts every clinical and social environment that deny Black maternal thriving from conception to postpartum. The statistical liturgy of the crisis discourse closely mirrors the February 23, 2022, Maternal Mortality Rate update from the Center for Disease Control's Division of Vital Statistics.

> In 2020, the maternal mortality rate for non-Hispanic Black women was 55.3 deaths per 100,000 live births, 2.9 times the rate for non-Hispanic White women (19.1). Rates for non-Hispanic Black women were significantly higher than rates for non-Hispanic White and Hispanic women. The increases from 2019 to 2020 for non-Hispanic Black and Hispanic women were significant. The observed increase from 2019 to 2020 for non-Hispanic White women was not significant.[258]

The liturgy derived from these statistics abstracts the deaths of 740 non-Hispanic Black women in 2020 to the nearly ubiquitous headline found in media, white papers, grant proposals, and conferences that the "U.S. Maternal Mortality Rate Among Black Women Is Nearly Triple That of White, Hispanic Peers."[259] The maternal morbidity rate abstracts a greater level suffering of tens of thousands of Black families.[260] This secular liturgy leverages the biomedical gaze to make Black women's reproductive suffering statistically significant and to shift the narrative of Black motherhood from apathy to pity.

The rhetorical power of statistical liturgies of Black women's reproductive suffering is their capacities for producing *an aesthetic of care* that signals a dual-membership in the

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258. "Maternal Mortality Rates in the United States, 2020."

259. "CDC WONDER," accessed February 16, 2023, https://wonder.cdc.gov/.

260. Elizabeth A Howell, "Reducing Disparities in Severe Maternal Morbidity and Mortality," *Clinical Obstetrics and Gynecology* 61, no. 2 (2018): 387–99, https://doi.org/10.1097/GRF.0000000000000349.

biomedical model and a counter-institutional ethic of care.[261] The genius of the birth injustice statistical liturgy is that birth workers in birth justice deploy the logics of the biomedical gaze to make suffering visible, legitimate, and legible. This liturgy is enacted at the beginning of every gathering of clinicians, public health professionals, advocates, nonprofit leaders, and philanthropists attempting to address the crisis to center attention to the severity of suffering. The danger of the liturgy is that it cements an ontological Blackness where nonwhite women are deserving of investment only cause they are tragically entered into a crisis of suffering. The effect of the liturgy makes Black women's reproductive suffering palatable to M.I.C stakeholders to operate in constant the crisis mode in responding to emergent sufferings. To constructively respond to this statistical liturgy of care, I turn to Afrofuturist and Black women's speculative fiction as models of a generative framework for addressing Black women reproductive suffering in ways resistant to the world ordering power of the biomedical gaze.

261. For additional discussion about the aesthetics of care within health care see: Steven P Black, "The Ethics and Aesthetics of Care," *Annual Review of Anthropology* 47, no. 1 (2018): 79–95, https://doi.org/10.1146/annurev-anthro-102317-050059.

CHAPTER 5

Toward Visionary Biomedical Imaginaries

The way we talk about birth equity focuses on death. You shouldn't have to die for it to be a trigger for care. Fear is not going to lead to better reproductive outcomes – we can't stay in the narrative of black pain and black suffering.

- Jennie Joseph, Founder and Executive Director Commonsense Children [262]

5.1 Introduction

As chapter two detailed, bioethics has focused its lens on the fantastic in ways that erased how race and gender became core to the construction of the field and its boundaries of inquiry. Legal scholar, Karla F. C. Holloway's meditation on the complexity of race and racism in bioethics suggests that bioethics has failed to attend to the "unique cultural and social histories attached to specific populations in the United States…that inevitably questions our presumptions regarding individual autonomy."[263] However, Holloway turns to Octavia Butler's science fiction for grounding her exploration of how bioethics might make space for biopolitical analyses:

> This genre places historical context outside of the frame of analysis because the characters in this story about reproduction (from which the chapter title is taken) are literally alien. The challenge of reading the issues that emerge from legal and medical frames of reproduction into an alien landscape is of no small consequence. But the (literal) alienation of the story brings the biases or presumptions we might have about women or race into focus. How do our presumptions translate into an interpretation of the issue of reproduction if the terrain is imaginary? This consideration renders our presumptions fairly stark in appearance and finally helpful in terms of our notice of difference.[264]

262. October 26, 2022, Field notes from the Moms & Babies Action Network Summit in Atlanta, GA

263. Holloway, *Private Bodies, Public Texts : Race, Gender, and a Cultural Bioethics*, 6.

264. Holloway, 21.

By disturbing the imagination and transporting readers to other worlds, science fiction, says Holloway, opens space for the investigation of I use Holloway's and other critical approaches that connect bioethics and speculative fictions. The trajectory of bioethics has mirrored that of speculative fiction, which rapidly expanded in the post-World War II era as society wrestled with the social, cultural, and economic implications of the rapid advance of technoscience.[265] The two fields similarly examine potential tensions between the advance of biotechnology and the range of possibilities for human thriving.[266]

Since the early 2010s, scholars, such as Holloway, have increasingly investigated the possibilities for critical, creative exchange between bioethics and speculative fiction. Strengthened by the public's rediscovery of Octavia Butler's *Parable of the Sower* series during the COVID-19 pandemic, scholars and activists began engaging speculative fiction to reimagine power relations in their respective spheres of influence.[267] In addition, science and technology scholars and literary critics such as Ruha Benjamin, Wendy Hui Kyong Chun, Alondra Nelson, and Sami Schalk use speculative fiction to challenge bioethics to incorporate approaches to biomedicine resistant to scientism and pave the way for a new imaginary.

In the previous chapter, I focused on bioethicists and *doulas*, two professional fields within the M.I.C. intended to put internal checks on the biomedical gaze. While *doulas* are often perceived as operating outside of the biomedical gaze, as with bioethicists, the profession is

265. Jay Clayton, "The Ridicule of Time: Science Fiction, Bioethics, and the Posthuman," *American Literary History* 25, no. 2 (2013): 322–23.

266. Ari Schick, "Whereto Speculative Bioethics? Technological Visions and Future Simulations in a Science Fictional Culture," *Medical Humanities* 42, no. 4 (December 2016): 228, https://doi.org/10.1136/medhum-2016-010951.

267. Monica A Coleman, "Octavia Tried to Tell Us: Parable for Today's Pandemic by Monica Coleman," *Feminism and Religion [BLOG]*, 2020.

created and sustained socially, financially, and politically mechanisms of the biomedical gaze. Both professions tenuously balance their professional obligations for solving immediate dilemmas and critically advocating for advancing the *standard of care practices* (See chapter 3) in healthcare. Efforts to wrest these professions from their loyalty to the biomedical gaze and scientism prioritized narrative inquiry and care ethics. However, both approaches inadequately address what intersectional feminists and womanists have surfaced, namely, that literature and social metanarratives fueled by the fantastic hegemonic imagination are primary contributors to the banality of reproductive suffering.

5.2 Narrative & Ethical Inquiry from the Margins

The structure of the M.I.C. maps neatly onto what Townes calls the *Fantastic Hegemonic Imagination*. As a Christian social ethicist who pivots from the work of H. Richard Niebuhr, Townes defines systemic evil as the social, political, and economic processes that produce inequitable misery and suffering.[268] By weaving the work of Michel Foucault and Antonio Gramsci, Townes suggests that the cognitive map of the relationships between whites and nonwhites that undergird racial relations in the U. S. was carefully developed through stereotypes deployed by American media:

> The fantastic hegemonic imagination traffics in peoples' lives that are caricatured or pillaged so that the imagination that creates the fantastic can control the world in its own image. This imagination conjures up worlds and their social structures that are not based on supernatural events and phantasms, but on the ordinariness of evil. It is this imagination, I argue, that helps to hold systematic, structural evil in place. The fantastic hegemonic imagination uses a politicized sense of history and memory to create and shape its worldview. It sets in motion whirlwinds of images used in the cultural production of evil. These images have an enormous impact on how we understand the world, as well as others and ourselves in that world….It is most important to note at this point that the fantastic hegemonic imagination is in all of us.

268. Townes, "Womanist Ethics and the Cultural Production of Evil. Black Religion, Womanist Thought."

> …None of us naturally escape it, for it is found in the deep cultural codings we live with and through in U.S. society.[269]

The fantastic hegemonic imagination structures expectations of the self and the other and is the mechanism that make invisible structures upholding and exacerbate gendered, racialized suffering. Furthermore, the fantastic hegemonic imagination shapes the stories that oppressed people tell themselves about their failure or successes while navigating social evil. In healthcare settings, it contributes to the *everydayness* of social suffering and allows social evil to operate in the managerial aspects of healthcare institutions.[13] The mundane nature of systemic and structural social evil in healthcare, aided by abstractions that dismember persons and statistical liturgies that contribute to the moral formation of clinicians, administrators and patients, allows healthcare institutions to serve as a sites of physical or psychological healing, while simultaneously being sites oppressing providers and receivers of care.

Womanist approaches to ethics address the power of the imagination by looking to the cultural productions of Black women to uncover how they morally engage sociopolitical suffering. Pioneered by theological ethicist, Katie Geneva Cannon, womanist approaches engage "how Black women live out a moral wisdom in their real-lived context that does not appeal to the fixed rules or absolute principles of the white-oriented, male structured society."[270] Expanded by her student Stacey Floyd-Thomas, womanist methodological approaches use narrative ethics for understanding how oppression is both internalized and resisted by Black women. Through Black literature, Floyd-Thomas asserts that ethicists can engage:

> [a]nalysis of the contexts of oppression within black women's writing in which the moral character development of black women is birthed and nurtured…to chart within the black female literary canon the moral wisdom of surviving and thriving in the face of

269. Townes, 21.

270. Cannon, *Black Womanist Ethics*, 4.

> oppression and the coping strategies that emerge out of their struggle for redemptive self-love.[271]

I build on Floyd-Thomas's approach to ethical inquiry by turning to visionary fiction, that is, speculative fiction created by subaltern groups that uses the genre to reimagine social, economic, and political structures. This chapter engages the womanist methodology of critical engagement with Black women's literature by turning to Black women's speculative fictions as a model of refusing the epistemic violence inherent in the biomedical gaze.

Building on the epistemological, methodological, and pedagogical approaches of womanist ethics of care and visionary medicine, I build a model of visionary bioethics that resists the logics and effects of the biomedical gaze operating on the demonic grounds of Black women's reproductive suffering. Visionary bioethics provides a pathway towards halting epistemic reliance on biomedicines algorithms of care, which reinforce racism or what Wendy Chung calls a "technology of medicalized domination."[272] Critical science and technology scholar, Ruha Benjamin argues that through speculative fiction one can see the biopolitical elements that bioethics wants to eschew. If as Berger and Luckman have argued, religion is essentially a process of worldmaking, the power of speculative fiction lies in its ability to expose how worlds are created and allow readers to look towards a different imagination.[273] Following Sylvia Wynter and Herbert Marcuse, Benjamin argues that while technoscience has promoted a

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271. Stacey M. Floyd-Thomas, *Mining the Motherlode : Methods in Womanist Ethics* (Cleveland, Ohio: Pilgrim Press, 2006), 35.

272. Wendy Hui Kyong Chun, "Introduction: Race and/as Technology; or, How to Do Things to Race," *Camera Obscura: Feminism, Culture, and Media Studies* 24, no. 1 (70) (May 1, 2009): 7–35, https://doi.org/10.1215/02705346-2008-013.;

273. Peter L. Berger and Thomas Luckmann, *The Social Construction of Reality : A Treatise in the Sociology of Knowledge*, Anchor books ed., Anchor Books; A589 (Garden City, N. Y: Doubleday, 1967).

post human world, post humanist visions assume that we have all had a chance to be human.[274] I find this reading particularly constructive to engage the tension in bioethics focus on the fantastic potentials of posthumanism as a interrelated struggle to engage the banality of racialized suffering. If racism functions as a biopolitical technology that is both reproduced by the "antiblack black boxes" of biomedicine and technoscience, then the use of the fantastic allows for the continuance of structured inattentiveness encoded as a rigorous approach to inquiry. This project is an attempt to understand the logics of the biomedical gaze as a particular type of code input into the antiblack boxes. Bioethicists and *doulas* are two actors in the M.I.C tasked with responding to the effects of these codes. By engaging visionary, Afrofuturist, and Black women's speculative fictions, I hope to explore how biopolitical analysis of the M.I.C. expose and *hack* demonic codes.

Visionary Medicine is coined by John Pasco, Camille Anderson, and Sayantani DasGupta to develop a model of conscientization in medical education that engages afrofuturist texts. Pasco and colleagues turn to afrofuturism to reshape their imagination concerning the futures of people suffering under structural and systemic oppression. Visionary medicine focuses on the power of the clinician to imagine patients' outcomes. Theorists surmise that shifts in provider's perceptions of poor and non-white patients will lead to systemic change in the practice of medicine. While important, this strategy for change is insufficient insofar as it does not address the locus of power in healthcare delivery, namely, healthcare administration. This work seeks to explore the possibilities of a visionary bioethics as a robust and sustainable mechanism of systemic change that might present a more substantial challenge to the uncritical administration

274. Ruha Benjamin, *Race after Technology: Abolitionist Tools for the New Jim Code* (Cambridge, UK ; Polity, 2019).

of acute care that reifies sociobiological inferiority. Using Peter Berger's concept of the sacred canopy, I look for ways that visionary fiction can provide mechanisms for both practitioner and administrators of biomedicine to examine the systems they maintain and to engage and encourage critical reflection to help reimagine and restructure the social worlds of healthcare.

5.3 Prophetic Visions & Science Fiction Imaginaries

I review three critical responses to the role of the science fiction imaginary in bioethics. Jay Clayton and Sarah Chun's charitable treatment of the shared sociocultural histories of bioethics and science fiction suggest a model of narrative bioethics that presents a more complex lifeworld than currently presented in case studies and thought experiments. Ari Schick provides less charitable response based on his reading of the power of the biomedical gaze and scientism in shaping the forms and functions of bioethics. The three scholars suggest that bioethicists have largely uncritically engaged the sociotechnical imaginary similarly to science fiction while feigning methodological priority due to their proximity to the M.I.C. When read together, these scholars propose an epistemological and methodological shift where bioethics can more closely examine biopolitical relationships between actors in institutions and imagine a future for a new humanism that moves beyond the focus on the *fantastical cases* and responses to legal, institutional, and policy dilemmas or patients' crisis.

Like bioethics, speculative fiction, especially the subgenre of science fiction, has erased race through idealistic multiculturalism or replicated racial hierarchies uncritically. As British-based bioethicist Sarah Chan argued, the primary methodological tools of bioethics (case studies, thought experiments) might well be considered forms of speculative fiction.[275] Bioethics as a

275. Sarah Chan, "More than Cautionary Tales: The Role of Fiction in Bioethics," *Journal of Medical Ethics* 35, no. 7 (July 2009): 1, https://doi.org/10.1136/jme.2009.031252.

discipline is a discursive field designed to develop intersubjective assumptions governing the boundaries of appropriate professional behavior. The early progenitors of bioethics, such as Daniel Callahan, invested professional social capital ensuring bioethics was taken seriously as more than a scholarly genre of speculative fiction and navel gazing. He argued that bioethics was meant to provide serious consideration of future technology while preventing science fiction "from overwhelming practical ethical deliberation."[276]

Chan argues that engaging bioethics as fiction moves bioethics toward a thicker description of moral cases and exploration of ethical issues. She proffers that the ability for fiction to allow for readers to be immersed in different worlds also allows for a deeper imaginative process that eschews the distance of the hegemonic frame of the biomedical gaze:

> Works of fiction allow us to consider ethical problems that fall outside our experience: either outside our immediate personal experience, allowing us to "personalize" and thus better understand the issues involved; or outside the limits of our common experience, acting as thought experiments that stretch the boundaries of our ethical imagination. They seek to expand the reader's understanding, not merely to inculcate or preach but to set us on a journey of ethical development in parallel with the narrative development experienced as we "journey" through the text.[277]

Chan suggests that by using the tools of fiction, narrative bioethics can more effectively engage the moral concerns that emerge within biomedicine and biomedical technology. While Chan's treatment of the connections between bioethics and fiction does not specifically engage speculative fiction, she, nevertheless, argues that engaging bioethics through fiction presents a more democratic approach to the subjects of bioethics that maintains scholarly integrity so "not to encourage misconceptions or false impressions" rampant in popular fiction on science and

276. Schick, "Whereto Speculative Bioethics?," 227.

277. Chan, "More than Cautionary Tales," 3.

biomedicine.[278] Chan's argues that counter to the neutral positions claimed by bioethics and science fiction, the ultimate aims of bioethics are persuasive. Bioethics and speculative fictions work together to persuade their respective audiences to consider what is and what most likely will not be personally experienced. Together, they "stretch the boundaries of our ethical imagination."[3] According to Chan, the potential of bioethics, as fiction, allows for a more generative form of bioethics that shifts from the discourse from the ontological priority of scientism to insist that all knowledges are situated in deeply personal experiences.

Literary scholar and medical humanist, Jay Clayton claims the discourse of bioethics and science fiction are parallel social responses to existential fears about the posthuman future that provide a model acknowledging multiple subjectivities. According to Clayton, while *Anglo-American science fiction* celebrates the possibilities of human transformation, bioethics inhabits a pessimistic approach rooted in social science realism and moral philosophy.[279] As noted in earlier chapters, bioethics' reliance on the social scientific imagination (scientism) misses the possibilities of engagement with critical theories of biopower in consideration of a posthuman future, which leads to methodological hypocrisy. "The nightmares of science fiction haunt the bioethical imagination, exerting a pervasive but unexamined influence on its analyses. But the failure of bioethicists to examine the images, metaphors, and storylines of the science fiction that they so frequently invoke distorts their findings and recommendations."[280]

Clayton argues that the inability of bioethics to engage full possibilities of the posthuman future makes the field less suited to the task of shaping public policy. He further argues that

278. Chan, 2.

279. Clayton, "The Ridicule of Time," 321.

280. Clayton, 318.

science fiction presents a methodologically approach more honest to thought experiments on posthumanism as science fiction but does not purport to be "free of larger cultural anxieties." For this reason, Clayton proposes "scientific thrillers and science fiction are better suited to this kind of thought experiment than most of the nonfiction about posthumanism that aims to influence public policy."[281] For Clayton, the underlying scientism of bioethics leads the field to "specialize in prophecies and predictions."[282] He calls these prophecies and predications, the "scientific jeremiad and encomia" and suggests they have more in common with science fiction than they care to admit.[283] He writes:

> Like jeremiads, scientific anticipations aspire to be prophetic, but theirs is a more prosaic form of prophecy, one that cannot trace its lineage from the warnings of Biblical seers. They traffic in mundane predictions, and their attempts to inspire awe at biotechnology's wonders sometimes result merely in the feeling of "gee whiz." Their predictions risk being disproven by the next twist or turn of history; the best they can aim for is the hit-or-miss success rate typical of Wells's prognostications (and he had an unusually high record of successes). Both jeremiad and the encomia have their uses, but the latter especially courts the ridicule of time.[284]

Clayton expresses concern at the prevalence of *encomia* and the *scientific jeremiad* in the genre of bioethics that seeks to shape public policy. Not only are these forms methodologically dishonest, but they are also critically non-reflective. Clayton posits that there might be a better dialogue between bioethics and the medical humanities, particularly literary critique, that "prevent policy makers and social commentators from generalizing glibly about cultural attitudes from a sample size consisting of a few decontextualized novels and films."[285]

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281. Clayton, 332.

282. Clayton, 333.

283. Clayton, 333–39.

284. Clayton, 338.

285. Clayton, 339.

Pointing to how the biomedical gaze has shaped the contours of Western life by "saturat[ing] our consciousness" and "science fictional habits of mind,"[286] Clayton worries that lay audiences may mistake *scientific jeremiads* and *encomia* for bioethics. When considering scientism as an ordering belief system and the role of bioethics in mediating technoscientific advances towards the teleological ends of biomedicine, bioethics might be seen as a type of prophetic engagement.

Ari Schick's critical bioethics theory picks up on Clayton's observations and suggests that bioethics is a form of prophecy and predication. Schick's discussion of speculative bioethics, a subfield of bioethics that anticipates the moral problems of future technologies, focuses on the subfield's adoption of the literary conventions of speculative fiction. He argues that this method is a moral bypass that collapses "the present as a site of moral agency and locates ethics within a simulation of the imagined future."[287] Western social and political institutions are saturated in sociotechnical imaginaries that turn speculative fiction from genre to a "cultural modality."[288] Contrary to Clayton's claims, Schick argues the sociotechnical imaginary negatively impacts the bioethical imagination. He argues the sociotechnical imaginary negatively constrains moral landscapes by ignoring the power of the biomedical gaze and scientism and shifts the burden of ethical decision making to the future.

> Once we distinguish the temporal subject of speculative bioethics (the future) from its actual point of influence (the present), we begin to notice that as bioethics has developed into an established field factoring into public policy deliberation, its speculative discourse has become a framework in which technological visions are transformed into sets of 'probable facts' demanding proactive ethical scrutiny.[289]

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286. Clayton, 320.

287. Schick, "Whereto Speculative Bioethics?," 225.

288. Schick, 226.

289. Schick, 225.

Bioethics' dealings in probable facts is directly tied to the power of the statistical liturgy in cueing professional membership in the M.I.C. Bioethics initially emerged with two distinct trajectories: *regulatory bioethics* focused on rights and choice led by legal and philosophical scholars and *prophetic bioethics* focused on sociocultural meanings governed by theologians, social scientists, and nonanalytic philosophers. Schick argues that speculative bioethics has become a more dominant approach to bioethical concerns, aided by the sociotechnical imaginary and rapid advance of medical technology.

The development of the Human Genome Project and Ethical Legal and Social Implications research initiative paved the way for what Schick calls anticipatory bioethics. For Schick the danger of anticipatory bioethics is it collapses the temporal imagination in ways that invite apocalyptic apathy regarding moral agency.[290] This reading of anticipatory bioethics leads Schick to advocate for a return to the conventions of prophetic modes of speculative bioethics.:

> Speculative bioethics in this vein would see its primary task as critical moral reflection on technological visions themselves, proceeding from a recognition that these visions both reveal and shape the present, molding our understanding of what is possible, what is likely and what is desirable. Finally, we would do well to remember that ethical discourse does not need to be about the future in order to reflect a deep concern with the future.[291]

For Schick, the prophetic approach appropriately locates moral agency in the present. Anticipatory bioethics reifies the imagined dystopian/utopian future while missing on moral obligations to ensure future generations imagined future. Against Clayton and Chun's positive readings of the possibilities of science fiction, Schick warns that bioethics informed by

290. Schick, 226.

291. Schick, 229.

speculative and science fiction have tempted bioethicists into a form of moral bypassing that limits the moral agency of the present.

5.4 Narrative & Ethical Inquiry from the Margins: Refashioning the Sociotechnical Imaginary in Biomedicine: Visionary Fiction, Afrofuturism & Black Women's Speculative Fiction

While Chun, Clayton and Schink provide fruitful insights into horizons of biomedical ethics, each avoids engaging in a biopolitical examination of how science fiction and bioethics rely on ontological claims about human nature rooted in eighteenth century racialized and gendered epistemic violence.[292] Clayton approaches a recognition of this reality by bracketing the context of his work to Anglo-American fiction in the first half of his history of science fiction and engaging the work of Octavia Butler in the second half. While Clayton notes the presence of social Darwinism, eugenics, and uncritical post-racialism in the first and second waves of science fiction, he does not contextualize Butler's work as a direct response to racism, classism, and sexism in science and science fiction. He rather refers to Butler as a "noted African-American and feminist writer who stretched the boundary of the genre" and who, "welcom[ed] a post human future as the only possible mode of survival."[293] Chun and Schick fail all-together to acknowledge how speculative and science fiction share pervasive threads of latent and explicit Eurocentrism in ways that limit the imaginary of nonwhite futures.

Medical humanists John Pasco, Camille Anderson, and Sayantani DasGupta directly address this link in their brief investigation of the relationship between science fiction and

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292. John Carlo Pasco, Camille Anderson, and Sayantani DasGupta, "Visionary Medicine: Speculative Fiction, Racial Justice and Octavia Butler's 'Bloodchild,'" *Medical Humanities* 42, no. 4 (2016): 248.

293. Clayton, "The Ridicule of Time," 331.

biomedicine. Their pedagogical model of *Visionary Medicine* builds on the work of narrative medicine and develops a pragmatic theory of institutional change focused on exposing physicians-in-training to science fiction as mechanism for increasing the moral imagination turned on the relationship between the medical sciences and the persistence of social and racial inequities.[294] The tools of the biomedical gaze (risk ratios, technologies of speculation, and sometimes mystical prognostication) might well be considered subgenres of speculative fiction. Like statistical liturgies, the tools of clinical biomedicine nurture the moral formation of clinical professionals and frame the range of appropriate clinical and moral possibilities in the medical encounter:

> Using information available in real time, physicians in the clinical encounter begin the work of time travel: backward to old labs and family histories, and forward to diagnoses, prognoses, and treatment plans. By imagining new cures, new discoveries and new futures for human beings in the face of illness, medicine is akin to science and speculative fiction in that it is necessarily always dissecting the art of the possible through acts of radical imagination.[7]

As chapter two detailed, the biomedical gaze is the undergirding logic undergirding the sociotechnical imaginary, which is a social algorithm that inequitably distributes suffering.[295] The imaginary cultivated by the biomedical gaze limits collective responsibility by hiding the functions of socioeconomic bias, medical realism, and neoliberalism behind the veil of objective technology. In this way the clinical and administrators are habituated to accept the inevitability

294. John Carlo Pasco, Camille Anderson, and Sayantani DasGupta, "Visionary Medicine: Speculative Fiction, Racial Justice and Octavia Butler's 'Bloodchild,'" *Medical Humanities* 42, no. 4 (2016): 248.

295. Sheila Jasanoff and Sang-Hyun Kim, "Containing the Atom: Sociotechnical Imaginaries and Nuclear Power in the United States and South Korea," *Minerva (London)* 47, no. 2 (2009): 119–46, https://doi.org/10.1007/s11024-009-9124-4.

of the demonic operations of the biomedical gaze in uplifting individual autonomy and responsibility as the gospel of biomedical salvation.

Science fiction also deploys liberalist portrayals of multiculturalism, subordinate dark-skinned species that replicate racialized hierarchies, or completely ignores race altogether. Pasco, Anderson, and DasGupta note that resistance to this epistemic violence has emerged via a new type of science fiction "defined by its insistence on imagining freer and more liberated worlds or critiquing injustice, rather than uncritically recreating the power structures of the world as we know it in fantastical garb."[8] Visionary fiction, dominated by nonwhite women, actively engages in biopolitical inquiry by demystifying, subverting, and resisting the biomedical gaze. These authors suggest that these works, when used as training tools for new clinicians, might move beyond the narrative medicine model, which invites a holistic narrative of suffering into the clinical space to help clinicians imagine a future that does not rely on the biomedical gaze's limited notions of flourishing. In the hands of subaltern groups, speculative fiction often refashions the sociopolitical imaginary in ways that can be helpful in the reconfiguration of the biomedical gaze. Afrofuturism and Black women's speculative fictions craft alternative notions of care and human thriving in ways that seek to end epistemic racial-gendered violence and its material corollaries.

5.4.1 A New Shade: Afrofuturism as Epistemic Resistance

Afrofuturism was first coined by cultural critic, Mark Dery in 1994 to refer to African American literature that appropriates the genre of speculative fiction towards liberative aims. Afrofuturism, he argues, "addresses African-American concerns in the context of twentieth century techno culture – and, more generally, African American signification that appropriates

images of technology and a prosthetically enhanced future."[296] Derry's early conceptualization of Afrofuturism was expanded by cultural critics including Alondra Nelson in the late 1980s. Together with other scholar-activists, Nelson developed a community of scholars who transformed the study of afrofuturism into an academic discourse through the publication of a special issue in the journal *Social Text*.[297] While early works classified as afrofuturism focused on asserting a place for people of color in the future, in *Future Texts* authors assert a second wave of afrofuturism emerging as a form of cultural critique. The second wave of afrofuturism provide crucial biopolitical analysis and "represents new directions in the study of African diaspora culture that are grounded in the histories of black communities, rather than seeking to sever all connections to them."[298]

Afrofuturist literature and scholarship has flourished as a sociopolitical discourse concerned with the futurity of nonwhite people and has expanded to create counternarratives that consciously seek to dismantle and intervene in necro politics advanced by the sociotechnical imaginary.[299] This approach leads afrofuturist scholar and artist Kodwo Eshun to characterize afrofuturism as a framework for epistemological liberation:

> Afrofuturism may be characterized as a program for recovering the histories of counter-futures created in a century hostile to Afrodiasporic projection and as a space within which the critical work of manufacturing tools capable of intervention within the current political dispensation may be undertaken.[300]

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296. Mark Dery, "Black to the Future: Interviews with Samuel R. Delany, Greg Tate, and Tricia Rose," January 1, 1994, https://doi.org/10.1215/9780822396765-010.

297. Alondra Nelson, "Introduction: Future Texts," *Social Text* 20, no. 2 (2002): 1–15.

298. Nelson, 9.

299. J.-A. Mbembé and Libby Meintjes, "Necropolitics," *Public Culture* 15, no. 1 (2003): 11–40.

300. Kodwo Eshun, "Further Considerations of Afrofuturism," *CR (East Lansing, Mich.)* 3, no. 2 (2003): 301, https://doi.org/10.1353/ncr.2003.0021.

Afrofuturism is a liberative methodology that engages a pedagogy of conscientization, which then necessitates active resistance to hegemonic frameworks.[301] Deemed Afrofuturism 2.0, these scholars and artists use their craft to weaken the framing power of the biomedical gaze by resisting the sociotechnical imaginary. [302]

To this end, critical theorist, Lonny Brooks proposes that afrofuturism serves as a counter strategy to sociopolitical cruelty. Engaging the speculative fiction of Octavia Butler, he suggests that afrofuturism is a larger field responsive to the "cruelty of the white imagination…out of which the African diaspora had to reimagine its future."[303] He suggests that almost all cultural productions by socio-politically marginalized peoples must be understood as moral agency:

> I expand the term here to discuss how black people and other marginalized groups have had to embed their environment on a daily basis with imagined affordances to see and expect more from the cultural artifacts and tools than what was intended by their original designers, or in the black diasporic case, our captors and enslavers. For example, imagined affordances[304] include black cultural technologies such as music, where the hymns of imposed Christianity became the odes of freedom and the seeds of rebellion. [305]

301. Walidah Imarisha et al., *Octavia's Brood: Science Fiction Stories from Social Justice Movements* (Oakland, CA: AK Press, 2015).

302. Ytasha Womack, *Afrofuturism: The World of Black Sci-Fi and Fantasy Culture* (Chicago: Review Press, 2013); Reynaldo Anderson and Charles E. Jones, *Afrofuturism 2.0: The Rise of Astro-Blackness* (Lanham, Maryland: Lexington Books, 2016).

303. Lonny J. Avi Brooks, "Cruelty and Afrofuturism," *Communication and Critical/Cultural Studies* 15, no. 1 (2018): 101, https://doi.org/10.1080/14791420.2018.1435078.

304. Brooks uses the concept of imagined affordances as developed by Gina Neff and Peter Nagy, to reflect how the imagined uses, values, and expectations users have often differ from the concept that designers intended. Brooks argues this is a similar process to the creative cultural practices that have emerged from the suffering of people in the black diaspora. (103)

305. Brooks, "Cruelty and Afrofuturism," 103.

Brooks use of *imagined affordances* follows Wendy Chun's assertion that race and racism function as technologies of domination that shape agential power and contribute toward ensuring that the mechanisms of social evils are invisible.[306] Afrofuturism exposes these demonic algorithms of domination and provides models for subaltern groups to hack these systems towards the redistribution of biopolitical power.[307]

As afrofuturism has matured as a cultural production, scholars of Black religion and theology have turned to the field to investigate how those within the movement craft socioreligious imaginations. Religious scholars Terrance Dean and Dale Andrews suggested that theologians ought to take seriously the work of afrofuturism for it represents a secular teleological meditation that allows "theological scholars, authors of Black art and cultural reflection, and community organizers [to] enter a common universe of prophetic analysis and fantasized visions that contemplate heretofore unimagined, transformed Black life."[308] Echoing the analytical posture Pasco, Anderson and Das Gupta concerning the power of *Visionary Fiction* as a pedagogy in medicine, Dean and Andrews argued that the power of afrofuturism is its ability to critique and reimagine the constructions of Black life. Black Studies professor, Michael Brandon McCormack proposes that afrofuturism is a ripe field for ethical analysis because it pushes scholars of Black religion beyond "a retrieval of resources from the past" and towards "critical engagement with cultural resources that imagine alternative, albeit (science-) fictional,

306. Chun, "Introduction."

307. Benjamin, *Race after Technology*.

308. Terrance Dean and Dale P. Andrews, "Introduction: Afrofuturism in Black Theology - Race, Gender, Sexuality, and the State of Black Religion in the Black Metropolis," *Black Theology : An International Journal* 14, no. 1 (2016): 5, https://doi.org/10.1080/14769948.2015.1131499.

possibilities for the future."[309] He suggests afrofuturism foregrounds practices of justice seeking and the "role of religious institutions, beliefs, and practices in such struggles."[310] Afrofuturism casts its vision into the future to wrestle with the concerns of those currently socio-politically marginalized using visionary and artistic methods.

Accordingly, afrofuturism is inherently prophetic and political. To be explicit, it is a form of *futuristic social gospel* that allows theologians and ethicists to investigate how artists "use religion as a lens through which to analyze and augur issues of difference, domination and deliverance."[311] For marginalized people, whose histories and subcultures have been intentionally suppressed and erased, the work of imagining a future that defies the current social arrangements is not just the work of fantasy or survival but defiance. While many Black identified writers in the U.S. illuminate the untold stories of the past and present, afrofuturism imagines and tell a new story. The work of imagining oneself and writing a suppressed culture into the future or what afrofuturist scholar Kodwo Eshun calls a *counter future* is a narrative form that holds possibilities of reshaping the imagination of both the oppressed and those who benefit from oppression.

Eshun argues that afrofuturist speculative fiction dwells not only on the fantastical but also what Townes calls the *everydayness* of injustice. Indeed, afrofuturist speculative fiction is rooted in critical analysis and "critically interrogates the social construction of difference in a

309. Michael Brandon McCormack, "'Your God Is a Racist, Sexist, Homophobic, and a Misogynist ... Our God Is Change': Ishmael Reed, Octavia Butler and Afrofuturist Critiques of (Black) American Religion," *Black Theology : An International Journal* 14, no. 1 (2016): 7, https://doi.org/10.1080/14769948.2015.1131503.

310. McCormack, 8.

311. McCormack, 9. Citing Sheree Renee Thomas

future where notions of the *alien* are brought down to earth."[312] This work runs counter to the overwhelming trends of science fiction to either diminish or ignorantly replicate socio-political marginalization based on phenotypical, religious, or economic difference. Afrofuturist speculative fiction is a fascinating genre that, at times, provides an "ancient-future that has reclaimed and re-signified African diasporic religious and cultural traditions as a means of liberation and innovation within a pluralistic American context" and, at other times, " presents a vision of a future socio-political context that demands an altogether new (black/feminist/youth) religious movement–one that is informed by, but ultimately leaves behind, prior expressions of Black religiosity for a more radical alternative."[313] For this reason, McCormack argues that afrofuturism is a ripe yet underexplored field for scholars of religion and social ethics.

5.4.2 The View from the Fold: Black Women's Speculative Fiction

Critical race and disability scholar Sami Schalk's approach to the genre of speculative fiction written by Black women further illuminate how speculative fictions emerging from subaltern groups might serve to radically reform the sociotechnical imaginary. Schalk engages speculative fiction rather than the subgenre of afrofuturism because it is an umbrella term encompassing several genres of creative writing from magical realism and fantasy to science fiction and ghost stories where socially constructed "rules of reality do not fully apply".[314] When viewed as a collective genre, the power of these works foregrounds how these forms of fiction

312. McCormack, 11.

313. McCormack, 24.

314. Samantha Dawn Schalk, *Bodyminds Reimagined : (Dis)Ability, Race, and Gender in Black Women's Speculative Fiction / Sami Schalk.* (Durham: Duke University Press, 2018), 17, https://doi.org/10.1515/9780822371830.

imaginatively construct *unburdened new worlds* that reject current sociopolitical constraints.[315] By creating unburdened worlds, Black women's speculative fiction can generate "a unique set of imaginative possibilities for a literary tradition that has long been burdened by the demands of realist social protest." [316]

Schalk suggests the power of Black women's speculative fiction is their conscious inclusion of narrators with disabilities and nonhuman relationships in ways that subvert the overall genre of speculative fiction. Shalk develops speculative fictions as a methodology contributing to the development of new imaginaries. She argues that speculative fictions allows readers to "reimagine the experience of people of color."[317] Rather than sociopolitical escapism, speculative fiction enacts epistemic resistance to the hegemonic power of the biomedical gaze:

> Instead these works are theorizations of the possibilities and meanings of bodyminds that change the rules of interpretation and require modes of analysis that take into account both the relationships between (dis)ability, race, and gender and the contexts in which these categories exist.[318]

Including narrators with disabilities and nonhuman relationships subvert the biomedical gaze and technoscientific imaginary that annihilates the agential possibilities of nonwhite body/minds. Schalk argues that through the rejection of reality, Black women's speculative fiction represents a liberative praxis of subversion of the *facts* and *rules* of racialized and gendered social, economic, and political oppression. Black women's speculative fiction is morally generative because of its potential to disrupt mind-body dualism and engage a holistic *body/mind*.

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315. Schalk, 21–22.

316. Madhu Dubey, "Speculative Fictions of Slavery," *American Literature* 82, no. 4 (2010): 779, https://doi.org/10.1215/00029831-2010-045.

317. Womack, *Afrofuturism*.

318. Schalk, *Bodyminds Reimagined : (Dis)Ability, Race, and Gender in Black Women's Speculative Fiction / Sami Schalk.*, 138.

> Speculative fiction can defamiliarize (dis)ability, race, and gender in ways that are intellectually and politically productive. By shifting our taken-for-granted social norms, speculative fiction makes unconscious preconceptions about (dis) ability, race, and gender more readily apparent, challenging readers to think outside of the accepted definitions of these categories. The nonnormative nature of the representation of (dis)ability, race, and gender in speculative fiction, however, often requires similarly nonnormative methods of reading and interpretation.[319]

Through non-realism, speculative fiction uses defamiliarization and denaturalization to draw the reader's attention to the mutability of social constructions and disrupts the normativity of gendered, raced, and abled performances. Schalk further suggests that the power of Black women's speculative fiction pays attention to how systems of oppression, "overlap, intersect, support, and sustain one another in real-world power dynamics and interactions."[320] Through speculative fiction, Black women engage in a pedagogical project of consciousness raising and moral reformation that is not only a pedagogy of the oppressed but also a pedagogy of the oppressor.

5.5 Dismantling the Sacrilegious Canopy

Engaging Black women's speculative fiction toward visionary bioethics holds liberative power through the engagement of the imagination, the *sacred canopy* over the biomedical gaze and scientism is exposed. Berger's sociological approach to religion suggests that *making religion* occurs through an unstable process of making sense of reality. The process of "externalization, objectivation, and internalization" tracs the processes from which a society creates a nomos – a stable, meaningful, and predictable order of meaning.[321] Religion serves as

319. Schalk, 23.

320. Schalk, 139.

321. Berger, *The Sacred Canopy; Elements of a Sociological Theory of Religion, by Peter L. Berger.*, 19.

an essential, but precarious, process of legitimizing world aiding societies to remember and reinforce their socially constructed institutions and arrangements under threat of anomy.[322] Berger proffers that the trend toward secularism, aided by economic and cultural modernization, decreases the role of religion in cosmic legitimization such that religion is restricted to the process of sub-world construction.[323] In this setting, meaning making turns into a *marketplace* where churches compete with other institutions thereby creating a crisis of authority.[324]

For Pasco, Anderson, and DasGupta, visionary fiction is a pathway to visionary medicine challenging the medical profession "not just to imagine new futures within the existing ideologies of difference, but to challenge and disrupt these ideologies in and of themselves."[9] Much of the work in narrative medicine focuses on helping medical services to understand the social life-worlds of the people they encounter in the clinical environment. Efforts to achieve cultural competency treat marginalized people as rooted in static understandings of diverse cultural contexts. Even Johnathan Metzl's construction of structural competency,' which recognizes the systems in which people are embedded, fails to fundamentally reshape our counter provider's imagination of justice outside of the contemporary or past structures of oppression.[325] Engaging afrofuturism helps providers resist these logics and envision a more transformative practice of care and futurity for those made vulnerable by socio-political systems. Visionary bioethics is a model of engaging in bioethics by beginning with biopolitical awareness

322. Peter L. Berger, *The Sacred Canopy: Elements of a Sociological Theory of Religion* (New York: Anchor Books, 1990), 40; Berger, *The Sacred Canopy; Elements of a Sociological Theory of Religion, by Peter L. Berger.*, 40.

323. Berger, *The Sacred Canopy*, 132–35.

324. Berger, 145.

and commitment to acknowledge how the technoscientific imaginary invites suffering beyond individual clinical interactions:

> Visionary speculative fiction, like visionary medicine, disrupts our current comfortable understandings, challenges our moral assumptions and requires an iterative process of introspection and political humility. Works such as Octavia Butler's 'Bloodchild' are ultimately useful because they provide a "pedagogy of discomfort" in medical training, a way for students to critically examine even their most deeply held assumptions regarding difference, power and race. Since medical epistemologies are so heavily rooted in a seeming '"objectivity knowledge, a pedagogy of discomfort is perhaps particularly useful in medical training. It is often said that children cannot be what they cannot see. The same can be said for medicine, as it gives birth to a more socially just future version of itself. We cannot become what we cannot imagine, but speculative fiction such as the works of Asian and Afrofuturism, Indigenous Imaginaries and Cosmos Latinos can help guide our imaginings.[326]

Afrofuturism and visionary fiction provide a way for administrators of health care to understand that the current structure of their system is not inherently a black box or something that is inherently good or given. These forms of fiction help to shape the moral imagination and reveal how structural oppression is constructed and maintained. Other forms of discourse concerning the moral landscape of the practice of medicine, including policy, critical histories of medicine, as well as prophetic and anticipatory bioethics, seek to diagnose and redress the operations of injustice using contemporary logics. Afrofuturism and other types of visionary fiction invite moral engagement that challenges readers to imagine new social relationships. Thus, unlike prophetic or anticipatory bioethics, visionary bioethics engages visionary fiction as a method of discovering new moral landscapes, encouraging critical ethical reflection to reimagine, and restructuring of the social worlds of medicine.

326. Pasco, Anderson, and DasGupta, "Visionary Medicine: Speculative Fiction, Racial Justice and Octavia Butler's 'Bloodchild,'" 251.

5.6 From Holistic to Afrocentric: Strategies for Dueling with Death

Doula trainees articulated the desire to provide a distinctly afrocentric approach to reproduction justice. They argue that care rooted in the Black grannie and imagined traditional African practices interrupt the racialized and gendered algorithms of suffering triggered by the biomedical gaze. *Doula* programs, focused on afrocentric birth methodologies, are highly influenced by "The SMC Full Circle Doula Birth Companion Training" developed by Oregon - based Shafia Moore in 2002 and popularized by Afrocentric celebrity Erykah Badu. Moore became ubiquitously recognized by Black feminist reproductive justice advocates as the "Queen Mother" of *doula* support for labor and delivery.[327] This work was seen as a counter to the Eurocentric, biomedical model of *doula* care focused on the boutique support to white women birthing in hospitals. Moore directs a recovering of a precolonial model of perinatal care and the Black granny tradition towards reclaiming the sacred nature of birth. Through the establishment of the "International Center for Traditional Childbearing", known as of April 2018 as the "National Association to Advance Black Birth", Shafia built a movement focused on the West African ethic of *Sankofa,* going back to fetch what has been lost, to inform moral reasoning:

> Mama Shafia brought "self-determination" into the discussion of doula care, empowering the Black community to take back, re-define, and reclaim the role of the doula as a practice rooted in Black tradition, instead of in slavery and racism. Mama Shafia promoted the way of the Grannie Midwife and the African Midwife — the individuals in the community who practice holistic, full-scope birth traditions by going above and beyond for birthing mothers by offering not only birthing assistance but postnatal care and supportive childcare. These are the Black traditions that she called upon doulas to embrace to "empower the Black community".[328]

327. Shafia M. Monroe et al., "Birth, Healing, and Women of Color: Symposium Keynote Lecture and Discussion," *Oregon Historical Quarterly* 117, no. 2 (2016): 232–51, https://doi.org/10.5403/oregonhistq.117.2.0232.

328. "Black Maternal Health Conference- April 2021," MOTHER Lab, May 7, 2021, https://motherlab.org/conference-blog/.

Monroe directly articulates a connection between contemporary Black birth work with the history of granny midwifery to protect Black knowledges from the ravages of the white and biomedical gaze. Monroe articulates a womanist ethics of care that regard Black birth work as counter to the detrimental effects of the medicalization of birth and the internalization of the biomedical gaze.

The National Black *Doula* Association (NBDA), founded by Tracie Collins, in 2017 is the largest Black *doula* association in North America and mimics the infrastructure of Doulas of North America (DONA) International. The organization includes the largest directory of *holistic* Black *doula* trainings that employ seven key types of trainings: Birth Doulas, Childbirth Educators, Holistic Fertility Doulas, Placenta Encapsulation, Sex Doulas/Intimacy Coaches, and Business Development. While NBDA and Monroe tie Black birth work to the history of granny midwifery, NBDA, which partners with Walmart, explicitly engages the lucrative business of Black birth work. Their website includes numerous targeted job and product advertisements on their website including calls for women to engage in remote *gig work* by serving as a surrogate.[329]

Although the term *holistic* signals how NBDAs training attends to Black women as whole persons, including their racial identity, the latent content of NBDA's training is that Black feminist birth work is a profitable part of the neoliberal marketplace. NBDA's social media presence fits into Nash's model of the crisis response. NBDA pairs the aesthetics of the Black feminist birth industry with statistical liturgies towards recruiting participants and sponsors in solving the crisis of back maternal mortality. NBDA's approach, including its focus on the

329. "Advertise," National Black Doulas Association®, accessed February 16, 2023, https://www.blackdoulas.org/advertise.

interpersonal level, licensure and regulation, including high-cost programs and additional costs to obtain and maintain certifications, replicates socioeconomic mechanisms contributing to the suffering for Black women including disproportion education and career training debt.[330]

No matter what path *doulas* take to become part of the birth work industry, they are ultimately tasked with navigating the wicked algorithms on demonic grounds. *Doulas* approach the work with varying levels of hope about Black futures. For participants in this study, the driver for participation in an afrocentric *doula* training was the personal or proximate experience with birth trauma or loss related to racism. Trainings regularly made space for participants to give testimony, often through tears, of wrenching experiences of reproductive suffering resulting from healthcare policies and the absence of health care practices from clinicians.

The collective's approach to reproductive justice allowed participants to balance personal and political approaches to reproductive justice care. Trainees' articulation of the goals of holistic or afrocentric birth work was closely connected to a desire to understand how multiple oppressions shape the potential for human thriving within the clinic and the larger community. *Doulas* noted that while the work was personal - disrupting individual experiences of suffering – it was simultaneously political – resisting biomedical metanarratives about Black women and families.[331] Their approach to an ethics of care begins with deep lament that, unlike the rehearsed, abstracted, generalizable bioethics case that begins Chapter 3, is particular,

330. Stella Min and Miles G. Taylor, "Racial and Ethnic Variation in the Relationship Between Student Loan Debt and the Transition to First Birth," *Demography* 55, no. 1 (2018): 165–88, https://doi.org/10.1007/s13524-017-0643-6.

331. Audre. Lorde, *Sister Outsider : Essays and Speeches / by Audre Lorde.*, Crossing Press Feminist Series (Trumansburg, NY: Crossing Press, 1984); Keeanga-Yamahtta Taylor, ed., *How We Get Free : Black Feminism and the Combahee River Collective*, Black Feminism and the Combahee River Collective (Chicago, Illinois: Haymarket Books, 2017).

unrehearsed, and messy. The use of testimony refused abstracted suffering and allowed participants space to transform suffering as they witnessed themselves and others. *Doula* trainees often used these testimonies as the basis for biopolitical analysis that generated solutions to enact reproductive thriving at the micro-level, meso-level, and macro-level.[332] In this way the collective used demonic grounds as a space to strategize hacking *anti-black-box*ed algorithms of care.[333] Their approach to *the crisis model* assumed that clinicians and administrators had no vested interest in dismantling antiblack boxes over the long run by incorporating ameliorative and transformative approaches to flourishing that include planting food gardens to decrease food insecurity, joining hospital boards and committees to influence institutional practices, and collaborating with other reproductive activists to advocate for policy reform.

5.7 Reimagining Paradise on Demonic Grounds

we seem to have so much knowledge
we are busy, oh so busy
searching for paradise in a world of theme parks
we have rushed in one too many times
to cover ourselves up with human-made delights that life will not crush us
we have sought one too many easy answers
to the dilemma of shaping a faith that moves beyond shouting
that looks, feels, and sounds like a postmodern minstrel show
to one that endures and deals with the realities of what it takes to confess our sins in a world *we* have helped create
and it is often a mean, cruel, self-interested, selfish world
we have tried that one additional quick-fix
that has pushed us into empty living[334]

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332. Brian Christens and Douglas D. Perkins, "Transdisciplinary, Multilevel Action Research to Enhance Ecological and Psychopolitical Validity," *Journal of Community Psychology* 36, no. 2 (2008): 214–31, https://doi.org/10.1002/jcop.20232.

333. Field Notes from March 19, 2022, Homeland Heart Doula Training, Nashville, TN

334. Townes, *Breaking the Fine Rain of Death : African American Health Issues and a Womanist Ethic of Care*, 170.

The biomedical gaze has created a theme park caricature of care ethics. In Townes' development of a womanist ethic of care, she argues that the reliance on knowledge and quick fixes to crises such as maternal mortality contributes to theme park caricatures of care that replicate suffering. For clinical ethics, the work to engage biopolitics in ethical inquiry were largely marginalized as unintellectual activism until the world turned its attention to health inequities during onset of the 2020 pandemic. The feminist birth industry, cloaked in the guise of radical change, engages in a type of neoliberal priming that keeps families in line with the aims of the M.I.C. I argue that statistical liturgies are the product of theme park ethics of care, which substitute the aesthetics of Afrocentrism and afrofuturism to stand in for the hard work of demystifying wicked problems and by doing so addressing the underlying algorithms contributing to multilevel oppressions.

Visionary speculative fiction has the potential to serve as a pedagogical tool for critical moral reflection and reflexive praxis toward exposing theme park approaches to liberation and human flourishing and investigating personal and collective complicity in the maintenance of the biomedical gaze. Furthermore, the mode of visionary fiction, unlike the current structure of bioethics and other forms of inquiry, does not rely on the necropolitical power of statistical liturgies that use crisis discourse to reinforce the ontological blackness of Black women reproductive suffering. Theme park ethics turns critical inquiry and social justice into a burden by cultivating a culture where "work is only recognizable as work if it is hard, if it exhausts us."[335] Schalk argues against the ideology that liberation work should be inextricably linked to

335. Schalk, *Bodyminds Reimagined : (Dis)Ability, Race, and Gender in Black Women's Speculative Fiction / Sami Schalk.*, 17.

335. Schalk, 21–22.

suffering, noting that the ideology inadvertently leads to oppression. Visionary fiction helps hold morally generative tension when working towards liberation in a "mean, cruel, self-interested, selfish world" that has been co-created. Visionary fiction models how the struggle [the demand of analyzing and dismantling the theme park] must exist alongside pleasure [the delight of reading and imagining a new paradise] to sustain stamina for the ends of liberation. Visionary fiction, she argues, creates a new habituation that allows activists, advocates, and academics to see these connections. "Pleasure does not exist outside of oppression because none of us exist outside of these systems of power, but pleasure can nonetheless arise in the midst of oppression, in the face of it, in spite of it, or sometimes even because of it."[336]

Schalk's connections between oppression, liberation, and pleasure align with Courtney Bryant's phenomenological approach to relating embodiment and moral agency.[337] Bryant, using womanist methods, argues that pleasure and other haptic experiences of joy in the struggle for liberation shows resistance to oppression. She call this *erotic defiance*:

> Erotic defiance a form of moral and political agency in which the erotic, that is, love manifested in and through the flesh, informs and makes possible a form of moral participation in which the marginalized and the privileged alike assert their rebellion against the assumed values and meanings of black and female corporeality as well as the convoluted concept of the erotic operative in the fantastic hegemonic imagination.[338]

336. Schalk, *Bodyminds Reimagined : (Dis)Ability, Race, and Gender in Black Women's Speculative Fiction / Sami Schalk.*, 140.

337. Courtney Bryant. Prince, "Erotic Defiance : A Womanist Ethic of Moral and Political Agency" (Nashville, Tenn, Vanderbilt University, 2018). Bryant's phenomenological account of erotic defiance builds upon the accounts of connection between the somatic experience and moral formation builds upon the work of womanist ethicists Kelly Brown Douglas, Shawn Copeland and Anthony Pinn, Michel Foucault, and phenomenologists Maurice Merleau-Ponty, Howard Harrod and Robert Sokolowski.

338. Prince.

Critical engagement with visionary fiction works is a fruitful pedagogical tool for resisting the hegemonic power of the biomedical gaze. In this chapter, I focused on ways that womanist and other critical approaches to visionary texts might serve as a tool of liberation for all those who are complicit in operations of oppression. While et al. focus on the potential of engaging visionary fiction for medical trainees, I argue that this scope can be expanded to all actors in the M.I.C., whether activist, advocate, academic, or administrator. This assertion begins with a critical reading of power and prophetic pragmatism rooted in systems analysis of sociopolitical flourishing. 339 I argue that visionary fiction presents a generative model that allows for critical reflexive praxis for multiple professions. Further, when viewed through a neuro-ethical approach, visionary fiction might serve as an accessible format of biopolitical analysis that can create space for moral reflection and new neural pathways for moral reformation.[340] Professional moral habituation within healthcare encourages reliance on theme park ethics stymied by despair and quick fixes that fit neatly into grant and IRB applications. Engagement with visionary fiction resists this habituation and moves towards a generative lament that messily integrates struggle and pleasure towards ultimately overwriting demonic codes and providing models of collective flourishing.

339. See discussion of prophetic pragmatism in Introduction.

340. Neil Levy, *Neuroethics / Neil Levy. [Electronic Resource]* (Cambridge: Cambridge University Press, 2007).

CHAPTER 6

Conclusion: Re/Visions for Bioethical Inquiry and Practice

Women like me are dying. I need to take all precautions to ensure that I do not become a statistic. My life depends on me being informed. – Kay Matthews.[341]

6.1 Unbecoming Circumstances and Statistics

By the time work on this dissertation began in 2020, I had developed a transdisciplinary methodological framework that blended my community psychology training with my work in social and biomedical ethics. As I looked to prepare the framework for the dissertation, I found myself as a Black woman on the edge of an abyss in the field of bioethics navigating a reckoning of race and gender. The structured ignorance of antiblack racism in the field led academic bioethicists to explore the marginalization of Black scholarship and applied bioethicists to wrestle with how pandemic response protocols exacerbated medical apartheid.[342] At the same time, reproductive justice scholars and activists were actively sounding alarms about what epidemiologists and policy makers have now quantified, namely, that the social, economic, and medical circumstances related to the pandemic escalated inequitable reproductive suffering.[343] These circumstances were compounded in May 2021 when the U.S. Supreme Court verified that it would take on the Dobbs v. Jackson Women's Health

341 Sunshine Muse, "Setting the Standard for Holistic Care of and for Black Women," Black Paper (Black Mamas Matter Alliance, April 2018), http://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf.

342 "About the Special Report," *Hastings Center Report* 52, no. S1 (March 1, 2022): inside_front_cover-inside_front_cover, https://doi.org/10.1002/hast.1359.

343 *Maternal Health : Outcomes Worsened and Disparities Persisted during the Pandemic : Report to Congressional Addressees.* (Washington, D.C: United States Government Accountability Office, 2022).

Organization case.[344]

Despite the academic and social milieu of the pandemic, bioethics largely avoided sustained engagement in discussion about racially disparate reproductive health outcomes and birth inequity, focusing instead on discussions about physician or institutional autonomy and the boundaries of personhood in abortion.[345] As noted in a recent lead article in the *American Journal of Bioethics* details, this is particularly important to address given that the field of bioethics has a unique balance between academic theory and applied practice.

> While thought experiments in philosophical ethics are often populated by fictional characters, the subjects of bioethics discourse are frequently real people—with names and families, stories and experiences. For every famous violinist, drowning child, and trolley bystander, there is a Jahi McMath, Louise Brown, and Dax Cowart.[346]

Despite the existence of robust critical discourses in bioethics attempting to address epistemic injustice, including feminist ethics of care and narrative ethics, bioethics maintained an apolitical approach to moral decision-making. As critical bioethicists have noted, epistemic injustice is exacted on *real people* because of the structured ignorance of the ways that the biopolitical circumstances of a case structure the boundaries of bioethical inquiry.

As I set out to engage in the research, I focused on systems analysis that foregrounded the agential power of systems using actor-network-theory approaches to make visible the relationships between subjective meaning-making algorithms hidden *black boxes*. Convinced

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344 Mary Ziegler, "The Supreme Court Just Took a Case That Could Kill Roe v. Wade — or Let It Die Slowly," *The Washington Post (Washington, D.C. 1974. Online)*, 2021.

345 Joia Crear-Perry, Asha Hassan, and Sara Daniel, "Advancing Birth Equity in a Post-Dobbs US," *JAMA : The Journal of the American Medical Association* 328, no. 17 (2022): 1689–90, https://doi.org/10.1001/jama.2022.19468; Susan A Stark, "Home Birth and the Maternity Outcomes Emergency: Attending to Race and Gender in Childbirth," *International Journal of Feminist Approaches to Bioethics* 14, no. 1 (2021): 2–18, https://doi.org/10.3138/ijfab-14.1.01.

346 Ryan H. Nelson et al., "Bioethics and the Moral Authority of Experience," *American Journal of Bioethics* 23, no. 1 (2023): 12–24, https://doi.org/10.1080/15265161.2022.2127968.

that institutions *can* care, I focused on structural inequities to illuminate the power of intersecting systems of oppression. However, through my womanist informed ethnographic work in and at the margins of the M.I.C., I witnessed how clinical ethicists and afrocentric birth workers used their sociopolitical power to crack and hack systems of oppression to create new spaces for meaning-making. I also witnessed unconscious and conscious complicity with harmful epistemological frames of the biomedical gaze in ways that collapsed the agency of practitioners, patients, and caregivers. This empirical work led me to put the two fields in conversation to explore the moral agency of practitioners in two seemingly disparate fields.

6.2 Toward Visionary Bioethics

This dissertation began with a discussion on the biomedical gaze that has taken up residency in the technoscientific practices and management of medicine. I illuminated how the biomedical gaze is framed by the manifestations of the medical gaze, colonial/white gaze, and normative gaze. I then investigated bioethics as a field that has been historically occupied by men with high socioeconomic and political capital, mostly practitioners with terminal degrees in law, medicine, theology, or philosophy, and situated as rational moral actors. This led to non-male and non-white actors being overwhelmingly engaged as fruitful subjects of objective inquiry rather than knowledge producers.

Further, in this dissertation, I placed clinical bioethics in conversation with Black feminist birth work practiced by lower middle- and middle-class Black women.[347] I found this engagement particularly fruitful because birth workers, especially those who provide care in

347. Christina Young, "Professional Ambivalence among Care Workers: The Case of Doula Practice," *Health (London, England : 1997)* 25, no. 3 (2021): 306–21, https://doi.org/10.1177/1363459319886115; Rachel R. Hardeman and Katy B. Kozhimannil, "Motivations for Entering the Doula Profession: Perspectives From Women of Color," *Journal of Midwifery & Women's Health* 61, no. 6 (2016): 773–80, https://doi.org/10.1111/jmwh.12497.

acute care settings navigated tensions between recognizing the embodied knowledge of their clients and the need to align with algorithms of the biomedical gaze. Their navigation of the demonic grounds of the M.I.C. was generative in seeking alternative holistic models in response Black women reproductive suffering.

To this end, I proposed a biopolitical approach to bioethics called *visionary bioethics*. My construction of *visionary bioethics* leveraged a transdisciplinary analysis of reproductive suffering and weaved womanist social ethics, critical health, and ethics of care theories with community psychology and empirical bioethical methods. The framework of visionary bioethics holds generative tensions between a womanist critique of the M.I.C., its byproducts, and an afrofuturist ethics of care. Intersectional approaches to sociopolitical care, including Black feminist, mujerista, latinx and womanist ethics, share a commitment to the demystification of external and internal mechanisms contributing to reproductive suffering.

Following this model, I detailed how the biomedical gaze has structured this ignorance through a genealogical analysis of the gaze paired with discourse analysis of bioethics. I used ideological criticism to examine the mechanisms of the biomedical gaze. I examined discourse concerning trans-racial surrogacy, gene selection, and the dearth of bioethical research about racialized disparities in fertility treatment in clinical responses to Black women's reproductive decision-making as an outgrowth of the biomedical gaze. I then moved to articulate how the biomedical gaze shaped the moral imagination of reproduction and health care outside of the M.I.C. in ways that reproduce oppressive ontologizing narratives even in resistance movements.

I used data collected through a mixed method community-engaged study to examine how Black women wrestled with reproductive suffering. The data allowed me to analyze the discursive power of *the birth equity crisis*, a carefully constructed rhetorical framework that

transformed persistent reproductive inequity into a sociopolitical crisis by focusing on inequity related to Black maternal and infant mortality. I argued, alongside Jennifer Nash, that the discourse of the birth inequity crisis has the danger of replicating the very systems it seeks to dismantle. To clarify this point, I deployed Peter Berger and Thomas Luckmann's work on the power of world making to investigate the biomedical gaze as exemplified through *statistical liturgies*. Statistical liturgies, I argued were morally habituating and served to constrict the possibilities for collective responsibility by abstracting suffering and relying on the biomedical gaze to benchmark successful resistance.

I then proposed that statistical liturgies contributed to the provision of demonically ineffective caricatures of care. These caricatures lead to cultural appropriations and imaginations of precolonial rituals that rely on the ontologically givenness of blackness and its indignity. The danger of these caricatures, I argue is that they prioritize rituals and material cultures with work to critically engage and resist structural inequity. This analysis, rooted in an ecological model of human flourishing, emerges from the pragmatic tradition of community psychology. This consideration led to a neuro-ethical consideration of pragmatic ways to engage professionals in the M.I.C. in epistemic resistance and moral reformation. To this end, I turned to womanist and critical bioethicists, Emilie M. Townes and Karla Holloway and examine the ways that speculative fictions produced by Black women could serve as pedagogical tools for liberation from internalized superiority and inferiority. For those who have obvious biopolitical power and are reproducing the contours of the biomedical gaze on the demonic grounds of reproductive suffering, speculative fictions provide moral imaginative scaffolding for alternative ways of engaging in community. For subaltern groups, speculative fiction affirms non-hegemonic moral agency and the inherent worth and dignity of those traversing demonic grounds.

While birth workers engaged in *mothercraft* to attune their clients to the birth marketplace as contentious consumers, they also adopted a womanist care ethics rooted in afrofuturist sensibilities. They unequivocally name evil and actively working to create spaces of thriving at the micro, meso and macro levels of power. They engage in a visionary speculative ethics of care to redistribute reproductive justice beyond the biomedical gaze. Afro-pessimistic *mothercraft* aligns with the analytical framework of Audre Lorde, who argued that systems of injustice might engage in moral signaling around justice while maintaining oppressive practices that contribute to material injustice, as she might put it, "the master's tools will not dismantle the master's house."

6.3 Contributions to Bioethical Inquiry

This dissertation contributes to the field of bioethics by examining subaltern approaches to ethics of care in reproductive health and investigating the ways that the Black feminist birth work industry resists yet replicates neoliberal health governance frames. It also contributes to the research of organizational bioethics by examining the tools and resources Black-identified birth workers use to navigate institutional and structural inequity. I have provided a model of grounded community-engaged empirical bioethics and attempt to move beyond engaging Black women as interesting subjects of bioethics to acknowledging how their moral decision-making practices around care can instruct the practice of bioethics.

This approach also provides a model of community-centric rather than biomedicine-centric bioethics research that allows for research participants to speak back to researchers and redefine the scope of the work as co-investigators. This model of inquiry blends ethnographic inquiry, digital humanities practices of reading literature, and social ethics. I pair womanist approaches, which honor how subaltern groups resist moral complicity or how groups such as Homeland Heart are wrestling with their interconnection with healthcare and their imagining of

a better future. By providing a thick narrative of refusal and resistance and replication I sought to investigate Black birth work that both critiqued the ways in which birth workers prioritizes the aesthetics of care and also engaged in how their biopolitical approach to care can be a model for other actors in healthcare.

6.4 Future Directions

Often complex social issues are framed as *wicked problems*. In this work, I demonstrate how *wicked problems* are an outgrowth of unaddressed regulations or policies at micro-, meso-, or macro social levels. I envision five potential and complementary future directions for this kind of work to engage in transdisciplinary bioethical inquiry that involves community-engaged research and digital humanist methodologies.

6.4.1 Moral Psychology & Neuroethics

This work asserts that moral formation is critical towards understanding the biomedical gaze. A future direction engages the emerging field of *moral psychology and neuro-ethics*. As many in healthcare quality improvement research have found, healthcare decision-making is often fraught with moral injury due to the pace of care and reliance on the biomedical gaze via technoscience. A future study would engage in empirical analysis of the neuro-ethical implications of the biomedical gaze for healthcare providers and healthcare administrators. My early literature review for this work reveal a lack of engagement with healthcare administrators as moral agents although shaping the boundaries of clinical actors.

6.4.2 Healthcare Administration Education

An assessment of the current state of bioethics education for healthcare administrators requires further research. This assessment would not only provide crucial information about the current knowledge gaps in bioethical inquiry but also map models to incorporate and test curricula in healthcare administration education. This assessment would develop a pathway for

bridging the visionary medicine framework proposed by Pasco, et al. to incorporate visionary speculative fictions in healthcare ethics trainings for clinicians *and* future healthcare administrators. As womanist ethicist, Sakena Young-Skaggs has argued, afrofuturism and Black women's speculative fiction can serve as a hermeneutic and an analytical frame that allows for imagining liminal spaces for Black moral agency. While I am interested in liminal space as a generative ground for those experiencing oppression, it may also provide pedagogical space for those caught in complicity with perpetuating reproductive suffering. As an increasing number of healthcare providers have contended, complicity in systems of injustice is far from neutral.

6.4.3 Womanist Policy and Impact Measurement Practices

Although mentioned earlier, the structural approach that dominated the original aims of this research shifted quickly as my research advanced, I, nevertheless, hold that there are policy and practice implications at meso- and macro-levels. There is growing interest in the work of womanist program evaluation and policy analysis. Scholars such as Jameta Barlow and Breya Johnson have argued for a model of Black feminist/womanist policy analysis committed to decolonial approaches to science and health. Their model begins with narratives and moves through a power analysis, stakeholder engagement, and feedback session.[348] A practical future direction would be to deploy the Barlow and Johnson analytical path to improve reproductive care policies, practices, and programs in healthcare systems.

6.4.4 Community Engaged and Participatory Implementation Sciences

Similarly, the research initiated by this dissertation has implications for health implementation science. Implementation science focuses on studying how theories and

348 Jameta N. Barlow and Breya M. Johnson, "Listen to Black Women: Do Black Feminist and Womanist Health Policy Analyses," *Women's Health Issues* 31, no. 2 (2021): 91–95, https://doi.org/10.1016/j.whi.2020.11.001.

practices identified in scholarship are applied in community settings. In maternity care, scholars identified a clear need for research studies that address barriers to implementing evidence-based practices in U.S. healthcare settings. [349] This community-based project, co-constructed in collaboration with birth workers, follows the path of scholar activists in reproductive justice, for instance, Alicia Bonaparte and Lisa Harris, to balance commitments to academic rigor with reproductive justice. These scholars provide a model for working in communities and healthcare systems to improve practices in and beyond clinical settings. As implementation scientists had found, much of the work that is completed in collaboration with community partners does not often contribute to the advancement of the community partner.

6.4.5 Afrofuturist and Speculative Approaches to Reproductive Flourishing

Another potential for this research is furthering investigation into the fruitfulness of specific afrofuturist and visionary fictions for the exploring alternative approaches to reproductive flourishing. Critical health scholars such as Donna Haraway, and bioethicists, like Karla Holloway, have found Octavia Butler's later work important for engaging the *post-humanist imagination*.[350] Much of the work on Butler, however, focuses on her shorter stories and later works including *Kindred*, *Xenogenesis*, and the *Parable* series. Butler's work is not only concerned with genomics and epigenetics as Haraway and Holloway have argued, but her corpus also engages in a critical reimagining of Black birth assistance.

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349. Ann Dadich, Annika Piper, and Dominiek Coates, "Implementation Science in Maternity Care: A Scoping Review," *Implementation Science : IS* 16, no. 1 (2021): 16–16, https://doi.org/10.1186/s13012-021-01083-6; Rachel Blankstein Breman, Rebecca Feldman Hamm, and Jennifer A. Callaghan-Koru, "Letter to the Editor of Implementation Science in Response to 'Implementation Science in Maternity Care, A Scoping Review' by Dadich, Piper, and Coates (2021)," *Implementation Science : IS* 16, no. 1 (2021): 1–79, https://doi.org/10.1186/s13012-021-01129-9.

350. Donna Haraway, "A Cyborg Manifesto: Science, Technology, and Socialist-Feminism in the Late Twentieth Century" (Routledge, 1990), 171–204. For more on Holloway's approach to Butler see Chapter 5.

By placing critical health scholarship with work of Karen and Barbara Jean Fields's study of *Racecraft*,[351] future work might deploy a critical reading of the role of afrofuturist and Black speculative fictions in disrupting the world-ordering power of racecraft and other technologies contributing to oppression. This work would constructively deploy digital and traditional discourse analysis to build on the idea of visionary bioethics using the analytical frame of afrofuturist and Black feminist speculative fiction.

6.5 Knowing, Full, Well

Finally, this dissertation is a product of the infinite possibilities of *knowing full well* the landscapes of demonic grounds. In 2020, as I reflected on the statistical liturgies of Black birth inequity that warned me that my own pregnancy was both a privilege and a peril, I knew *full well* that my choice to birth at the very institution in which I had trained in bioethicist was a risky decision that could have death-dealing consequences. My decision was not risky because of my health or socioeconomic status but because of the algorithms, policies, and persons in the healthcare institution constructed me a risk. My choosing parenthood, as with many of my peers who study reproductive and other health inequities, was an act of afrofuturist informed refusal of the biomedical gaze.[352]

This dissertation is also a practice in exposing the boundaries of bioethics. I was curious that bioethicists had rendered some reproductive issues out of the scope for inequity. In my

351. Fields and Fields, *Racecraft : The Soul of Inequality in American Life*.

352. Benjamin argues that informed refusal is a critical corollary to informed consent that resists the construction of nonwhite, nonmale persons as irrational or inferior decision-makers. She writes, "Rather than simply acknowledge that "refusers" are justified in their distrust of the medical and scientific establishment, a substantive approach to enacting justice requires a reorientation away from the purported traits and dispositions of "problem people," to paraphrase Du Bois (1903), toward the relative trustworthiness of institutions." For more see: Ruha Benjamin, "Informed Refusal: Toward a Justice-Based Bioethics," *Science, Technology, & Human Values* 41, no. 6 (November 1, 2016): 983–84, https://doi.org/10.1177/0162243916656059.

initial literature review of bioethics, I struggled to find scholarship addressing inequitable infertility rates and clinical decision-making leading to maternal and infant morbidity. So, through this dissertation, I wanted to know how the historical and socioeconomic circumstances of the healthcare industry contributed to racialized reproductive suffering and why this was illegible in bioethics. In this dissertation, I engage in applied participatory research in community. This practice helped me to craft a patchwork approach to scholar activism. To this end, I work to make reproductive suffering legible to academic bioethics through visionary bioethics and to ensure that clinical bioethics resources are legible to birth workers. To *know full well* is an episteme of refusal and resistance to the biomedical gaze, its demonic algorithms of care, the wicked problems it created, and advancing visions of reproductive flourishing.

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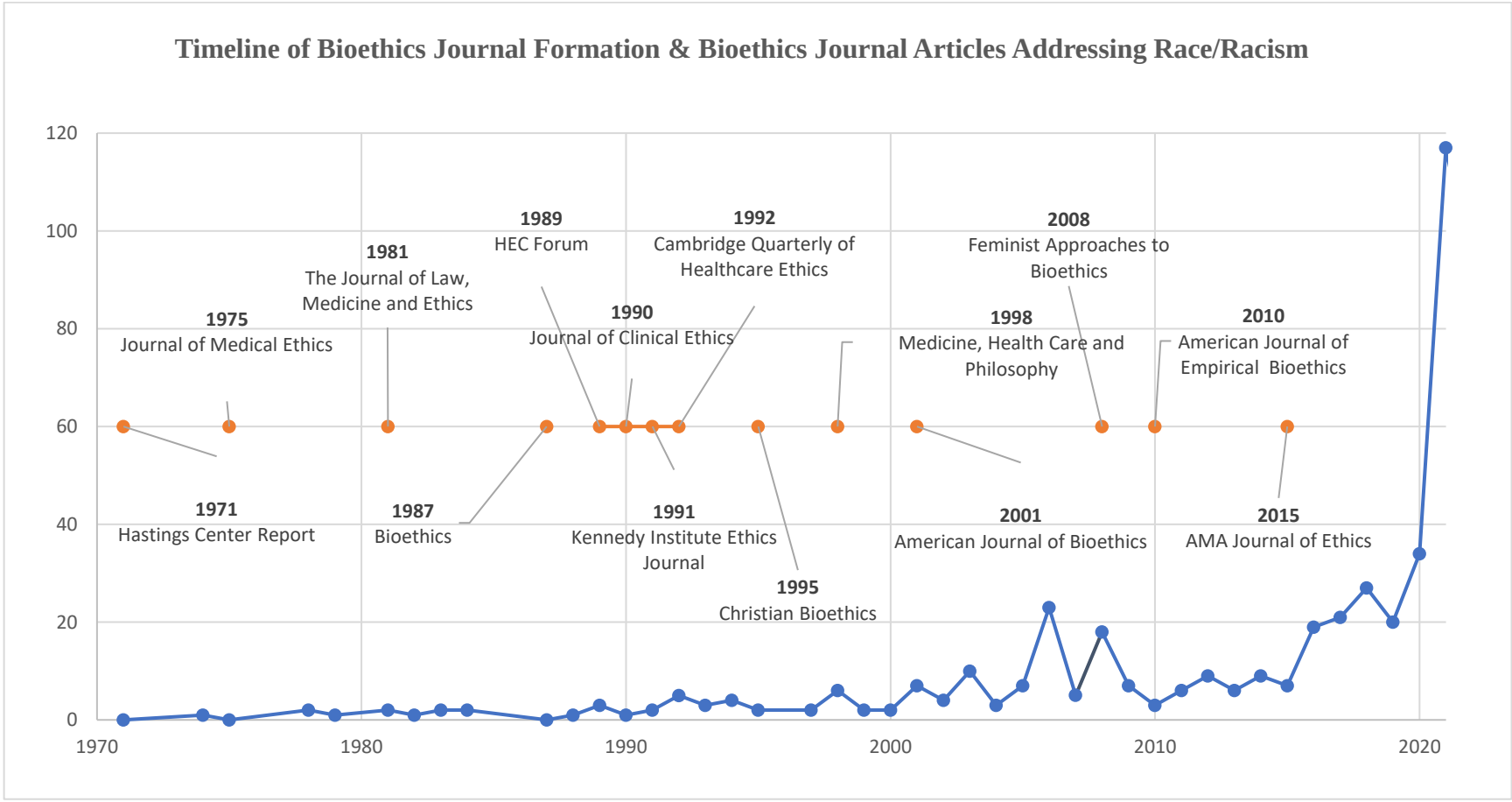
Appendix A: Bioethics Timeline