Breastfeeding: A Choice or Predetermined by Race? A Multidisciplinary Analysis of Breastfeeding and Maternal Health Care in the U.S.

By Radhika Trivedi, Irvine Valley College
Mentor: Kristen Skjonsby

May 23, 1949, marked a day of a medical marvel, the world's first identical quadruplets were born in Reidsville, North Carolina. Annie Mae Fultz, a Black Cherokee woman, endured a strenuous delivery and gave birth to her four baby girls. Soon enough, her white doctor, Dr. Klenner, became the sole determiner of how the little girls would lead a lifetime of exploitation. He signed a deal with a formula company, Pet Milk, and consequently signed away the lives of millions of black babies to come (Freeman, 1). Pet Milk and other companies like them have continued to heavily advertise baby formula to black mothers, discouraging traditional breastfeeding methods. What Pet Milk failed to disclose in their commercials were the harmful implications associated with depriving an infant of breast milk- including increased levels of infectious morbidity, pneumonia, childhood obesity, and other health risks. This exploitation is just one aspect of our broken maternal healthcare system. The lack of sufficient health care for Annie Mae Fultz and many other black mothers and infants signifies a bigger public health crisis in the way maternal health is handled in our healthcare system. Maternal health refers to the well-being of a woman or person carrying a child before, during, and after pregnancy. Its relevance is not limited to physical care but also encompasses mental and social health facets. To define poor maternal health, it's imperative to define proper maternal health. *Proper* maternal health is high-quality care and attention that is effective and equitable to all who need it. Some of what it entails includes access to well-equipped health facilities, an obstetrician who respects their patient and acknowledges their pain, access to different types of necessary medications, maternal training and education regarding important topics such as breastfeeding, and parenting, and continuous up-to-date research that works to improve health care. *Poor* or *insufficient* maternal health care is characterized by increased rates of maternal mortality and morbidity, lower rates of breastfeeding, and postpartum depression, in addition to the absence of the aforementioned list. Confronting the failures of our healthcare system with respect to Black mothers requires acknowledging that disparities in maternal deaths and breastfeeding rates in the United States are rooted in systemic racism, affecting the social institutions that govern individuals' lives. As a result of acknowledging the issues within our society, we can begin to promote equitable healthcare while also alleviating strain on our healthcare system.

A Black mother's mental health, social health, and physical health are threatened by the attitudes of those around them, both in and out of the hospital. These three modes of well-being are intertwined like a lattice, constantly overlapping and forming intersections. Social health, or the relationship with those in one's society, affects mental well-being which can be a determinant of physical health. This explains why when factors such as genetics and socioeconomic status are held constant, Black women are still at a disadvantage. Moms Rising, a social welfare organization focused on advocacy of maternal health, states, "On average, Black women with higher incomes and college educations have worse health than white women who have not graduated from high school" (MomsRising). One cause of these findings can be attributed to chronic stress. The condition "allostatic load," coined by Bruce McEwan and Elliot Stellar best describes this phenomenon. Allostatic load refers to the overexertion of one's body due to persistent stress. It leads to serious repercussions affecting the body's regulatory processes, including the endocrine, immune, and circulatory systems, as well as blood-glucose and hormonal levels. As a result, poor health outcomes such as heart disease, diabetes, high blood pressure, loss of brain function, anxiety and depression may develop (Alissa Greenberg). The significant stress experienced by African Americans finds its root cause in structural and

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individual racial discrimination. Being black in America means being perceived as a threat and not an equal, in all aspects of our social institutions. Whether that is dealing with microaggressions at school, work, or the grocery store, being racially profiled by a police officer, or not receiving quality care at the doctor's office. On a biological level, the body initiates its stress response, attempting to justify and protect itself against society. When these obstacles are coupled with the stress of being a pregnant mom, the product is undeniably alarming for the mother and her baby. The leading cause of maternal mortality is cardiovascular disease. Black women are more susceptible to stroke, heart attack, and high blood pressure-all factors linked to increased levels of chronic stress and its implications. According to the American Heart Association, Black mothers are "23% more likely to have a heart attack, 57% more likely to have a stroke, 42% more likely to develop blood clots, and 71% more likely to develop heart muscle weakness" (American Heart Association). The health risks do not only adversely impact the mom, but also influence the child's health. As mentioned before stress can affect brain function, even when it comes to a growing fetus in the stomach of a stressed mother. The future baby is at risk of decreased hormone receptors in the hippocampus and increased receptors in the amygdala, which is part of the brain responsible for regulating emotion. In turn, higher rates of anxiety and depression can arise before a black baby is even born (Greenberg). These unique circumstances cause Black women to need meticulous care and attention, but at the hospital, they face the same prejudice they encountered before. Tabitha Walrond's tragic story demonstrates the detrimental results of a racist healthcare system. In 1997, Tabitha gave birth to her baby boy, Tyler, despite facing many complications before delivery that had lasting effects on her body and ability to breastfeed. She expressed her pain to her doctors who continued to ignore her symptoms and claimed she was ready to provide sufficient breast milk to her child. This proved to be incorrect, as after eight weeks Tyler died of malnutrition (Freeman, 3). Unfortunately, Tabitha's experience with the American healthcare system is not singular. Implicit bias, racism, and stereotyping are common across hospitals and play a significant role in the high rates of maternal and infant deaths. Injustice in the medical sphere lives in medical procedures, the attitudes of doctors, and the quality of healthcare. Black women receive cesarean deliveries at the highest rate in the country, more than 10% greater than white women. This is concerning because when comparing c-section deliveries to vaginal deliveries, c-sections result in three times more maternal mortality and morbidity (*Structural Racism and Maternal Health Among Black Women*). Although c-sections are sometimes necessary in delivery, Black women receive them even in low-risk surgeries. Reasons, why black women receive these procedures, are both financial and dependent on systemic racism. Hospitals profit from c-sections, as they are almost twice the cost of regular vaginal deliveries. The exploitation of a woman's body and the health of her child is disregarded when a financial gain for private corporations that run the US healthcare system enters the equation. The other explanation for the high rate of c-sections, as well as overlooked pain for Black mothers, is the implicit bias that resides amongst doctors. The stereotype of the Black woman as strong, and impermeable to pain perpetuates systemic racism in the healthcare system. They are less likely to receive necessary pain medication, undergo invasive surgeries, and are victims of negligence from physicians. Stereotypes and preconceptions doctors adopt also have dire consequences when it comes to providing infants with the nutrition they need to survive-breast milk.

Breastfeeding rates among black mothers are at an all-time low, and the major contributors to this public health crisis are present in permanent structures in our society-the government and media. Their alliance incapacitates Black mothers and their babies considering the gender and racial intersections created for Black women. This intersection is the birth of damaging stereotypes dating back to slavery and institutional racism that inhabits the hospitals, government, media, and everyday interactions. Time after time, breastmilk has been proven to be the safer, healthier option compared to formula milk. It contains nutrients including proteins and health that are lacking in formula milk, which are necessary for brain and nervous system development. Breast milk also supports better immune function, preventing infections that can cause infant death and sickness. However, these advantages of breastfeeding are practically inaccessible to Black mothers due to formula companies that control the media and the relations made with the US government. Formula companies have

made billions of dollars at the expense of Black mothers and babies with persistent and persuasive advertising. In the late 1900s, these ads appeared in Ebony Magazine, directly appealing to its audience, who were African American. In contemporary times, as social media became the next mainstream medium, formula companies began to offer free samples and incentives promoting their product via Facebook, Instagram, and Twitter. In these ads, they work to confuse mothers into thinking formula milk is breastmilk. Claiming formula has “added nutrients” that are advertised as essential for a growing baby, or insisting their specific formula is gentle are some tactics formula companies use to equate breastmilk to formula milk. Andrea Freeman, the author of Skimmed, explains that these strategies are especially harmful in communities that don’t provide clinics or organizations that offer support to new mothers (Freeman 52). In an increasing demand for their product, formula companies provide contributions to hospitals and government programs that encourage the use of formula milk. Due to implicit bias and lack of attention from physicians, Black mothers are often deprived of breastfeeding training at hospitals and introduced to formula alternatives. However, the primary abuser of this relationship, is the formula companies’ largest purchaser, the US government. The US Department of Agriculture (USDA) gets rebates from these companies that offer a formula for 80% of the price, used in welfare programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). WIC provides health and nutrition to low-income pregnant women, who are disproportionately Black. They offer six months of free formula to Black mothers who are hesitant to refuse the offer since they often face workplace restrictions. Freeman proposes that workplaces are discriminant towards black breastfeeding mothers. “Laws designed to protect breastfeeding mothers at work do not apply to part time jobs or small businesses that employ many Black women” (Freeman 6). These workplaces do not allow for ample time to breastfeed, or other effective opportunities such as a private place to pump, flexible breaks, or refrigerators specifically designed for milk. After six months, the babies are dependent on the formula, and black mothers are no longer producing breast milk, so the only option becomes to purchase formula. In this way, the government and formula companies have created a relationship to profit them both and disadvantage Black mothers.

Systemic racism, which stays prevalent in all forms of our social institutions, affects the health and wellness of black mothers and babies. Racism at the workplace, school, hospitals, media, and the government results in poor health, including diseases such as cardiovascular disease that have serious effects on a pregnant woman and her child. The next section will explain the roots of institutional racism in American maternal health.

Historical Analysis

Infant nourishment practices and opinions on breastfeeding have fluctuated across American history. However, the oppression and exclusion of Black women have remained a constant throughout these times. The effects of slavery and the persistent subjugation of Black Americans linger to create discriminatory legislation, stigmas, and stereotypes whose influences permeate American social institutions and result in the disempowerment of Black women.

The Antebellum Era for Black Mothers was characterized by coercive breastfeeding practices which signified the predetermined social status of Black slaves and upheld the dominance of White Americans, representative of the social hierarchy in contemporary times. Breastfeeding was seen as demeaning and reserved for the lower classes during this period. Consequently, enslaved Black mothers were instructed to become “wet nurses,” and nurture their master’s babies (Freeman 39). These women’s bodies were commodified and exploited as a tool of white advancement, providing essential milk for an infant’s survival and serving as a social symbol of wealth for white women. The enslaved women continued to care for the white children often up until adulthood. The care and attention Black mothers paid to white babies came at the expense of their own children. In a communal approach called “cross-feeding,” enslaved mothers would take turns feeding their own baby and their master’s baby. However, as slave owners often did, they dismissed the needs of Black

mothers and their children. Black women were forced to give priority to children who were not their own, depriving black babies of nourishment and affection. While white babies were fed “liquid gold,” black babies received goat or cow milk which led to higher morbidity and mortality rates in black babies (Freeman 36). The unique experiences of a Black slave woman created further distress in a Black female’s body. Violence, sexual assault, forced mating, and strenuous labor were universal experiences amongst enslaved women. The physical toll of day-to-day life on the plantation combined with nonstop, exhaustive, breastfeeding had detrimental effects. The act of breastfeeding itself is one of extreme exertion. It is accompanied by physical and mental issues. Physical pain includes back, chest, and wrist pain, cramping, bruising on the breast, and Osteoporosis. Osteoporosis, or the weakening of the bones, is the product of ensuring breastmilk contains enough calcium for the baby, it's taken directly from the bones. Mara Horwitz, M.D., associate professor of medicine at the University of Pittsburgh, reports that on average new mothers lose between 5 and 10 percent of their bone mass during the first six months of breastfeeding. This causes weight loss, weakness, and increased risk of other illnesses. Elles Betts, a wet nurse on a Texas plantation describes the grueling life of a wet nurse, “I nuss so many chillen it done went and stunted my growth and dats why I ain’t nothin but bones to dis day” (Freeman 41). Breastfeeding also affects the mental health of a mother. In order to produce breast milk, prolactin levels must rise. In order to maintain homeostasis, the body will decrease dopamine levels. Decreased dopamine levels result in anxiety, depression, anger, and feelings of insecurity. These taxing experiences were only exacerbated by slavery, proving to have agonizing effects on the enslaved women and their descendants.

The unforgivable violations endured during the slavery era have discouraged Black women from breastfeeding today. Breastfeeding serves as a reminder of the painful past and dehumanization of wet nursing. Hess Love, a writer and cultural worker in Baltimore, MD, writes a poem representative of many Black women’s attitudes toward breastfeeding;

I wish I dried up

I wish every drop of my milk slipped passed those pink lips and nourished the ground

Where the bones lay

Of my babies

Starved while I feed their murderer

I wish I dried up

So the missus babies would dry up too

And be brittle

So I could crumble them to dust

Return them to the ground

Where all children of my bosom lay equal. (Love 1-11)

This powerful yet harrowing poem gives insight to those who are not black mothers on the tribulations of the past, and their impact on thoughts in the present. Love admits this is not her experience, it's her ancestors. But the feelings do not die with enslaved women. They are expressed by older generations. The pain is so immense in these stories, it is relayed as Black mothers are privy to slavery’s authority over every right of a Black person, including something as intimate as breastfeeding. Death or the “return to the ground” was the only way to escape inequality. As a result of these horrific truths, negative stigmas have surrounded breastfeeding in black families. Many elderly women advise against breastfeeding, reminding themselves of haunting memories and the fact that breastfeeding was reserved for lower societal classes. Blogger La Sha of Kinfolk Kollective, a website that explores Black racial injustice, reflects upon this legacy. “Refusing to breastfeed initially felt like a way to reject an act that signified re-enslavement and take back Black women’s

power and control over their bodies" (Freeman 41). This view embodies the stance many Black women take, one that reveals the deep-rooted Mammy stereotype. The term, "Mammy" ages back to slavery, where a black woman would serve the needs of a white family. The Black mammy simplifies Black women as servile and docile beings that are content with their life purpose of nurturing white families. It celebrates subordinate citizens who do not question injustice in society. Black women who reject this identity may find justification to reject breastfeeding too. This nonacceptance holds a strong influence in society. In sociology, the differential association theory states that individuals are shaped through associations and interactions with those closest to them. A Black woman in her ethnic group is not surrounded by other females commemorating breastfeeding. Consequently, they lack role models that willing mothers can look up to and take guidance. Innate ability becomes the unknown. The effects of slavery on generations of Black women's attitudes toward breastfeeding contributes to low breastfeeding rates within this community, however, their attitudes are not the only ones impacted.

In the medical sphere, healthcare workers operate with predispositions created by a society prone to unwavering racial injustice. These stigmas are formed as a result of living in an environment that tolerates the unrealistic stereotypes and beliefs of those in power hundreds of years before them. Cognitive biases in health care are oftentimes labeled as physicians' biases or prejudiced views held by healthcare providers about their patients. They appear in both explicit and implicit forms but are commonly unconscious. Implicit racial biases held by physicians, media managers, medical professors, bosses in the workplace, policymakers, and virtually anyone in a place of power and influence serve as one of the biggest obstacles in overcoming systemic roadblocks created by slavery. In this paper, primarily influencers in the medical sphere will be analyzed, specifically in medical schools and hospitals. Negative stigmas and stereotypes are still prominent and damaging in all our social institutions, but their prevalence in hospitals is proven to be fatal. Medical universities carry a responsibility to ensure their future physicians are providing quality healthcare to all their patients. However, current medical education does not promote an equitable healthcare system. Equitable healthcare is a birthright that should traverse race, however implicit biases and theories such as racial essentialism make this a difficult feat.

In explaining physicians' bias and social injustice in the medical sphere, it is important to define racial essentialism. In her article, "How Should Educators and Publishers Eliminate Racial Essentialism", Jennifer Tsai refers to racial essentialism as "the belief that socially constructed racial categories reflect "inherent" biological differences." This belief serves as a basis of epistemological evidence that one's race and genetics determine the health capacities of an individual. Combined with preexisting implicit and explicit biases, medical education that promotes racial essentialist teachings… threatens the health of minorities that fight the most unjust social narratives. The stereotypes of Black mothers from the antebellum period, such as Mammy, haven't escaped society, instead, they've presented themselves as reality regardless of their flawed, forgotten historical justification and achieved acceptance into our institutions. Kimberly Wallace-Sanders, a scholar of African American Studies, highlights how the mammy's role was imagined in the nineteenth century. In her book, *Mammy: A Century of Race, Gender, and Southern Memory*, Sanders explains, "because of widespread theories of nineteenth-century racial essentialism, African American women were thought to be innately superior in their abilities as caretakers of white children" (Sanders 8). According to this notion, Mammy—and by extension, all Black mothers—were unfit to breastfeed their own children because their maternal instincts exclusively appeased the needs of a white baby. Instead of recognizing societal constraints that explained low breastfeeding rates, this perception that Black mothers lacked maternal instincts toward their children and consequently did not breastfeed was adopted (Freeman 89). As time progressed, the view that most Black mothers choose not to breastfeed has prevailed. Although data disproves this misconception. A longitudinal cohort study conducted by the USDA's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) located prenatal intentions for breastfeeding initiation and fulfillment of those breastfeeding goals. The participants of this study included mothers from the WIC program. It was found that Non-Hispanic

White women and Non-Hispanic Black women shared the same rate of intention to breastfeed (86.9% and 87.2% respectively). However, at three months postpartum, 44.9% of Non-Hispanic White mothers met their breastfeeding intentions, while a significantly lower 26.4% of Non-Hispanic Black mothers met their breastfeeding intentions (WIC). One cause of this disparity can be attributed to the interactions with healthcare providers that Black women encounter. Healthcare providers operate with implicit biases, and in turn, limit the resources available to Black mothers. This bias results in Black patients receiving substandard care in comparison to their white counterparts. Sufficient breastfeeding care is characterized by proper antenatal and postnatal care, promoting breast milk as opposed to formula feeding, rooming in, lactation consultations, providing breastfeeding support, and providing an informed discharge that secures breastfeeding support after a mother leaves the hospital. The hospital staff is largely responsible for ensuring that each mother receives this quality of care to ensure the well-being of them and their baby. According to the quantitative analysis article, “Breastfeeding Support for African-American Women in Louisiana Hospitals'' proper feeding care does not reach all patients (Gee et al). Researchers analyzed data from the 2007 to 2008 Louisiana Pregnancy Risk Assessment, finding that black mothers self-reported fewer experiences in “breastfeeding in hospital, receiving breastfeeding resources to call for assistance after discharge, rooming in, and newborn being fed only breastmilk in the hospital” (Gee et al). Encouraging and initiating breastfeeding at the hospital plays a crucial role in breastfeeding continuation. Healthcare workers are trusted by their patients and hold a strong influence over their feeding decisions. New mothers are especially vulnerable after they give birth and rely on their healthcare providers to ensure safety, especially when it comes to the well-being of their newborn babies. For this reason, healthcare workers should be very careful and attentive to the way they advise mothers on feeding their newborns. Discouraging language and an unenthusiastic approach to breastfeeding can have lasting impacts on the decision to breastfeed. Lactation consultant, Aqueelah Russell, recounts her experiences in the hospital room after delivering her child, “your baby is starving, and you definitely don’t want that.” Hearing this as a very new mother who is attempting to feed her baby for the first time can be painful to hear. It can result in feelings of self-blaming and guilt, making a mother feel she is at fault for not providing her baby with the sustenance it needs to live. An immediate response Aqueelah says is “Of course, I do not want to starve my baby” If formula milk is the only option that is presented as viable, then it will be the option mothers choose. Aqueelah states this is “compliance through fear.” This fear is especially damaging when collaboration and support are nonexistent. Aqueelah says that she had the support of her mother to correctly guide her into her breastfeeding journey, but many Black mothers do not have this support system from family and friends. In this case, it is imperative for the hospital staff to step in and supplement that aid to new mothers.

Other assumptions are made based on generalizations related to the degree to which one Black individual can feel pain. In order to justify the inhumane treatment of enslaved Black people in medical research, physicians and scientists at the time claimed that Black people had “thicker skin and less sensitive nerve endings' ' making them less susceptible to pain (Tsai). Kelly H. Hoffman, a psychological and cognitive scientist who studies racial bias in American health care, explains how racial essentialism allowed white researchers at the time to perform invasive surgeries in efforts to discover the “peculiarities'' of the Black body while maintaining the same care that would be given to a mere lab rat. Hoffman cites a direct quote from the famous Antebellum physician, Samuel A. Cartwright. “Negro disease [making them] insensible to pain when subjected to punishment” (Hoffman). While these claims may not still be taught explicitly in textbooks today, implicit variations of their definition still prevail- Black individuals are more athletic and physically robust, Black individuals are biologically less intelligent than others, and other stigmas manifested in our society and health care systems. These implicit biases have relevance in maternal health. As mentioned before, breastfeeding is truly the ultimate sacrifice, where the impact is noticeable at each body system. The pain is all-encompassing, and often time requires the assistance of medication to alleviate. Regardless of this anguish, Black women are neglected necessary painkillers due to the belief that their body can withstand the pain or that the pain itself is simply not severe. Mothers who are willing to breastfeed may be quickly discouraged when they are not given

proper care, making their breastfeeding experiences too unpleasant to continue. The World Health Organization reports that “35% of racial minority patients received the appropriate prescriptions compared with 50% of nonminority patients'' (WHO).

Medical schools are yet to recognize the interplay of social health and physical health in their curriculum. As previously defined, social health refers to the relationship with one’s society: unique experiences specific to individual people. In a country where racism is entrenched in all of our social institutions, it is important to consider these social determinants of health. Current medical education continues to view race as a biological category, one that does not include the sociological implications and their biological consequences. Race is a social construct that is influenced by the socioeconomic and political climate, which produces healthcare inequalities reflecting poor health outcomes and disparities. This understanding that highlights the relationship between race, racism, and health, one that advocates health should be considered from an interdisciplinary lens. However, medical coursework lacks this nuanced definition of race in healthcare and plays a role in propagating physicians' bias. Medical educators misrepresent race in lecture halls in two notable ways, pathologizing race, and race-based diagnosis. “Misrepresenting Race- The Role of Medical Schools in Propagating Physician Bias,” an entry in the New England Journal of Medicine, claims that medical school instructors “commonly link minorities with pathology in general,” they *pathologize* race. In pathologizing race, educators will overrepresent marginalized racial/ethnic groups in disease burden. As race is misunderstood as a proxy for genetic differences, socioeconomic status, and genetic difference, correlating minorities with perpetual sickness becomes an avenue for the formation of implicit bias. Just mentioning the prevalence of these disparities, without providing any context can lead to the “implicit link between race and predisposition to disease, which reinforces the view that race/ethnicity disparities in health stem from innate racial differences” (Amutah, et al). Lack of context primes students to associate racial health disparities as a patient-dependent issue, such as personal choice or genetic predispositions. However, in reality, these racial disparities in health are in part due to the social aspect of an individual’s health, pertaining to the environment and interactions they face. Amutah et al describe these patterns as a result of continuous historical insults, rather than personal or genetic aptitudes. By adhering to a learning model that oversimplifies racial disparities to just statistics, medical educators miss opportunities to address historical backing to the realities in healthcare today. This can be applied to the breastfeeding inequalities discussed above. Simply mentioning breastfeeding disparities without addressing the echoes of Mammy, wet nurses and slavery-era breastfeeding experiences of Black women in the past does injustice to Black patients in the present. Similarly, instructors perpetuate race-based diagnostic bias in their students by connecting diseases to certain racial groups, suggesting that race is an “essential-biological-causal mechanism.” Amutah et al provide the example of cystic fibrosis, which is considered a “white disease.” This notion that a specific illness is correlated with a race neglects to consider other populations in its diagnosis. The Cystic Fibrosis (CFF) Foundation finds data in diagnosing the disease that reflects race-based diagnostics. “Infants of color with CF carry mutations that are less likely to be evaluated and identified on prenatal and newborn screens, are older than their white counterparts at the time of diagnosis and first clinic evaluation, and are two and one-half times more likely than white infants to have failure to thrive” (CFF).The inequalities in healthcare reminiscent of past injustice demand the reform of the way physicians, medical professors, and students approach medicine in medical schools and hospitals.

Advocacy

In order to alleviate and ultimately reverse low breastfeeding rates, a comprehensive approach requiring a change in our societal structures must take place. Freeman advises that focusing on altering racist policies and agendas themselves, rather than advocating for others to change their beliefs, behaviors, and perspectives is the more effective solution. Direct policy changes in these institutions can allow for increased education of their members and the public they serve, and as a result, a switch in attitudes necessary to tackle implicit biases can be achieved. The California Dignity in Pregnancy and Childbirth Act is a recent initiative that aims to

reduce implicit bias in the perinatal care continuum. Policy change such as this act consciously overrides unconscious bias and helps close the gap in racial disparities. Eliminating physician bias as well as providing breastfeeding support in hospitals is a step in the right direction towards uplifting Black mothers in healthcare. However, implicit bias can be significantly reduced before even reaching the hospital, through implicit bias training in medical schools. Freeman states that the role of education is “to expose and challenge the lingering stereotypes that falsely make these barriers look like personal choices or failings" (Freeman, 174). Medical universities carry a responsibility to ensure their future physicians are providing quality healthcare to all their patients. However, current medical education does not promote an equitable healthcare system. Pertaining to the medical domain, reimagining education in medical schools may be the first step in eliminating discrimination in healthcare, alongside implementing evidence-based implicit bias training for physicians in hospitals.

Medical schools play a pivotal role in elevating opportunities for future healthcare workers to minimize implicit bias before these attitudes beyond one's awareness become entrenched in a race-infected healthcare system. Reimagining medical curricula to include training sessions that implore students to acknowledge, access, and diminish unconscious assumptions entails addressing the key issues previously mentioned in current medical education. Currently, many medical schools employ the Harvard Implicit Association Test (IAT) to increase awareness of implicit bias in medical students. This test uses a series of stimuli in the form of words and images, revealing associations made in four different rounds. These associations signify a correlation in the level of implicit bias a student holds. The IAT is an effective tool in acknowledging implicit bias, but the competency training that occurs afterward is most effective in reducing these biases. Typically, interventions are reported to be single lectures within another course that consists of health disparities and ethics condensed into a single lesson. However, a single lecture is not sufficient in eliminating implicit bias. Scholars Megan Ruben and Norma S. Saks from Rutgers University seek a new training program that comes from an interdisciplinary approach. In this method, training sessions draw from the visual arts, medical anthropology, and sociology. This three-part training session occurred during the first year of medical school, consisting of five different learning sessions, each taking place every other month. During the fall semester, students participated in the art museum sessions which focuses on addressing the following themes, “history of medicine, non-Western attitudes towards medicine, and confronting implicit bias through portraiture” with aims to “broaden student perspectives regarding the relationship of institutionalized racism, healthcare, culture and race within the USA and globally” (Ruben et al). One notable exercise conducted included students' studying several self-portraits portraying race, gender, weight, age, and cultural backgrounds as means to deconstruct their own implicit racial biases when approaching these portraits. The second session occurring in spring includes an interactive lecture with a medical anthropologist from Rutgers University, and the final summer session was to watch a Ted Talk delivered by Princeton University sociologist, Ruha Benjamin. The final two sessions were aimed to “increase awareness of institutional bias in the healthcare system and medical research in order to reduce future students' contributions to these discriminations” (Caspers). Each activity was followed by a small group discussion where students were able to reflect on their own biases and lecture material together. As determined by an IAT exam taken by participants at the beginning and the end of the study, participants showed a decrease in implicit bias at the end of their training session. There are numerous interventions like Ruben and Sak’s, although not all medical schools prioritize this type of education. Incorporating some type of multidisciplinary training program such as this one can help reduce implicit bias and its effects. Another effective strategy to prevent bias from reaching the hospital is to diversify the student body at medical schools. The lack of diversity in medicine is a significant driver of healthcare disparities. Data finds that White physicians possess a preference for white male patients, while Black physicians show little to no biases toward their patients (Sabin et. al. 2012). Scholar, Quinn Capers IV from the Ohio State University College of Medicine, advocates for greater opportunities for people of color to join the medical workforce in her journal, “How Clinicians and Educators Can Mitigate Implicit Bias in Patient Care and Candidate Selection in

Medical Education." Capers asserts that "implicit bias may negatively affect health care indirectly by influencing the medical school and Graduate Medical Education (GME) selection processes" (Capers). Unconscious decisions based on race, sex, weight, socioeconomic status, etc. influence members of selection committees for medical schools, residency programs, and fellowship programs. Mitigation of these implicit biases can be accomplished by conscious mandating. Diversifying selection committees themselves to represent their applicants will allow for those on the committee to relate to matriculants and identify with their unique experiences. Capers suggest implementing a four-step process prior to selection. Step 1 removes any bias based on appearance by voiding any photos on the application. Next, Capers suggests a select group of staff review information on MCAT scores and all academic scores, ensuring applicants meet a certain threshold of success, and then submit metric-blinded applications to committee members. The third step requires that committee members have completed three different IATs (based on race, sexuality, and sex-career stereotype) and discussed their results at mandatory admission committee orientations. The fourth step entails participation in "case-based implicit bias mitigation workshops moderated by a trained workshop moderated by a trained workshop moderator" (Capers). Finally, immediately before the interview, committee members review implicit bias reduction techniques. This five-step works to eliminate implicit bias in selection processes and consequently diversifies the medical acceptance pool.

Supporting black mothers in the hospital with breastfeeding demands policy change that focuses on the elimination of physician's bias and upstreaming breastfeeding support for Black mothers. The California Dignity in Pregnancy and Childbirth Act (SB 464), signed in 2019, was created to deconstruct bias in maternal healthcare and decrease Black maternal deaths. The California Black Health Network states "This law requires that physicians complete evidence-based implicit bias training at least every 2 years." This new training program involves new curricula that will allow health professionals to further their understanding of the relationship between structural racism and health outcomes for Black birthing people. This culturally inclusive training will be used as a corrective measure in efforts to prevent further adverse health outcomes. An in-depth analysis by Erin M. Evans from Cal State Northridge, states the bill will train physicians "on diverse communities and the way power dynamics show up in patient and physician relationships." In explaining these power dynamics, healthcare workers will be made aware of the discriminatory and neglected experiences Black mothers encounter in healthcare. The California Black Health Network informs, "it also requires hospitals to let patients know their rights to be treated fairly and without discrimination and where to file a complaint if they feel this right has been violated." This addition to the bill allows mothers to retain autonomy over their healthcare decisions. SB 464 provides a promising avenue of change in maternal healthcare. Another patient-centered approach in medicine that can lead to positive health outcomes for Black mothers is racially-concordant care. Racially concordant care is defined as care provided by a healthcare provider who shares the racial identity of the patient. This care focuses on strengthening the patient-physician relationship and increases levels of trust in healthcare providers. A 2020 medical journal centered on "Physician-patient racial concordance and disparities in birthing mortality for newborns" found that when Black newborns are cared for by Black physicians, the mortality rate of these newborns is halved (Greenwood et al). This data, along with other studies and personal surveys, suggest that quality of care reaches higher levels when the patient and doctor share the same identity. Finally, healthcare workers can alleviate breastfeeding disparities by following the World Health Organization's (WHO) "Ten Steps to Successful Breastfeeding." These steps lay out procedures to secure successful breastfeeding. They begin with formally setting proper hospital policies, such as not promoting infant formula and ensuring cultural competence in their staff. Next, they highlight the importance of properly preparing the mother to breastfeed in the antenatal birth period and helping mothers feed right after birth. Continuing to support mothers with breastfeeding throughout the visit looks like frequently checking positioning, attachment, and suckling, allowing rooming-in, and helping mothers develop responsive feeding skills. Finally, WHO underlines the significance of proper discharge care, equipped with resources within their community for breastfeeding mothers.

Uplifting Black breastfeeding communities demands the attention of future physicians in medical school, and present healthcare workers in hospitals. Mitigating implicit bias is effective in creating a culturally competent environment that allows mothers to feel safe in the hospital. Implicit bias training programs in medical schools and hospitals are efficient. Hospitals should follow specific procedures to make breastfeeding universally accessible. Equitable breastfeeding care is attainable with the correct course of action, and dedication from healthcare structures.

Future Outcomes

Breastfeeding inequalities are a reflection of America's broken maternal healthcare system, alluding to deep-rooted systemic issues that are a constant within all of our social systems. Equal healthcare for all is achievable by treating medical issues as social issues with specific health consequences. Understanding that health outcomes one showcases are not independent of their own genetic makeup or personal failings or personal choices requires those in the medical community to reassess what current medical care looks like. The persistence of barriers faced by Black mothers in the maternal healthcare system for centuries makes it seem like these issues are permanent walls instead of hurdles. But, these barriers in our healthcare system are modifiable with the correct course of action. Bringing a maternal healthcare system that is solely dedicated to the mother and their child will require change in policy from all institutions that impact a pregnant person, every aspect of society they interact with. This commands recognition and reform from the government and those of socioeconomic power. Obtaining support from multiple social structures is intimidating, so focusing on each sector separately may be an effective path. Reform in the medical sector is of utmost priority since physicians hold a tremendous responsibility in dictating the lives of their patients. A growing amount of data proves that implicit bias is substantial in the type of assistance provided to patients. The plan provided above is just one step in decreasing obstacles in attaining quality healthcare through the elimination of physicians' bias.

My suggestion to implement evidence-based training programs while also educating future physicians in medical schools works to reduce racism in the medical sphere, and in turn, lead to better overall health for marginalized populations. Breaking destructive habits such as stereotyping and ignoring patient concerns will help to eventually break the cycle of adverse health outcomes in Black mothers. Past research is shown that reducing implicit bias is possible. For example, a 12-week longitudinal study that implemented an intervention that was designed to target implicit bias showed a drastic reduction in this bias by utilizing a few different techniques (Devine et al). These practices included stereotype replacement, counter-stereotypic imaging, individuation, perspective talking, and increasing opportunities for contact. All these practices work to identify personal beliefs held by participants, how to replace biased responses, humanizing those around them, and understand them based on personal attributes based on group/societal influences (Devine et al). The implicit bias training programs presented in the previous section sought to use similar techniques. These techniques are created using a psychological and sociological understanding and can help override unconscious prejudiced views. Refraining from a surface-level analysis of one's biases, interventions previously mentioned are ones that invite deeper discussion about the relationship between racism and health. Ensuring these training programs reach clinicians will take much work from public health officials who can work with policymakers. These efforts are already in place with initiatives like The California Dignity in Pregnancy and Childbirth Act. Another public health official that plays a key role in maternal health reform is the Surgeon General. Former Surgeon General Jerome Adams released his call to action to improve maternal health. Leading federal agencies including the CDC, Health Resources and Services Administration (HRSA), the Office of Disease Prevention and Health Promotion (ODPHP), and the National Center for Health Statistics (NCHS) are all part of the maternal, infant, and child health workgroup in order to improve health conditions. According to the ODPHP, there has been some improvement in certain sectors of maternal healthcare, including the reduction of fetal and infant death rates, abstinence of smoking for pregnant women, an increase in back sleeping for infants, and an increased amount of screenings for newborns and developing children.

Still, policy changes specific to breastfeeding are needed. In order for this to happen, there must be more research done on the reasons for low breastfeeding rates and which course of action can best improve these rates. There need to be more clinical trials as well as an addition to the scientific literature. There is an increasing amount of awareness of this topic, however, increased research can lead to the basis of evidence-based implementation by public health officials.

Works Cited

Facts on Maternal Morality & Morbidity in the United States, https://s3.amazonaws.com/s3.momsrising.org/images/Maternal_Health_Infographics_Factsheet.pdf. Accessed 25 May 2023.

Structural Racism and Maternal Health among Black Women, https://journals.sagepub.com/doi/full/10.1177/1073110520958875. Accessed 25 May 2023.

Latoya Hill, Samantha Artiga. Nov 2022. “Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them.” KFF, 14 Mar. 2023, https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/.

“Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries.” Maternal Mortality Maternity Care US Compared 10 Other Countries | Commonwealth Fund, 18 Nov. 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries#:~:text=Key%20Findings%3A%20The%20U.S.%20has,and%20midwives).

“Fact Sheet: Health Disparities and Stress.” American Psychological Association, https://www.apa.org/topics/racism-bias-discrimination/health-disparities-stress. Accessed 24 May 2023.

Julion, Wrenetha A. “Black Mothers Are Dying: The Toll of Racism on Maternal Health.” STAT, 11 Jan. 2018, https://www.statnews.com/2018/01/11/racism-maternal-health-erica-garner/.

Stevens, Emily E, et al. “A History of Infant Feeding.” The Journal of Perinatal Education, 2009, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2684040/.

Charlie Middleton. “Dysphoric Milk Ejection: The Real Reason You Might Feel Sad When Breastfeeding.” The Conversation, 13 Sept. 2022, https://theconversation.com/dysphoric-milk-ejection-the-real-reason-you-might-feel-sad-when-breastfeeding-103896#:~:text=When%20women%20breastfeed%2C%20dopamine%20.

“Popular and Pervasive Stereotypes of African Americans.” National Museum of African American History and Culture, 19 July 2019, https://nmaahc.si.edu/explore/stories/popular-and-pervasive-stereotypes-african-americans.

Racial Bias in Pain Assessment and Treatment Recommendations, and False ..., https://www.pnas.org/doi/10.1073/pnas.1516047113. Accessed 25 May 2023.

Tsai, Jennifer. “How Should Educators and Publishers Eliminate Racial Essentialism?” Journal of Ethics | American Medical Association, 1 Mar. 2022, https://journalofethics.ama-assn.org/article/how-should-educators-and-publishers-eliminate-racial-essentialism/2022-03.

Braun, Lundy, and Barry Saunders. “Avoiding Racial Essentialism in Medical Science Curricula.” Journal of Ethics | American Medical Association, 1 June 2017, https://journalofethics.ama-assn.org/article/avoiding-racial-essentialism-medical-science-curricula/2017-06.

Misrepresenting Race - The New England Journal of Medicine, https://www.nejm.org/doi/full/10.1056/NEJMms2025768. Accessed 25 May 2023.

Basic Search - Gale Academic Onefile, https://go.gale.com/ps/start.do?p=AONE&u. Accessed 25 May 2023.

Marquette University E-Publications@marquette, https://epublications.marquette.edu/cgi/viewcontent.cgi?article=1661&context=nursing_fac. Accessed 25 May 2023.

Taking Back Control—Can Quality Improvement Enhance the Physician ..., https://www.healthaffairs.org/do/10.1377/forefront.20200110.543513. Accessed 25 May 2023.

“Uplifting Black Breastfeeding with Community Resources, Culturally Concordant Care, Legal Aid & More.” YouTube, 26 Oct. 2022, https://www.youtube.com/watch?v=OKphJFWaXpY.

Slowed Canonical Progress in Large Fields of Science | PNAS, https://www.pnas.org/doi/10.1073/pnas.2021636118. Accessed 25 May 2023.

"How Medical Schools Can Transform Curriculums to Undo Racial Biases." Penn Medicine, https://www.pennmedicine.org/news/news-releases/2021/january/how-medical-schools-can-transform-curriculums-to-undo-racial-biases. Accessed 24 May 2023.

Glicksman, Eve, et al. "Unconscious Bias in Academic Medicine: Overcoming the Prejudices We Don't Know We Have." AAMC, 27 Sept. 2016, https://www.aamc.org/news-insights/unconscious-bias-academic-medicine-overcoming-prejudices-we-don-t-know-we-have.

"Combatting the Lack of Implicit Bias Training in Medical Education." Kennedy Krieger Institute, https://www.kennedykrieger.org/community/initiatives/maryland-center-developmental-disabilities/information-dissemination/posters/combatting-lack-implicit-bias-training-medical-education. Accessed 24 May 2023.

Meeting Breastfeeding Intentions Differ by Race ... - Wiley Online Library, https://onlinelibrary.wiley.com/doi/10.1111/mcn.13093. Accessed 25 May 2023.

Ruben, Megan, and Norma S Saks. "Addressing Implicit Bias in First-Year Medical Students: A Longitudinal, Multidisciplinary Training Program." Medical Science Educator, 14 Aug. 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8368581/.

Hhs.Gov, https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf. Accessed 25 May 2023.

Devine, Patricia G, et al. "Long-Term Reduction in Implicit Race Bias: A Prejudice Habit-Breaking Intervention." Journal of Experimental Social Psychology, Nov. 2012, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3603687/.

"Maternal, Infant, and Child Health Workgroup." Maternal, Infant, and Child Health Workgroup - Healthy People 2030, https://health.gov/healthypeople/about/workgroups/maternal-infant-and-child-health-workgroup. Accessed 24 May 2023.

Bascomb, Neal. A Century of Race, Gender, and Southern Memory. Neal Bascomb.