

Babies

ARE NOT

PIZZAS

THEY'RE *BORN*, NOT *DELIVERED*!

REBECCA DEKKER,
PHD, RN

EVIDENCE BASED BIRTH

Babies Are Not Pizzas is a work of nonfiction. Some names, identifying details, and dates have been changed to protect the privacy of individuals.

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Chapter Eight

WOKE

THANKFULLY, AS SOON AS Susie was born, I felt amazing. The migraines lifted and, like last time, I felt a surge of energy. With the pain gone, I was able to become a better mom to Clara and Henry again. They were so adorable, always asking to cuddle with Susie. I was excited and feeling incredibly lucky that I would get 12 weeks paid leave at home with my three little ones—something that was unheard of among most of my family and friends (most of whom went back to work at 4 to 6 weeks postpartum).

I was feeling so inspired that I published a big blog article before I went back to work, called “Evidence on Vitamin K for Newborns.” Surprisingly, the article was so controversial that the website kept crashing due to the traffic demand on the servers. Dan and I had to scramble to find a new web host that could handle the traffic, and it was a week before our website was back online.

I went back to work at the end of March, mulling over the public's reaction to the Vitamin K article. I hadn't thought an article about a vitamin would be a big deal. But, apparently, there was a lot of misinformation out there on the Internet, and people had been misled into believing myths about Vitamin K being harmful (it isn't). I'd also discovered that part of the controversy was related to the fact that some people thought I should only write about the evidence for *avoiding* interventions. They were upset that I'd written that evidence clearly supports the use of Vitamin K—an intervention—for newborns!

One midwife from another country was so angry with me that she figured out where I worked, called my university, got an administrative assistant on the phone, and yelled at her about how I was a horrible person and a "tyrant." She was mad that there wasn't a comments section on my website—that makes me a tyrant?

But, as Dan reminded me, people needed to learn that I wasn't out there to promote any one type of birth. I was, as he said, "on the side of the evidence." In the end, this position—being on the side of the evidence—solidified my following. A lot of my readers were relieved I didn't have a secret agenda, that I really was just there to serve them by democratizing the evidence and making it available to everyone. And so, my audience grew.

As Susie's first year progressed, Dan and I continued to experience difficulties with childcare. We had to hire a new nanny (our fifth) at the end of my maternity leave in March, and when August rolled around, she quit. With the beginning of the academic year looming over me, I gritted my teeth,

sat down at my desk at home, and posted another nanny ad. As usual, I got responses right away and began the screening process. One candidate in particular stood out to me. She wanted to leave daycare work to spend more time with families. During her interview, she sat on the floor and played with Susie, seemingly enamored with my youngest child, who was now about 8 months old.

I thought, “Maybe this is it! Maybe she’s the one who will finally work out!”

This sixth nanny started the next week. I was excited for her first day, and I planned to work from home so I could show her everything around the house and answer her questions. School was still out for the summer, so all three kids were around.

The morning seemed to go well, but, at 1 p.m., the new nanny walked into my home office.

She said, “I don’t think I want to work for you. This isn’t the right fit for me.”

I said, “Wait . . . what’s going on? What’s wrong?”

“You know what? I really only want to take care of babies. I could see myself caring for your baby, she’s adorable, but older children? Like a five-year-old and two-year-old? That’s just not my thing.”

“Wait . . . what?” I thought. “Then why did you take this job, when I have an infant, a two-year-old, *and* a five-year-old?”

She packed up her bag and left. I sat on the floor and cried. It was just too much. How could I do everything I wanted to do—my faculty job and my blog—when I couldn’t get help with my kids? Was it impossible to be a working mom? I felt an ache in my heart—one I’m sure many parents have

felt—when you're in that horrible dilemma of trying to figure out how to make a living while finding affordable, reliable care for beloved children.

For the seventh time in two years, we were stuck without anybody to watch our children the next day.

This sixth nanny—the one who quit on her first day—this was the straw that broke my camel's back. I called Dan. He answered, and, sobbing, I told him what had happened.

“Hold on,” he said. “I'm coming home.”

A few minutes later, I heard the back door open and Dan's footsteps as he walked toward the nursery. He knelt on the floor next to me and I melted into his arms. Dan has always been my other half, my best friend in the whole world. He is strong, and smart, and funny, and handsome, and good with kids, and the best dad ever.

I looked up at him and said, “I want you. I want to hire YOU.”

He laughed, and we held on to each other, sitting with that idea.

“Let's think about it,” Dan said. “It's a possibility.”

Over the next few days, we wrestled with our options. We put everything on the table. Unfortunately, I couldn't quit my job to stay home with the kids. My salary was higher than Dan's, and I'd gone through too many years of education to give up my tenure-track position. We also looked at daycare (which, before, we'd ruled out because Clara developed health problems when she was in daycare the first year of her life). I called every reputable center in town. There was not a single daycare with an opening right now for one child, much less three! We considered hiring another nanny, but I couldn't

stomach that. The thought of going through a seventh search, likely to end in failure again, was nauseating. I couldn't do it. We talked about Dan cutting his hours to part-time, but that still left us with no one to watch our children the other 20 hours of the week.

Finally, we talked about the possibility of Dan quitting his job to be a stay-at-home parent. He'd lose his salary—it would be a big pay cut for us—but with the money we'd save from not paying for childcare, we'd just barely be able to pay our basic monthly bills. We wouldn't have any money left over for leisure activities or eating out, but our kids would benefit immensely from having a stable caregiver—a parent who loved them unconditionally and wouldn't quit abruptly or call in sick—with them every day. A bonus was that I'd have more time to work on the blog, because I wouldn't constantly be stressing about childcare.

The next day, Dan gave his two weeks' notice. He left his good-paying job to support me, to make the kids his priority, and to help out EBB. He left his friends, his coworkers, a job he loved, retirement and health benefits, and his career. And he didn't hesitate, either. He never once looked back. He announced to our family and friends that he was quitting so that he could “party with Clara, Henry, and Susie full time.”

Dan's first week home, we realized that all this time we'd been trying to run a rat race, with both of us working 40–50 hours per week and hiring out childcare. Mornings and evenings and even weekends had been *so* stressful. Now, I could leave for work knowing the kids were in good hands, and that when I came home, supper would already be started. Our pace

slowed. There was no doubt—with Dan at home, we were all happier and less stressed.

It also became easier for me to travel for my faculty job or to birth conferences, knowing Dan was at home. Within a few weeks after Dan quit his job, I was on a plane headed to Kansas City, Missouri for a doula conference. I'd actually taken vacation time from work so I could give a presentation at this conference, since childbirth research wasn't part of my official faculty role.

After the plane landed, I grabbed a taxi to head downtown. I was excited and nervous—what would this kind of event be like?

I walked around the conference grounds curiously. Everywhere I looked, there were doulas, doulas, and more doulas! There were vendor exhibits for rebozos (soft, handwoven scarves made in Mexico that are used for comfort during labor), MamAmor birthing dolls (handmade dolls used to demonstrate birth to children), and a booth for Spinning Babies® (a website for pregnant parents wanting resources and self-care activities to avoid Cesareans or childbirth challenges relating to baby's position in the womb).

After snatching a water bottle, I followed the crowds into the main ballroom and grabbed a seat.

An obstetrician was the keynote speaker that morning. She was speaking on "Preventing the First Cesarean," a review of factors that contribute to preventable Cesarean births. I reached for a pen and pad lying on the table and began to take notes furiously, determined to capture as much information as I could.

There were some statements the speaker made that I agreed with, like, “You can’t sacrifice someone’s normal vaginal delivery just because you need the room” (talking about how so many doctors will send someone to the operating room for a Cesarean because they’ve got other patients coming through) and “We’re facing a national crisis” (in reference to Cesarean rates).

However, as she spoke, I grew disturbed by some of the phrases I heard emerging:

“How we *manage* pregnancy.”

“How we *manage* labor.”

“We might *let them* have a longer labor induction.”

I was saddened that this obstetrician, as progressive as she was, still did not seem to understand the bigger picture. She was entrenched in the mindset that labor was something to be “managed” by obstetricians, that babies were “delivered” by doctors.

“Why,” I thought to myself, “Why do so many people think they can control a bodily process?”

As the speaker came to the end of her talk, the moderator asked for questions. A group of people began lining up at the microphone. I don’t know why, but I stood up and walked to the back of the line. And then, when the microphone was mine, I realized I had no idea what I was going to say.

But in the end, it didn’t really matter.

I leaned toward the microphone and said, “Hi, my name is Rebecca Dekker, and I’m a nurse with my PhD, and the founder of Evidence Based Birth.”

It seemed like every single person’s head snapped around. There were hundreds of eyes staring at me. People were

whispering and pointing. “That’s Rebecca? That’s Rebecca Dekker!”

I made a comment that critiqued one of the studies she mentioned and sat back down.

Eyes continued to follow me back to my seat. As I left the banquet room, I was approached by dozens of curious strangers.

“Hi Rebecca, it’s so nice to meet you!”

“I am such a huge fan of your work . . .”

“I can’t believe I’m meeting you in person!”

For the rest of the conference, everywhere I went, people stopped to speak with me. It was clear that the work that I was doing, this little side project, had become a really big deal. Doulas and childbirth educators from all over the world were using my website, and telling all of their friends and clients to use it, as well!

The last day of the conference, after a long day of enjoying other people’s educational sessions, as well as teaching one of my own, I walked back into the ballroom for a keynote speech by Ngozi Tibbs, called “Diversity in Childbirth Education and Breastfeeding.” I was interested in the topic, but didn’t think I had that much to learn. We’d covered a lot of information about diversity in health care in my nursing program.

Ngozi began her session by flashing a series of photos on the screen. She asked us to think, to ourselves, what was the first word that popped into our heads when we saw each photo?

A Hispanic woman holding a baby.

“Spanish speaking,” I automatically thought.

A Black pregnant woman.

“Single mom.”

A plus-size woman.

“Overeating.”

A person in a wheelchair.

“Disabled.”

I sat there, horrified at the words that were popping into my brain. I, who prided myself on using my little bit of Spanish to establish rapport with my patients, who valued my relationships with my Black and plus-size friends and coworkers. I even have an older sister who is in a wheelchair, and she means the world to me. Yet, when I saw that picture, all I could think of was the word “disabled”?

What was wrong with me?

It turns out that what I suffered from, and what everyone possesses, is something called implicit bias.

Implicit bias is defined as unconsciously labeling members of a group as having specific qualities. This tendency—to hold unintentional stereotypes—probably stems from a basic human instinct to “categorize” groups in order to make snap judgments about potential threats. If you were a hunter-gatherer out in the wild more than 20,000 years ago, you would need to be able to quickly size up someone and the level of danger they presented.¹²⁷

Unfortunately, today, these implicit biases permeate society. We are all raised to believe certain things about certain groups, and those beliefs seep into our subconscious. What’s more, these biases lead to substantially worse health care for people from stigmatized groups. As a nurse, even if I consciously reject negative biases, as long as they exist in my subconscious, my implicit biases will affect how I understand,

act, and make decisions about providing health care to people from different groups.

I sat there pondering my childhood, and asked myself: What could have led to my categorizing a Black woman in a photograph as a single mom? The answer came quickly.

I grew up in Memphis, Tennessee. Or, more accurately, I should say I grew up outside of Memphis. When I was growing up, Black people made up 63% of the population inside the city limits of Memphis. Meanwhile, in the suburb of Germantown, Tennessee, where I lived as a child, Black people were only about 10% of the population. Despite the proximity between Memphis and Germantown, I grew up without a single Black friend or acquaintance. Memphis suffered from rampant poverty and crime, while Germantown—affluent, with large brick homes on oak-lined streets—was considered the “safe” place to live.

I was raised in a home where we were taught that everybody was our neighbor, no matter who they were, where they lived, or what the color of their skin was. But I remember my friends’ parents talking about Black people with a scathing tone. I remember the few Black kids in my school sitting at a cafeteria table by themselves. I remember overhearing conversations where adults said things like, “Did you hear? That neighborhood is going downhill [translation: a Black family just moved in]. The Joneses are putting their house up for sale to get out before things get worse.” (What they were promoting was white flight, defined as White people moving away from neighborhoods when Black families move in.)

What I witnessed as a young child was the result of hundreds of years of racism, prejudice, and power-wielding of

White people over Black people—beliefs not only held by individuals, but written into law and policy for generations. These beliefs and structures, I later learned, were particularly powerful in former slave-holding states like the one I grew up in. As a child, I was aware of the language and actions of racism and prejudice around me, but I didn't understand what was going on, nor why it persisted. It certainly wasn't explained to me in school. Not even in college or graduate school.

Now I realized, sitting in that conference ballroom, that even though I'd consciously rejected the phenomenon of racism, and viewed it as wrong, it was still being perpetuated through me, via the simple act of my continuing to subconsciously believe harmful stereotypes.

Ngozi went on.

She began to read a poem she had written about what it's like to be a Black mom at the playground. In the poem, her child is carefree, swinging on the swing set. Another mom notices the Black child and makes a sour face. She hushes her child away while the Black mom prays her own child doesn't notice—that her child will be innocent of the effects of racism for just a little bit longer. "Swing away," she says sadly.

I was stunned. I had never before thought of innocent children being subjected to racist thoughts and behaviors. Or what it would be like to be a mom on the playground, watching other parents making ugly faces at my child, just because of the color of my baby's skin.

As I left the conference, I vowed to do as much as I could to educate myself about the effects of racism on birthing families.

What I found shocked me. According to the Centers for Disease Control, non-Hispanic Black women and American

Indian/Alaskan Native women are three to four times more likely to die during or after pregnancy and childbirth than White women. More specifically, there are 43 maternal deaths per 100,000 live births for Black women, 33 deaths per 100,000 live births for American Indian and Alaskan Native women, and 13 deaths per 100,000 live births for White women and 11 deaths per 100,000 live births for Hispanic women.¹²⁸ Nearly two-thirds of these deaths (60%) are considered preventable!¹²⁹

But it's not just maternal mortality rates that are higher. Black families are substantially more likely to experience a pre-term birth, have a low birth weight infant, lose a baby in stillbirth, and experience the death of their infant in the first year of life. What's more, researchers have consistently found that these differences between Black and White birth outcomes persist even after controlling for other risk factors, such as income level, prenatal care, and education level. In other words, these disparities are not due to socioeconomic status.¹³⁰

If it's not because of socioeconomic status, then why are Black mothers and babies dying at higher rates?

Once I dove into the research, I found that negative birth outcomes are directly due to racism inflicted upon black women.^{131,132} First, racial discrimination increases inflammatory markers of stress. Racism causes both acute stress from specific incidents of discrimination and chronic stress from a lifetime of exposure. It's documented in experimental studies that exposing Black people to racist material in laboratory settings causes an understandably negative cardiovascular response, with changes in heart rate and blood pressure.¹³³ Other researchers have found that Black mothers who give birth to very low birth weight pre-term infants are more likely

to report experiencing racial discrimination during their lifetime compared to Black mothers who give birth to normal weight infants at term, even after considering the mothers' age, education, and smoking status.¹³⁴

What's more, it's thought that these stressors have accumulated over generations—an effect called intergenerational trauma.¹³⁵ Researchers are starting to look to *epigenetics* to explain how an environmental exposure (such as a traumatic event) can lead to a change in the function of an individual's DNA that can then be passed on to future generations. Epigenetics is a relatively new subfield of genetics concerned with how exposures in the environment can change our genes by switching them on and off (for better or for worse). This makes sense when you think about it. For example, when my grandmother was pregnant with my mom, the environment that shaped my grandma's pregnancy might have had an impact on the health of both my mom's and my pregnancies. That's because my mom was present as a fetus, and I was partially present as an egg, while my grandmother was pregnant! Thus, it's thought that the historical context of how women are treated during pregnancy and birth—even if it happened many years ago—can have an impact on birth outcomes today.

However, unlike my grandmother, who was White, a Black woman's grandmother would have experienced racism throughout her entire life. And so would her daughter, and her daughter's daughter. Researchers have found that babies of African immigrant mothers have outcomes more like White babies rather than U.S.-born African American babies—they are bigger and less likely to be premature.¹³⁶ But, decades later, the grandchildren of African immigrant women are

more likely to be premature, like African American babies.¹³⁷ Grandchildren of White immigrants, on the other hand, are even bigger than their mothers were at birth! This is evidence that the increased risk of low birth weight and prematurity among Black babies is *not* a risk that's inherent to having Black skin or African ancestry. Instead, it's the harmful environmental exposure of racism directed towards people with brown or black skin that causes poor outcomes. In other words, these risks are not related to race. They're related to *racism*.

Before I go any further, it's important to mention that there is a common misconception that we can be categorized into different human "races." But biologically and genetically, all human beings are *Homo sapiens*—there is more genetic variability among people of a certain "racial" group than there is *between* "races."¹³⁸ The dominant viewpoint among scientists and anthropologists today is that race is a socially constructed concept used by White people to categorize and oppress people of other groups, particularly Black people.¹³⁹ This is why being "color blind" doesn't work. A White person may pretend not to notice someone's skin color, but it's unethical for the White person to ignore that society has constructed an entire system to oppress Black and Brown people, and that the White person is perpetuating that system and benefiting from it!

Second, I know there's a lot of confusion about the loaded term of "racism," so let me help clear the air. Dr. Beverly Daniel Tatum, a clinical psychologist and author of the book *Why Are All the Black Kids Sitting Together in the Cafeteria?*, defines racism as a "system of advantage based on race, that involves cultural messages, institutional policies and practices, and the beliefs and actions of individuals."¹⁴⁰

Racism is often confused with prejudice. But racism, also known as white supremacy, is a system we all live in, that includes prejudiced beliefs as one part of that system. Racism is driven by the power that White people have (whether they realize it or not) to oppress others in all areas of their lives—through laws, policies, educational systems, reproduction, health, and media. On the other hand, prejudice is defined as a preconceived notion or opinion that can often lead to racist actions that perpetuate the system of racism.

Racial prejudice is likely a contributing factor to those disparately high mortality rates I mentioned earlier. That's because health care professionals don't always listen to Black women—frequently dismissing their symptoms and concerns. Now this “not listening” may not be intentional—in many cases it may be due to subconscious biases—but research has shown that it definitely happens more frequently to Black women.^{141,142} A large national survey recently found that Black women, Hispanic women, Indigenous women, and Asian women in the maternity care system were twice as likely as White women to report that a health care provider ignored them, refused to answer their request for help, or failed to respond to their request for help in a reasonable amount of time.¹⁴² Women of color were also more likely than White women to report that their physical privacy was violated and that they were shouted at, scolded, threatened, or physically abused by health care providers.

For example, a Hispanic woman in the study who gave birth in a “birth center” inside of a hospital in North Carolina described her mistreatment:

"I hated being shouted at and lied to by the midwife . . . I never dreamed that a woman would treat a laboring woman that way. She was abusive and downright mean. I was refused food and water for 26 hours. I wasn't allowed to move out of bed to walk around. I felt like I lost my autonomy over my own body. I had given up and I remember weeping when my son was born. I was at least glad he was safe. I felt like a child and I felt so unlike my usual self. These professionals broke my spirit."¹⁴²

Years after I attended Ngozi's presentation at the doula conference, I was struck by the news reports detailing Serena Williams's complications after childbirth. In interviews, Serena describes how she realized she was experiencing a blood clot in her lungs. She had a history of blood clots and had to stop taking her anti-clotting medication because she'd had a Cesarean. The day after she gave birth by Cesarean, Serena stepped into the hallway, gasping, to alert a nurse that she needed a CT scan and IV heparin for a pulmonary embolism. The nurse thought Serena was confused from pain medications. Serena insisted they carry out a CT scan of her *lungs*, but instead, a doctor performed an ultrasound on her *legs*. Finally, the hospital staff sent her for a CT scan of her lungs, and sure enough, there were several small blood clots in her lungs.¹⁴³ If a world-class athlete like Serena Williams, who probably knows her body better than anyone, can't be believed when she's experiencing a life-threatening childbirth complication, what are the chances that other Black women will be ignored or dismissed when they speak up about their symptoms?

Now that my eyes were opened to what racism really is (a combination of oppressive systems and individual prejudices),

and how it affects families of color, I've realized racism isn't just present in labor and delivery—it's everywhere in our society. Black people experience racism in many everyday settings—schools, neighborhoods, playgrounds, shopping malls, and grocery stores. Can you imagine being followed around by a suspicious store clerk while you're browsing for new clothes? Being rejected for a job interview or mortgage application because you have a black-sounding first name? Hearing that another, unarmed man in your community was killed by a police officer? These are common occurrences for people with brown or black skin.

Also, because of the way our systems are set up—including health care and housing and school systems—and because of the individual prejudice they face, most Black people are forced to think about their race on a daily basis. They also have to consciously prepare and protect their children from experiences of racism and prejudice. This constant trauma of needing to protect yourself and your children can lead to physical symptoms such as nausea, headaches, stomach aches, and anxiety.¹⁴⁴ It can also translate into worse birth outcomes down through the generations.

This all made sense to me on an academic level, but the day after I came home from my first birth conference, I saw the effects of racism play out in real life.

I was heading to work the next morning when a notification popped up on my phone. I'd just gotten an email, and the first line said, "Someone suggested I reach out to you about my birth experience . . ."

Once I got to my desk, I sat down and digested the information in the email. Chaundrise* was a well-educated Black woman in her early thirties who lived in a town just down the highway from me. After reading some of the blog articles on the Evidence Based Birth® website, she'd decided to switch to a nurse-midwife practice that was supportive of a wide range of birth plan options.

Chaundrise did everything she was supposed to in order to stack the odds in favor of a healthy birth. She followed all of her care provider's advice. She ate healthy foods during pregnancy, exercised regularly, went to all her prenatal visits, and went to prenatal yoga classes weekly. Her husband was supportive and attended a comprehensive six-week childbirth class with her. They felt about as prepared as they could for the birth of their first child.

Leading up to the birth, Chaundrise's plans were flexible. She expected to be able to use non-drug pain management strategies, like the hospital tub, and mobility and position changes. She thought she'd hold off on an epidural as long as possible, but she wasn't opposed to getting one if she felt like she needed it. She was looking forward to the hospital's celebratory "post-birth" meal, and the complementary massage they offered to all women who birthed there. But mostly, she hoped to be supported in this exciting and scary time of her life. Although none of Chaundrise's midwives were Black like her (she would have preferred a midwife from a similar background, but there were no Black midwives in the entire

* For privacy reasons, Chaundrise's name is a pseudonym, and her story is a compilation of multiple stories told to me over the years by Black families.

region—only one in the whole state, in fact), she felt good about the practice she'd chosen.

Chaundrise's water broke at 40 weeks and she headed to the hospital with her husband, with contractions immediately picking up and coming every four minutes. She arrived at the hospital, visibly in active labor.

"I need you to get in the bed so I can do a vaginal exam," the nurse directed, without even introducing herself.

"I can't!" Chaundrise exclaimed. "I can't lie on my back. It hurts too much!"

Frowning, the nurse walked out of the room, leaving Chaundrise and her husband alone. She came back in about 15 minutes later, rolling the computer on wheels for the intake exam, still with an unfriendly attitude. Chaundrise began to have a bad gut feeling about the whole situation.

As the nurse asked the long list of questions about Chaundrise's health history, Chaundrise became increasingly uncomfortable. The contractions were coming every four minutes, lasting more than a minute, and nobody had offered her any pain medication or comfort measures yet. There didn't seem to be a tub in her room, even though she'd asked for the room with the tub. Chaundrise became more anxious and fearful, and soon the pain during each contraction became unbearable.

"I think I need an epidural," she gasped to the nurse, who was still working on the intake computer form.

"You're going to have to wait," the nurse said, staring at the computer. "We have to get you checked in first."

"But can't you call the anesthesiologist?" Chaundrise's husband asked.

“I can,” the nurse replied. “But it won’t make any difference. Besides, it doesn’t seem like the pain is that bad. She can’t be that far along.”

Chaundrise began moaning and swaying on the side of the bed, deep in the throes of another contraction.

“I need you to get in the bed *now*,” the nurse said again, ignoring the fact that Chaundrise was in the middle of a contraction. “I have to do your vaginal exam before you can be admitted.”

Chaundrise moaned and looked up, breaking her concentration. “But I don’t want you to do it,” Chaundrise said, gasping, “I want my midwife. She said she would do all my exams. I talked with her about that. It’s on my birth plan.”

“I told you,” the nurse said. “I need to do your exam *NOW*. Now get in the bed if you want that epidural!”

Chaundrise got into the bed, frightened. The nurse put on gloves, then moved Chaundrise’s legs apart, and began to do a vaginal exam. Chaundrise cried out in pain and said, “Stop!”

“Is that really necessary?” her husband asked.

The nurse ignored them both and proceeded to do a very rough exam as Chaundrise begged her to stop and tried to move away.

After the nurse finished, she took off her gloves and washed her hands without speaking. She then set a urine sample container on the bedside table.

“I need you to do this before I can call for your epidural,” the nurse said.

“What’s that?” Chaundrise asked.

“It’s a urine test. It’s standard.”

“But I just had a urine test yesterday at my midwife’s office and it was fine. What are you testing for?”

The nurse frowned, and said, “We just want to keep your baby safe. It’s a drug screening test. Make sure you wipe yourself off before you fill up the cup,” and walked out the door.

Chaundrise was in shock—scared and anxious. An hour later, her midwife arrived, and the midwife helped her get an epidural quickly and arranged for a different nurse to take the other nurse’s place. Half an hour after getting her epidural, Chaundrise’s baby was born healthy and without complications. Afterward, though, she was afraid to send her baby to the nursery for routine tests. If this was how a nurse would treat a Black woman, how rough might they be with a Black baby—with no one around to see?

After she was discharged, the anxiety wore off, and Chaundrise became furious. Later, she debriefed the entire experience with her midwife. The midwife apologized profusely for the first nurse’s behavior, and admitted that how the nurse had treated her was probably related to racism.

This is what happened: the nurse, either consciously or subconsciously, saw Chaundrise as less worthy of compassion than a White patient, which affected how she behaved toward her.

First, the nurse dismissed Chaundrise’s pain and withheld pain medications. A common prejudice against Black people is that they don’t “feel pain” like White people. This prejudice goes back as far in time as Dr. J. Marion Sims, considered by many to be the “father of gynecology,” who performed experimental surgeries on enslaved women without anesthesia,

under the racist opinion that Black women don't feel pain like White women.¹⁴⁵

Second, the nurse performed a non-consented, intentionally rough vaginal exam. This was obstetric violence. Imagine how much more horrifying this would have been if Chaundrise had been a survivor of rape, like 21% of American women?¹⁴⁶

And third, the nurse attempted to carry out unnecessary drug testing without getting Chaundrise's consent first. This action was not only illegal (the Supreme Court ruled in 2001 that it is a violation of a pregnant woman's Fourth Amendment right for a hospital to conduct a drug test without consent),¹⁴⁷ but done in a discriminatory way. Like most women, Chaundrise had already undergone routine drug testing earlier in pregnancy, and the results were clearly documented in her chart—all negative. This nurse suspected Chaundrise of being on drugs only because of the color of her skin.

I wrote back to Chaundrise, expressing sympathy and anger at what she had been through. I gave her several suggestions—first, to write out her story and complaint in great detail, and second, to send it to the nurse manager at that hospital, whose email address I gave to her. I offered to help her in any way I could with the complaint process.

Chaundrise wrote back, saying that she felt discouraged by the thought that nothing might ever change. She wasn't sure if she wanted to relive the trauma by writing down her story in detail and sending it to the hospital. I encouraged her to seek out a therapist and offered to support her in any way I could.

Chaundrise did contact the hospital and, after some time, they told her that after a review, they had decided her care was "medically appropriate." They were "sorry they did not meet

her expectations”—implying that her expectations, rather than their racist actions, were to blame for her dissatisfaction. She called them to say that she had never even gotten the chance to share her full story with them before they reviewed her case, and that she’d like to do so now. But they said there was no need, because the investigation was closed.

About the Author



REBECA DEKKER, PHD, RN, is the founder and CEO of Evidence Based Birth®. After earning her Bachelor's, Master's, and PhD in Nursing, Rebecca embarked on a career as a nurse scientist and teacher. In 2016, she left academia to become a full-time entrepreneur and consumer advocate for evidence based care. Rebecca lives in Lexington, Kentucky, where she and her husband Dan are raising three children and an assortment of pets. *Babies Are Not Pizzas* is her first book.