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Reproducing while Black: The crisis of Black maternal health, obstetric racism and assisted reproductive technology

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Abstract Black women bear the burden of a number of crises related to reproduction. Historically, their reproduction has been governed in relation to the slave economy, and connected to this, they have been experimented upon and subjected to exploitative medical interventions and policies. Even now, they are more likely to experience premature births and more likely to die from pregnancy-related complications. Their reproductive lives have been beleaguered by racism. This reality, as this article points out, shapes the use of assisted reproductive technology (ART) by Black women. Using the framework of obstetric racism, I suggest that, in addition to the crisis of adverse maternal health outcomes, such as premature birth, low-birthweight infants and maternal death, Black women also face the crisis of racism in their medical encounters as they attempt to conceive through ART. Obstetric racism is enacted on racialized bodies that have historically experienced subjugation, especially, but not solely, reproductive subjugation. In my prior work, I delineated four dimensions of obstetric racism: diagnostic lapses; neglect, dismissiveness or disrespect; intentionally causing pain; and coercion. In this article, I extend that framework and explore three additional dimensions of obstetric racism: ceremonies of degradation; medical abuse; and racial reconnaissance. This article is based on ethnographic work from 2011 to 2019, during which time I collected narratives of US-based Black women and documented the circumstances under which they experienced obstetric racism in their interactions with medical personnel while attempting conception through ART.

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Introduction

Melissa, an African American lesbian, was 46 years old when we first spoke in June 2016. She was memorable for a number of reasons, not the least of which was that her smile made you feel that anything was possible. We had friends in common. I was glad when she responded to my Facebook post to interview people whose children had been born prematurely. I had forgotten that she had even been pregnant. Maybe it was because it had been 3 years since I had last seen her at the birthday party of a mutual friend in 2013. At that party, Melissa and the woman she was with danced as if no one else was in the room, their fingers interlocked as the woman — who would become Melissa's wife — twirled her in loving syncopation to the music. They were a beautiful couple. However, speaking with Melissa on that June day, I learned that her joy and buoyancy in 2013 was tempered by the fact that she had been attempting to become pregnant since 2007.

During what was the first of two interviews, the first for the book *Reproductive Injustice: Racism, Pregnancy, and Premature Birth* (Davis, 2019) and the second for this article, I asked Melissa if she thought race or racism influenced her medical encounters during her pregnancy and after her son's birth. She told me that she did not. Her wife was an emergency room doctor, she told me, and was privy to expert knowledge about how the medical system worked and felt she could navigate it safely. However, when we spoke again 3 years later, Melissa retold her birth story. In the retelling, I was struck by the range of predicaments that beset Melissa during her quest to conceive and after her pregnancy. What differed between the two interviews was that while racism did not factor into her assessment of giving birth and having a premature infant in the first interview, in the second, she shared her perception that racism cast a pall over her attempts to conceive. Her second-told tale revolved around the process of conception: different meanings and interpretations surfaced, and new details emerged of her feelings about the multiple courses of in-vitro fertilization (IVF) and artificial insemination she underwent. Melissa propelled herself through the journey of conception by the sheer force of wanting to be a mother, despite the financial costs and emotional exhaustion. In the end, Melissa became a mother, but the archive of that experience was riddled by crisis for her.

In search of an affordable option to conceive, Melissa travelled from the USA to the Caribbean to India and back to the USA. After four attempts with artificial insemination, a miscarriage due to fibroids, and a myomectomy[1] to address that problem, she pursued IVF in India. In the first telling of her story, Melissa focused on the class dimensions of her pursuit of assisted reproductive technology (ART); she wondered about the way the doctors and nurses seemed to hound her for money. She said, "I was alone...I felt like the doctors were fishing to see if I could pay more. The doctors asked, 'What do you do for work?' It was all very financially driven" (Davis, 2018: 53). She also felt that the doctors and nurses searched for reasons to require additional services and tests, ultimately costing her more money. However, during the second interview, Melissa brought up the issue of race and racism as she wondered, "Was I an easy target because I was Black and single? I have thought about the whole experience and realize that I was very conscious of the issue of race. I felt like I was being 'sized up'. Maybe that is why they asked me what I did for work. Maybe they wanted to know if I made enough as a Black woman to be there". As she recalled her interactions with clinical staff, Melissa remembered the other single Black woman who also received IVF services at the same clinic. The two of them went to the beach and compared notes, Melissa told me. Ultimately, they decided that they both felt they were being treated differently because they were Black. Melissa also recalled something else she had not mentioned during the first interview — that clinic nurses badgered her to buy items they sold on the black market. She believed they did so because, 'They saw a Black woman with money and they needed to earn extra income'. Melissa told me that she felt obligated to accommodate the women because, in her mind, they controlled the success or 'failure' of her conception.

After two futile attempts at IVF in India, Melissa returned to the USA and met the woman she ultimately married. Together they tried artificial insemination and when that did not 'take', as Melissa put it, they paid US$5000 for the remaining eggs in India to be returned to the USA and utilized the services of an IVF clinic in New York. That time they were successful. However, at 25 weeks, Melissa had a caesarean section and gave birth prematurely to her son Kyle.

What are we to make of Melissa's experience in addition to the fact that she engaged in the increasingly common trend of transnational reproduction, driven by lower healthcare costs in the Global South? We could emphasize the emotional rollercoaster of being inseminated followed by miscarriage. Her story speaks of issues around IVF outcomes: she underwent two unsuccessful cycles, and the one successful pregnancy resulted in premature labour and a caesarean section with her son's subsequent admission to a neonatal intensive care unit. This is certainly a common enough adverse birth outcome for many Black women. Taken together, these parts of the story coalesce into a reproductive narrative of multiple crises: the crisis of difficulty in conceiving; the crisis of unsuccessful conception; and the crisis of an adverse birth outcome. However, her story also serves as a touchstone to explore an often-ignored aspect of reproduction that accompanies ART: the crisis of experiencing obstetric racism.

For Black women in the USA, racism is part of the web of significance that is frequently overlooked as a set of institutional practices that shape assisted reproductive processes. Generally, scholars focus on the difficulty that Black women face in accessing such technologies. Although data are collected in the USA on the racial disparity of access to ART, little — if any — data index the experiences of racism of Black women: how it is felt and how it affects intimate encounters with ART providers.

This article explores the experiences of Black women of 'reproducing while Black', asking what kinds of crises are faced by Black women who use ART? I apply the concept of obstetric racism, by which I mean the mechanisms of sub-

[1] Myomectomy is the preferred treatment for women with fibroids who want to become pregnant. It involves surgical removal of the fibroids, allowing the uterus to be left in place.

ordination to which reproduction in Black women are subjected that track along histories of anti-Black racism (Davis, 2018). As an analytic, I use the concept of obstetric racism to highlight forms of violence and abuse that medical personnel and institutions routinely perpetrate against Black women during conception, pregnancy, childbirth and post partum. It is comprised of beliefs and practices levelled against the reproducing Black body that sit at the intersection of obstetric violence and medical racism (Davis, 2018).

Scholars across such disciplines as anthropology, law, public health and other related fields typically use the term 'obstetric violence' to characterize situations when obstetric patients are controlled and subjected to dehumanizing treatment because medical professionals and staff exert reproductive dominance over their clients. Highlighting the extent to which women are explicitly abused by medical staff reveals the degree to which healthcare infrastructure is built on institutional relations of power and violence, especially during pregnancy, childbirth and post partum (Chattopadhyay et al., 2018; Diaz-Tello, 2016; Dixon, 2015). Medical racism occurs when the race of a patient influences the treatment or diagnostic decision in the broad context of medical provision, and involves the racialization of every aspect of every organ of every Black body (Hoberman, 2012). While the frameworks of obstetric violence and medical racism elucidate many attributes of the medical field more generally, I am invested in exploring the entanglements of these two forms of violence. Obstetric racism transcends the limits of each and locates the specific ways that the reproducing Black body is subjected to medical intervention. By using the lens of obstetric racism, I suggest, we gain a deeper understanding of the impact of the logics of racial domination on Black women at any point in their reproductive lives. In short, obstetric racism rests on the fact that racial hierarchies have led to differential practices, tasks and clinical decisions. So, while I think with the concepts of obstetric violence and medical racism, I would argue that obstetric racism delineates particular forms of exploitation that are historically created and structure Black value as it is constituted in the engagements of Black women within biomedical and healthcare infrastructures. Obstetric racism serves as a theoretical framework that can help clarify our understanding of a type of crisis in which the significance of anti-Blackness serves as the rationale underlying medical encounters. It offers a way for scholars and reproductive activists to be attentive, not just to race as a sorting mechanism that determines the availability of ART. It also structures the experiences for those Black women who have access to it. This is particularly important given that institutionalized paternalism is prevalent in reproductive medicine, and that paternalism can overshadow the historical groundedness of racist medicine in ways that screen out important aspects of the engagement of Black women with ART. The racial logics that shape this engagement may not become fully legible via conventional social science research focused on who does and does not have access to ART. What is necessary are more nuanced investigations of Black women's felt intuition and situated knowledge of reproduction (McClaurin, 2001; Rodriguez et al., 2015). By chronicling the stories of Black women, placing their narratives in dialogue with Black feminist theorizing and anthropology, the urgent political task of 'unhiding' obstetric racism becomes possible. Taking a cue from Imani Perry, Black feminist theorizing centres Black women within the political, economic, ideological and patriarchal order to understand modes of domination (Perry, 2018). Black feminist theorizing refuses dependency on analyses that narrow the scope of a problem in ways that make the experiences of Black women impossible to apprehend, and seeks to broaden the legibility of Black life in scholarly work. Obstetric racism provides a 'language' for assessing circumstances conditioned by the materiality of the medical encounter: what that encounter feels like and how it is interpreted.

I want to stress here that racism is not external to the process of ART. Rather, women encounter racism as part of the exhaustive experience of being Black due to the strategic patterns of subjugation that medicine, medical research and treatment, and exploitative practices have embossed on Black bodies. Views of the Black body are typically limited, if you will, to the distorted racial imaginaries of science and medicine. For instance, Hogarth (2017), in her enlightening discussion of the role that doctors played in medicalizing racial difference in the 18th and 19th centuries, shows that white bodies were deemed susceptible to yellow fever while Black bodies were believed to be immune. Consequently, Blacks were dispatched to manage colonial interests that included caring for plantations and whites. Specifically regarding reproduction, we can look to the role that slavery, racism and racial capitalism played in the development of obstetrics and gynaecology. Cooper Owens (2017) offers an astute assessment of how enslaved women's bodies were subjected to gynaecological and obstetric interventions around which both specialties developed. Finally, Harriet Washington (2006) demonstrates the longue durée of medical experimentation on Black Americans, of which they were often unaware, including a multitude of examples where the reproductive capacities of Black women were exploited in the form of forced reproduction and sterilization. Although these are but some of the ideas and practices that justify the use of obstetric racism as an analytic, it is important to note that such ideas and practices need not be willfully imported into the interactions of medical personnel with Black patients. The reconfiguration of ideas about, say, susceptibility, immunity, fecundity or pain thresholds is embedded within the historical contexts of reproductive medicine, and structures the encounters both of and between patients and practitioners. These ideas and histories contribute to the adverse experiences confronted by some Black patients who seek ART. Importantly, it is not only the exportation of racism from the past into the present with which I am concerned; it is also the intuitive and sensory dimension of racism that haunts Black women.

In this article, I draw from the birth narratives of US-based Black women to map various scales of racism encountered when undergoing ART. Melissa was among the 17 parents interviewed for a project on racism, pregnancy and premature birth that took place between 2011 and 2018, and was one of two women who had sought IVF (Davis, 2019). An additional six women were interviewed in 2019 in order to elaborate on the original project to examine race, racism and ART.

In what follows, I take up two concerns in relation to assisted reproduction and Black women. First, I describe in fuller detail the broader crisis of 'reproducing while

Black' in the US context. Explicating this crisis through the utilization of statistical data, I show the numerical instantiation of Black maternal health that depicts the realities of adverse birth outcomes in racial terms. As there is a dearth of anthropological scholarship on race and ART broadly, and almost no work on the engagement of Black women with ART, I show the limits of an approach in ART scholarship that focuses too narrowly on the question of (in)accessibility to ART. I follow this with a discussion of the broader reproductive crisis affecting Black women and how ART is part of that crisis. I then return to Melissa's narrative and the narratives of four other women to elucidate the different registers of how obstetric racism was manifest in their assisted reproductive lives. Finally, I conclude by pointing out that having access to ART does not preclude maternal crises when racism is factored into the analysis.

Scaling the crisis of reproducing while Black

Currently, a crisis hovers over Black maternal and infant health in the USA and is made knowable through corralling data, specifically the tabulation of life and death. Adverse outcomes, such as morbidity, are frequently reported in the press in the form of alarming statistics and case studies (Carpenter, 2017; Villarosa, 2018). Black mothers die during or within 1 year of giving birth at three to four times the rate of white mothers (Centers for Disease Control and Prevention, 2019; Smith et al., 2018). After a steady decline in premature births between 2007 and 2016, the rate of preterm birth in the USA began to increase and is just five-tenths away from being at its highest rate since 2007 (March of Dimes, 2019). Black women are three to four times more likely to give birth prematurely than white women.

These data do not cohere around class, so socio-economic status is not the only culprit contributing to these birth outcomes. What it does mean is that we cannot, nor should we, make low-income Black women and low-income women of all groups the scapegoats of poor birth outcomes. As I have shown elsewhere, professional Black women have birth outcomes that are not only explained by lack of access to resources or services (Davis, 2019). Rather, we must consider the role that racism plays in these outcomes. While racism is often understood to be structured in such domains as housing opportunities and employment discrimination (Prather et al., 2018), less attention is paid to how it is interpreted in the medical encounters of Black women. Moreover, there is little focus on crises that emerge in the context of the use of ART by Black women. Just what are some of those crises?

Race and ART

Melissa and the other women interviewed who used ART represent a small but growing percentage of Black women who employed reproductive technology. The familiarity of Black women with ART is now heightened due to well-known women sharing their conception and surrogacy stories, as Michelle Obama has done in her autobiography (Obama, 2018). Obama and other famous Black women have described using ART (Luna, 2018). Nonetheless, Black women, who have higher rates of infertility, are less likely to pursue infertility services than white women, and, when they do, the success rates are much lower (Shapiro et al., 2017; Wiltshire et al., 2019). Typically, differences in success rates are attributed to a combination of genetic factors, environmental issues, socio-economic status and behavioural factors (Tal and Seifer, 2013). While one study shows that, between 1999 and 2000, 86.5% of ART cycles in the USA were among white women, and Black women accounted for only 4.6%,[2] there has been an upturn in ART utilization. From 2004 to 2006, the use of ART among Black women increased to 6.5% (Feinberg et al., 2006).[3] A more recent study by Kotlyar et al. (2019) shows that while the use of ART by Black women increased slightly between 2014 and 2016 compared with the period between 2004 and 2006, there were still disparities in the successful outcomes between Black and white women.

Although reproduction in Black women has been a subject of inquiry across disciplines, scholars tend to discuss their use of ART narrowly, likely because their numbers are too small to accrue statistical relevance and therefore academic interest. Another potential reason for the narrow scope is that Black maternalism is presumably the result of coital 'unassisted reproduction' — to riff off of Charis Thompson's definition of 'assisted reproduction' (Thompson, 2005). Whatever the case, too little attention has been paid to various domains of this aspect of reproduction. Indeed, the use of ART by Black women has been characterized primarily in terms of unaffordability and inaccessibility (Ragoné, 1994; Roberts, 1998; Twine, 2012). Twine and Roberts both assess that ART resolves the crisis of infertility for white women, but frame ART as a crisis of unattainability for Black women. Roberts (1998), for instance, points to a reproductive technology caste system that contributes to the reification of whiteness. Similarly, American studies scholar Mason (1999) argues that ART has functioned in support of white supremacy through its representational practices in which the racial traffic of ART, fetuses and newborns centre whiteness.

However, race has been deployed for descriptive purposes (see, for example, Schmidt and Moore, 1998). In only a limited number of research contexts have scholars gone beyond using race as a marker of difference among ART users, and instead drawn from the particularities of the racialized experiences of people and foreground structurally constituted identities in relation to being treated differentially (Cussins, 1998; Rapp, 1999). In other instances, critics of ART focus on how advantage can be taken of people. Historian Marsha J. Tyson Darling argues that the biotechnology industry has the power and potential to exploit and subjugate people based on race, class, disability, age, sexuality and gender (Darling, 2006). It was not until the mid-2000s that we saw academics exploring the topic of reproduction, race and racism (Bridges, 2011;

[2] ART utilization in the USA is highest among Asian-Pacific Islanders in states that have an insurance mandate for IVF treatment. Asian-Pacific Islanders are followed by white non-Hispanics and then Black non-Hispanics (Dieke et al., 2017).

[3] Feinberg et al. (2006) did report that among women in the military, the differential in use of IVF decreased proportionally between Black and white women, most likely because they had insurance coverage.

Mullings and Wali, 2001) with increased attention to the fact that racialized groups were a market for ART-related procedures (Roberts, 2009).

Some discussions of race and ART have been generative, especially among anthropologists who explore the issue in transnational contexts. From them we learn how race is constructed through statecraft in India (Deomampo, 2016), and how race is achieved through the medical practices that accompany assisted reproductive means in Ecuador (Roberts, 2012). Essentially, analyses concentrating on Black women in the USA who do use ART and questions exploring how race, racialization and racism are interpreted in the process of securing ART, have remained elusive. Although the percentage of Black women using ART is small, there are precarities that are worth exploring. As we know that some Black women do indeed use ART, we must stretch the limitations of binaristic inquiries that highlight accessibility versus inaccessibility and success versus failure. A suppler inquiry seeks to understand that what unfolds in their lives is not only about the unobtainability of ART. It is also about the racism that intrudes upon reproductive processes in Black women when they access ART.

Obstetric racism as reproductive crisis

Many Black women interpret repeated exposures to various incidents or knowledge of the exposure that others have undergone as racism, and those interpretations do not arise out of nowhere. Indeed, they are the contemporary manifestations of ideologies, practices and exploitations of reproduction in Black women established during enslavement and imperialism (Cooper Owens, 2017). Since ideas about the Black body have circulated with such force, even in the absence of a direct act or incident, an action may be viewed as racism. Why? Because Black life induces such ruminations and continuously renders even the most mundane acts as possible acts of racism (Harper, 2000). One example is Melissa's appraisal concerning what happened during her time in India, which may be characterized as an intuition. Intuitions, as Phillip Harper calls them, rest on incessant encounters whereby a kind of way of knowing becomes the explanatory mechanism for the quotidian (Harper, 2000). It is not unusual or unreasonable for Melissa (or any other Black woman) to consider that an encounter is punctuated by racism given that reproduction in Black women has been the site of exploitation — including capitalist expansion, medical intervention, and legislative and medical control — even after the antebellum period. The aftermath of slavery has bequeathed a racial hierarchy of reproduction and medical treatment structured by economic, social and political forces, similar to stratified reproduction (Colen, 1995). Thus, obstetric racism exists in medical encounters that shapeshift from plantations to urban centres, from clinics to private hospitals to laboratories, and occurs in research and service provision. In each of those spheres, Black women can and do feel differentiated from other women, particularly white women. In what follows, I elaborate on the concept of obstetric racism to enable interpretation of the encounters of Black women as they attempt conception through ART.

The original four dimensions of obstetric racism were: critical lapses in diagnosis; being subjected to neglectful, dismissive or disrespectful treatment; being subjected to pain that was intentionally inflicted; and being coerced to undergo procedures (Davis, 2018). Here, I identify three additional attributes of obstetric racism: ceremonies of degradation, which represents the ways that Black women experience feeling or being degraded; medical abuse, which involves thinking or feeling that one was used for purposes of experimentation; and what I call 'racial reconnaissance', which describes the Herculean effort that Black women make to avoid or mitigate the racist encounters they presume they will encounter at IVF clinics.

Ceremonies of degradation

Ceremonies of degradation are the various ways that antagonize. They deploy the burden of embarrassment, humiliation, shame or holding someone emotionally hostage (Davis, 2006:68). Degradation is possible because the person(s) doing the degrading has power over the patient. Being 'sized up', as Melissa described, can be understood as a form of power that is exercised over someone. From Melissa's perspective, staff made determinations about her suitability, capability and the level of threat (or promise) she may have posed. 'Sizing up' was a mechanism of judgement, the contours of which rest, for instance, in a manner of speech or the clothes one is wearing — any characteristic that the person with authority deems an adequate measure to referee one's acceptability. However, such ceremonies can quickly be translated into a scene of subjection; as Hartman (2007) so eloquently argues, a performance that results from domination. It is the way that Black people are sometimes coerced into performing their Black selves to appear as non-threatening as possible. One performative expression some Black people use is smiling, an accommodation in the face of domination. The accommodation is a forced mastery; a form of compliance in an attempt to fit into the folds of a white imaginary of perfection. Achieving perfection is rooted in the belief that complying will serve as a protective measure against threats of repercussion. In Melissa's case, being 'sized up' required a performance of acquiescence resulting from her concern that not doing so might pose a risk to her chances of being treated properly during the IVF process. By Melissa's own admission, she did what she might not ordinarily have done when people asked such questions of her; in other words, she delivered an accommodation that facilitated securing the conception services for which she had paid.

Medical abuse

In the early 1990s, Ella, a Black woman aged 60 years when I interviewed her, was recently married and a state employee. Entering her fourth year of marriage and having had no luck at becoming pregnant, at age 35, Ella went to a fertility specialist. After 3 months of being 'pumped' with hormones and undergoing what she felt were experimental approaches to achieve egg production without a real plan, Ella ended her relationship with the clinic. Depressed and anxious from the trauma of trying, she waited a few months

and then found another fertility specialist who determined that Ella was unable to produce eggs. It was the second fertility specialist who suggested egg sharing. He 'enlisted' a woman who remained anonymous, was unable to conceive, and did not have the money for procedures to address her own infertility. The specialist suggested that Ella's insurance could cover the cost of medication to facilitate egg production for the anonymous woman. In return, Ella received 60% of the eggs for IVF while the anonymous woman received 40% of her own eggs. The doctor termed the transaction as an 'in-kind donation' and Ella agreed. The first egg harvesting produced seven eggs. Ella received four, all of which were implanted. The woman received three. Of the four, one 'took' and Ella gave birth to her first child, a girl. She underwent IVF a second time in 1998 and gave birth to a boy. The entire procedure cost approximately US$1500.

Ella experienced overlapping crises consisting of both infertility and obstetric racism, specifically medical abuse, due to how her infertility 'invited' what she saw as experimentation through the use of various hormonal cocktails to facilitate egg production. Of course, there are precedents confirming her opinion about Black bodies being used for experimental purposes: Black women's bodies have been used experimentally for reproduction-related processes. For instance, most people are familiar with experiments conducted by J. Marion Sims on enslaved women to correct vesico-vaginal fistulas, which he did without anaesthesia (Cooper Owens, 2017). Just over 100 years later, in 1973, the US Food and Drug Administration (FDA) learned that Depo-Provera caused breast cancer in Beagles and refused to fund testing its use as a contraceptive. However, according to Harriet Washington, in 1978, 'American doctors found it appropriate to administer Depo-Provera as an experimental contraceptive to healthy Native American and Black patients. In 1978, the FDA criticized Emory University for the study of Depo-Provera as having needlessly imperiled the lives of 4,700 women, all Black' (Washington, 2006: 206). An even more recent example of Black bodies having experimental use-value concerns coronavirus disease 2019. Two French doctors suggested that testing a vaccine for the virus should be conducted in Africa (Rosman, 2020). As experimentation has happened and continues to happen, the intuitive dimensions of Ella's sense of being experimented upon holds a logical place in the interpretation of her experience, and the same is true for other Black women.

Ella's story reveals another crisis in that the second doctor cast his use of Ella's insurance to facilitate egg production for a less-resourced woman whose eggs Ella would ultimately access as an 'in-kind' donation or a gift exchange. However, his perspective of the process as an exchange is not the only way to view this situation. While exploitation is typically meted against women who are under-resourced, Ella, who was very resourced, was exploited differently. The doctor brokered her desires to become pregnant by having Ella pay for someone else's eggs through her insurance in exchange for those eggs. This may be viewed as an aspect of affective market logics in which the other woman's eggs were being extracted for Ella based on the hopes that both of them would benefit. However, Ella had no way of knowing what the second doctor told the woman, because they never met. She did not know if the doctor received some payment from both women: one for a higher priced procedure covered by Ella's insurance, and possibly some payment or reimbursement from the anonymous woman. What Ella viewed as a good deal for both herself and the other woman also gestures towards an unethical engagement on the part of the doctor.

Of course, this situation may have occurred with any two women who went to this IVF clinic in the early stages of ART, thereby increasing the likelihood of gendered exploitation. However, Ella's subject position, as a Black woman, had her occupying the position of someone jeopardized by both gendered and racialized systems of domination.

Racial reconnaissance

Racism causes bedlam, and in certain situations — some more than others — requires the emotional and practical labour of avoiding it. The ART experiences of some Black women involved a form of racial reconnaissance because they assumed that obstetric racism would be part of the content of their medical experiences. They tried to mitigate those encounters but, in some instances, still experienced what they interpreted as racism.

Valerie, Selina and Angela are all African American women. Valerie and Selina, both lesbians, were in their 30 s when they sought ART, and both had 'successful' outcomes in that they conceived and birthed children. Angela, who is in a relationship with a man, is in her 40 s and at the time of writing was attempting to conceive using donor eggs and her partner's sperm.

While Valerie, Selina and Angela knew that their class status served as a protective mechanism in which their doctors would, and in Valerie's case did, treat her well, prior to selecting an IVF clinic, Valerie and Selina each articulated concern that racism would be a part of their ART-seeking medical encounters. Compounding Selina's primary concerns about racism was that she sought IVF as a lesbian in a southern state. She reported, "I called one clinic and said I wanted IVF but that infertility was not my issue. I said, 'We are a same-sex couple'. The doctor just went silent". Additionally, she mediated racism even when it was not explicitly present. Selina believes that doctors police the behaviour of Black people, viewing them as irrational. Not wanting to stoke that stereotype, she did what she considered to be a 'disservice' to herself by remaining calm and not being more adamant about how she felt and was treated during her labour. Selina's efforts to assuage being racialized and to deflect racism functioned as a form of self-managed arbitration.

Valerie and Selina searched for ART clinics that they might use, in their respective geographic locations, in order to eliminate those where they thought racism might surface. They used the possibility of encountering racism as a filter to assess their choice of clinic. Valerie said that she spent hours in search of clinics that would not treat her as a racialized 'other' when she and her wife sought to conceive. They were not only in search of the best services for IVF, but also wanted to find a care provider who would treat them — the Black lesbian couple that they were — with dignity. Wanting to minimize the likelihood that her doctor

would assemble a set of racialized characteristics on her body, Valerie noted that she 'curated the clinics and the doctors with great care'. They searched for clinics where they hoped racist encounters with medical professionals would be arbitrated by having attended elite schools and having the resources to pay for ART, and sought clinics where they would be treated with dignity. Valerie identified clinics within a 100-mile radius of where she lived, and would sit outside them to see how many Black people came and went. That measure of considering a clinic's suitability is unlikely something white women have to consider undertaking. In the end, an expression of obstetric racism asserted itself; what Valerie interpreted as a diagnostic lapse. Valerie told me that she got on quite well with the doctor at the clinic she and her partner ultimately chose. However, she recalled, "That maybe the doctor had some preconceived notions about Black women's fecundity, because she told me I should have absolutely no problem conceiving. I found this hard to believe because I was 'clinically obese' and have a rather serious thyroid condition". Valerie was right to express concern because hypothyroidism lowers the response to hormonal ovarian stimulation and there is a lower success rate of embryo transfer. In the end, Valerie believed that stereotypes of hyperfertile black femininity governed the doctor's medical judgement in her diagnosis.

Another point worth noting is that, like Selina and Valerie, Melissa's experience exemplifies how ART is a queer endeavour in contrast to coital modes of reproduction (Luna, 2018). ART is not only accessed to address the crisis of infertility, as was the case for Ella (Mamo, 2007; Smietana et al., 2018), but Black women intentionally deploy reproductive technology in the production of Black queer family making.

Angela's crisis of racial reconnaissance can best be described as 'Janus-like'. Angela began our conversation by sharing that when she decided to conceive, she searched for a gynaecologist and actively sought out a non-white male medical professional. Her decision resulted from two encounters 30 years earlier. Angela remarked that, at 18 years of age, she underwent an abortion performed by a white doctor who was very curt when he had to shift from giving her local to general anaesthesia. To her, the doctor appeared to be impatient and annoyed that things were not going as he anticipated, taking up more of his time than he wanted. In a second incident, shortly after the abortion, Angela planned to travel overseas, which required a medical examination. She saw a doctor who made a sexually suggestive comment about not being able to hear her heartbeat because of her breast size. Those two incidents led to mistrust, and Angela told me, 'Since then, I have never had a white male gynaecologist'.

Angela's search for an IVF clinic included wanting the best doctor. She did not, however, want to be treated disrespectfully, as she had been by the doctor who provided the abortion, nor did she want to feel objectified, as she did with the second doctor. As a Black woman, Angela sought to mitigate the potential of racism surfacing during her treatment, and did not want to be under the care of a white male doctor cognizant, as she said, 'of the kind of distortions and projections of Black women that white medical professionals carry'. When she met with the IVF clinic's medical director, Angela shared that her parents were physicians. Her goal was to circumvent being judged stereotypically and with the hope that clinic staff would treat her with greater respect. However, Angela admitted that in sharing the professional status of her parents, she was colluding with racial and class hierarchies by drawing on her class status in an attempt to be exempt from racial stereotyping. It worked, somewhat. On one hand, her interactions with the Latino doctor at the clinic located in the southeastern part of the USA went well — they had many things in common, having attended the same Ivy League university for undergraduate school. On the other hand, Angela was unable to establish any solidarity with the clinic's IVF coordinator, who ignored her calls; this left her feeling perplexed. She was frustrated with the lack of information when told she would have to take birth control pills after attempting artificial insemination and then deciding on IVF. Angela did not know why she had to take the pill or for how long. Multiple calls to the IVF coordinator went unanswered, which led Angela to panic. As a Black woman, the process of trying to reproduce felt, at times, like a crisis. Angela told me:

Crisis is what I am experiencing now. Who do I talk to? What do I do? I called to speak with the IVF coordinator who is not returning my phone calls. I don't know why. I don't know if it is race...I have that feeling of being in the dark and being beholden to the nurses and the services I am not getting. And I feel like my only option is to change clinics.

Angela believed that being Black led to the inattention of the IVF coordinator. She wondered if maybe the coordinator did not think Angela deserved to conceive because she was Black. Who knows? But that is exactly what can happen with racism: the lack of certainty if something is connected to racism is just as disconcerting as when one is certain. The fact that Angela thought race played a part in not having her calls returned led her to embark on a racial reconnaissance investigation to find a clinic that would meet her needs, where she hopefully would not have to be burdened by thinking that racism factored into her encounters. Ultimately, Angela changed clinics, locating one that was almost 300 miles from her home.

Narratives of racial reconnaissance spell out the imbricated stresses of 'reproducing while Black'. It is possible that non-Black women might experience similarly careless treatment. However, Black women, who have already learned to be vigilant in the face of racism, have longstanding reasons for perceiving such slights as racially motivated, whether conscious or not. Racism and its entanglement with medical history cannot be removed from the experience of fertility treatment.

Conclusion

Black women enter into situations concerned that racism will bleed into their lives, and their engagement with ART is no different. ART is often cast as inaccessible to poor and low-income Black people in contrast to white women whose access 'solves' the problem of infertility. While these characterizations are not untrue, they flatten out the contours of reproduction in Black women. Based on

conversations with my interlocutors, we can understand the apprehensions and mistrust that accompany the treatment of Black women by medical and clinic staff as they seek to fulfil their desires to create family. The interpretations of those encounters reveal that access to ART does not preclude crisis. Adverse birth outcomes represent one of a number of crises that Black women experience in reproduction. However, when they are utilizing ART, we can shift the focus to adverse conception processes. When we frame the issue of ART and race in terms of inaccessibility and unaffordability, there is an underlying presumption that accessibility and affordability will produce positive results. Of course, the provisional nature of infertility treatment affects all women seeking ART. However, the point I am making in this article is that previous and ongoing encounters of Black women with medical racism multiply stress, uncertainty and the need for profound vigilance in an already burdensome situation. By investigating the entanglements of Black women with ART using obstetric racism as the framework, we find that crisis comes in different forms all along the continuum including pre-conception, conception, loss, pregnancy, labouring, birthing and post partum. We can also point to where various nodes of chaos, caused by racism, are located. Obstetric racism refuses to allow points of chaos to fade into the background when discussing reproduction generally, and ART in particular. Instead, naming obstetric racism urges us to remain alert to what racism feels like to people who are most harmed by it.

I do not expect obstetric racism as the framework for understanding medical encounters to be a perfect theoretical articulation of the types of experiences of Black women, but it is an important feature of the logics of reproductive biomedicine. Black women possess a situated knowledge of Black life that serves as a crucial point in understanding where obstetric racism is asserted, and their views are based on having had particular racialized experiences. The everyday nature of racism circumscribes the speculation that there are generalized forms of exploitation in the process of securing and utilizing ART. Rather, obstetric racism attends to differential histories, experiences and knowledge of the reproductive lives of people.

Every crisis may be experienced broadly relative to the categories of being a woman, a lesbian, of a lower socioeconomic status, or any other all-encompassing subject position because the logics of reproductive biomedicine come with power differentials. However, we must also recognize the ways that people discuss, understand and interpret their crises, which are lived in racial terms. Obstetric racism allows us to investigate the entanglements of Black women with ART. Silence around racism and discriminatory practices most certainly bleeds into reproductive health care and ART, and for the women in this article, the body is a site of racial experience (Fassin, 2001).

I am reminded of the degree to which the Black body is a site of racial experience when I re-read scholar Deirdre Cooper Owens' traumatic story in her book *Medical Bondage: Race, Gender, and American Gynecology* (Cooper Owens, 2017). In the Afterword, she describes that after deciding to undergo IVF, she saw a fertility doctor who subjected her to a dilation procedure, twice, without the use of anaesthesia. The pain was overwhelming and the belief she was impervious to pain was a remnant of the historical gaze of J. Marion Sims who, as I mentioned earlier, conducted experiments on enslaved women without anaesthesia. Deirdre Cooper Owens, Melissa, Ella, Valerie, Selina and Angela carry the burden of racism in their stories, illustrating how it structures reconsideration of ART. Their stories allow us to place the use of ART by Black women on a continuum of concern rather than as evidentiary binaries of white accessibility versus Black inaccessibility; white wealth versus Black poverty; success versus failure. We can locate crisis in contexts that result from a fine-grained assessment of the predicaments faced by Black women. As Cooper Owens sardonically and accurately commented, 'The legacies of the nineteenth century are always present' (Cooper Owens, 2017: 124).

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