Rhetorics of Motherhood, Agency, and Reproductive Injustice in Healthcare Providers' Narratives

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Discriminatory policy structures related to segregation, criminalization, environmental regulation, and loan financing intersect to create severe racial inequities in reproductive health. These structures, and their material consequences for human lives, are constituted and perpetuated through discourse. Dominant narratives (DNs) provide stories that naturalize inequalities and are repeated until they become "common sense" by cultural members. The Reproductive Justice Movement (RJM) was founded by women of color activists and scholars to change oppressive structures and to promote the reproductive and human rights of all people. RJM activists have used personal stories as a resistive tool, recognizing that resistive stories can destabilize the taken-for-granted nature of DNs and the violent structures they uphold. In this article, we perform a Critical Narrative Analysis of three personal stories shared by reproductive healthcare providers to understand how their stories can perpetuate and/or resist oppressive DNs through their construction of marginalized patients as characters. We found that, in constructing narratives of patients, participants relied on three main DNs: Western Modernity, White Supremacy, and Neoliberalism. Drawing on these DNs, providers characterize patients as: Good or Bad (M)others, Victims, and Adversaries. Our goal is to show that narratives created with providers are political texts that constitute understandings of patients' reproductive lives. We

conclude with a re-telling of one narrative to emphasize the goals of reproductive justice and highlight the importance of re-framing the inequitable present in order to imagine equitable futures.

Significant reproductive health inequities exist between White women and women of color (American College of Obstetricians and Gynecologists 2015; Owen, Goldstein, Clayton, and Segars 2013). Traditionally, public health researchers have positioned "lifestyle choices" as the cause of these disparities (Ross, Roberts, Derkas, Peoples, and Bridgewater Toure 2017). However, there is growing recognition of the ways in which structural forces—such as segregation, criminalization, environmental regulation, and loan financing— have led to different opportunity structures and, therefore, health outcomes for Whites and people of color (Omi and Winant 2015).

The Reproductive Justice Movement (RJM), a mode of theory and activism conceptualized and led by women of color, has promoted the shift from individualist to systemic approaches to improving reproductive health (Ross et al. 2017). Reproductive Justice highlights "three interconnected human rights values: the right *not to have children* . . . the right *to have children* under the conditions we choose; and the right *to parent the children we have* in safe and healthy environments" and particularly attends to the intersectional forms of oppression that affect women of color (Ross et al. 2017, 11).

Sharing personal narratives is one tactic for engaging in political organizing (Polletta 2008b). Creating and telling narratives has been key for many political movements, including women activists in Latin America and advocates for Black liberation in the U.S. (Collier 2019; K. M. Smith 2010). Creating, sharing, and listening to narratives has been a key tactic for RJM because narratives have the potential to transform our perspectives and relationships (Ross 2017). Narratives are powerful rhetorical devices which engage not only our intellects but also our emotions, aesthetic sensibilities, memories, and values (Charon 2012).

Healthcare providers (HPs) are important sources of cultural narratives around reproductive health; their privileged status in Western societies, technical expertise, and roles as "witnesses" position HPs as credible narrators (Mullan, Ficklen, and Rubin 2006). Based on a recognition of HPs' stories as political texts—particularly potent forms of speech which may influence knowledge, beliefs, and ideologies—in this article we conduct a Critical Narrative Analysis (CNA) of three stories shared by HPs. In these narratives, participants discussed their experiences caring for a marginalized patient and engaged with issues key to RJM: structural injustice, patient agency, and motherhood. Our goal through this analysis is to understand how HPs construct these key issues and how, in doing so, they may maintain and/or contest oppressive structures. In what follows, we first introduce CNA as a theory, outline three dominant narratives that are key to understanding our participants' stories, and describe our analytical process. We then present our data (i.e., the stories we analyzed), our findings, and our reflections on how these stories could be told differently.

CRITICAL NARRATIVE ANALYSIS AS THEORY

Critical Narrative Analysis (CNA) is a theoretical and methodological approach which analyzes personal narratives to understand relations of power, oppression, and liberation. Here, "narratives"[1] are defined as discursive and symbolic formations which "organize events across time and space, identify characters and their relationships, and determine causes and effects" (Harter and Chadwick 2014, 912). CNA assumes that discourses and structures (e.g., policies, institutions, etc. which distribute material goods) are co-constitutive and mutually reinforcing because "social actions become realities through discourses" and, at the same time, patterns of discourse are "rendered meaningful through certain structural arrangement⌈s⌋" (Dutta and Zoller 2008, 30). Therefore, scrutinizing discourses/narratives is a tool for understanding how health inequities are produced and perpetuated. In CNA, personal stories are a particularly important discourse genre because "personal narratives are constructed and situated in social and institutional realms . . . when individuals make sense of their experiences through narratives, they bring together

1 For the purposes of this article, we use "narrative" and "story" interchangeably.

the micro (personal) and macro (social or institutional) situations in place" (Souto-Manning 2014, 163). Thus, CNA provides a way of understanding the connections between oppression at the structural level and the lived experiences of individuals.

One generative way of understanding power, control, and resistance in personal stories is to examine the extent to which dominant narratives are taken up, recycled, and/or contested in these stories (Souto-Manning 2014). Dominant narratives (DNs) are essentially "cultural codes" which constitute, uphold, and naturalize "dominant systems of knowledge, power, and discourse that comprise the symbolic order" (Buchanan 2013, 6). In these narratives we are concerned with the cultural code of "motherhood" which is applied unevenly across intersectional social identities including race, class, and gender.

By naturalizing socially constructed phenomenon and inequalities, DNs maintain the stability of social inequalities (Delgado 1989). DNs are spread through powerful social institutions, such as schools, news media, and legislation, so that they become familiar and taken for granted by cultural members (Delgado 1989). While scholars have identified many DNs, through our analytical process (described below) we identified three DNs that narrators clearly engaged with in their stories: Western Modernity, White Supremacy, and Neoliberalism.

Western Modernity is the dominant narrative of European coloniality which valorizes scientific knowledge produced by those who claim objectivity and neutrality and works to delegitimize forms of knowing which recognize emotionality, subjectivity, and fragmentation (Dussel and Ibarra-Colado 2006; Hedge 1998, 277; Broadfoot and Munshi 2007). *White Supremacy* complements Western Modernity by constructing White people (and attributes associated with Whiteness) as superior, natural, and normal and people of color as inferior, irresponsible, and expendable (Bonds and Inwood 2016). *Neoliberalism* is a dominant narrative which supports competition-driven markets by constructing individuals "as autonomous, rational producers and consumers whose decisions are motivated primarily by economic or material concerns" (Farmer 2004, 5). Neoliberalism

naturalizes racial inequities by suggesting that, if people of color experience higher rates of poverty or illness, this is due to poor choices rather than discrimination or inequitable distributions of resources (Omi and Winant 2015). Having introduced these three DNs, we now turn to discussing the methods we used to generate our data and to identify these DNs as key to our participants' stories.

RESEARCH METHODOLOGY

Data Generation

Data for this study were produced as part of a larger study on the intersections of race, reproductive health, and policy (Cusanno 2019). Study recruitment began in August of 2018, after the project received University of South Florida IRB approval. All healthcare providers (HPs) who had completed their medical training, could participate in an English-only interview, and frequently discussed reproductive health with patients were eligible to participate.

We conducted twenty-four semi-structured interviews addressing a broad range of issues (including contraception counseling, pregnancy ambivalence, and abortion care) in order to solicit rich, evocative narratives from participants (Lindlof and Taylor 2019). This resulted in 816 pages of transcripts, all transcribed by the first author (BRC). Both authors have positionalities with investments in creating a racially just healthcare system for themselves and others. As a White, cisgender woman living with stigmatized chronic illnesses, BRC has direct experience being told, both by HPs and by broader cultural narratives, that she is not worthy of motherhood. As a woman of color, the second author (NK) often navigates complex birth control counseling that is both oppressive and empowering. As reproductive justice advocates, we hope to influence the field medicine to critically engage with pervasive gendered, raced oppressions.

Critical Narrative Analysis as Methodology

CNA integrates thematic, interactional, and structural approaches to narrative analysis (Riessman 2005), scrutinizing both *how talk is accomplished* through interaction and *what meanings are produced* through talk to understand how power operates through everyday narratives (Souto-Manning 2014). In contrast to thematic analysis, CNA necessitates close readings of "an extended account preserved

and treated analytically as a unit" (Rance, Gray, and Hopwood 2017, 2223). CNA provides a granular perspective which is useful for identifying points of tension and contradiction that might otherwise be overlooked (Rance et al. 2017). Our approach to CNA involved iterative, cyclical processes (S. J. Tracy 2012). These three processes were: identifying narratives, analyzing narratives, and (re)creating narratives.

BC identified narratives by reviewing transcripts to distinguish sections in which HPs shared stories about specific patient cases. BC then reread these sections, ultimately selecting three stories which centered on structural oppression, motherhood, and agency for further analysis, due to the granular method of CNA. We then analyzed narratives through a process of "close reading," using the taxonomy of questions included in CNA (Cusanno 2019) as a guide. By comparing our data to existing reproductive justice and health literature, we identified three DNs (Western Modernity, White Supremacy, and Neoliberalism) that were useful for understanding how our participants engaged with the concepts of motherhood, agency, and structural oppression. We (re)created narratives by revising and shortening participants' stories to present in this article, given the space constraints of the journal. However, readers should note that the narratives presented below are *not* the actual transcripts we analyzed, but abbreviated versions we created based on the original transcripts. To view the transcripts of the full narratives, please see the online supplemental file available.

Narratives

Below, we present abbreviated versions of our participants' narratives, based primarily on direct quotes drawn from interviews. Some of what we discuss in our analysis is not included in the abbreviated narratives below. Therefore, we hope readers will review the transcripts included in the supplemental file so as to fully engage with our findings. We also note that all participants chose their own pseudonyms. Pseudonyms used for patients referenced by participants were chosen by the authors. Dr. Stacy and Dr. Scott are both obstetrician-gynecologists who practice in a university medical setting. Nurse Jane is an experienced nurse who works at an obstetrics

clinic that primarily serves women with high risk pregnancies who receive Medicaid insurance.

Dr. Scott's Narrative

There's such an idea of, 'We're in a meritocracy.' The idea that if you work hard, you'll get somewhere. But that's not *true.* That's not true when you constantly get a hit from something you can't control. If you really wanna make a meritocracy, you need to raise the whole standard of living.

I had a patient in residency, Sarah. She had a heart condition, caused from smoking crack cocaine. It was this horrible story of all the ups and downs. She had premature twins. Could we have tied her tubes? Yes. But we didn't. We weren't sure the babies would survive.

Years later she comes back, pregnant again. You talk about, 'Planned or unplanned pregnancy?' She'd been told she can't have birth control, because of the cocaine heart problem. You talk about, 'Why didn't she use condoms?' Her living situation was shaky. She had no job. She can't get a job.

So, she has this accidental pregnancy. She doesn't believe in termination, but she can't *bear* the idea of going through it all again. If she didn't terminate, she had a 50% chance of death. She has other kids. She wants to go home. She decides to terminate. And after all that, she was the most thankful person.

I wonder sometimes, 'What would it take me to do cocaine? How crappy does your life have to be, that smoking crack actually sounds like a good idea?'

There's so many places someone could have intervened in Sarah's life. That would have made such a big difference. With psych. With an IUD. That would have made a *huge* difference. She wouldn't have had to go through that termination. She wouldn't

have had to make that choice.

Nurse Jane's Narrative

It's like a revolving door, at this clinic. Talking to people about birth control. Trying to get them to use it. We make it easy for them. We give out condoms. We're discussing birth control from the *minute* they come in. But you see these people getting pregnant over and over and over and over again.

We had one lady, Kye. She's had nine children, all in foster care. She's been in jail. Prostitution. Drugs. She had a court order to come in here and get Depo [contraception shot]. A court order! Okay? She stole another patient's urine so she could pretend she was pregnant and we couldn't give her birth control.

'Why? Did she want to have another baby?'

Yeah. Cause she keeps thinking she's gonna be able to keep custody of the next one.

Another patient, Lee, says God told her that she should have as many kids as she can. She doesn't have a place to live. The Department of Child and Family Services is investigating her. We're always doing whatever we can to get these people on birth control.

Dr. Stacy's Narrative

The things that keep me up at night? I wouldn't say they are policies or systems. They're medical things and dead babies and decision making. Like Rhea, a multiple drug user who has a still birth. Her baby, dead in my arms. I watched her roll away to the ICU.

Nobody thinks about what it's like to deliver a dead baby.

To watch a patient die in front of your eyes.

About the toll it takes on the people who care for them.

Six, maybe seven months later, Rhea's pregnant again. It's selfish. It's not. It's more complicated than that. But it's selfish.

I almost quit before I finished residency. We've told doctors that if they're good at what they do, if they're strong, that they will never feel that way. That's why people finish residency and say, 'I hate the person I became.' We don't acknowledge that it's a broken system. That it's a system designed to destroy.

ANALYSIS

Through analysis of Nurse Jane, Dr. Scott, and Dr. Stacy's narratives, we found that attending closely to their constructions of themselves and their patients as characters was a useful way to understand the political work accomplished through these stories. Consequently, we present our findings and analysis through examination of the three sets of characters we identified in these narratives: The Good Mother and Bad (m)Other; the patient as adversary, the HP as victim; and the patient as victim. Below, we discuss each of these characters in more detail.

The Good Mother and Bad (m)Other

Buchanan (2013) writes that "Mother" and "Woman" exist on a rhetorical continuum and are expressions of the cultural code of "motherhood." "Mother" is associated with positive attributes and used to praise while "Woman" is associated with negative attributes and used to condemn (Buchanan 2013, 8). "Bad mothering" thus is associated with attributes on the "Woman" side of the continuum; women are condemned by associating motherhood with traits such as selfishness and irresponsibility. In our analysis we understand

this relationship as narratives of "the good mother" and "the bad (m)Other." These narratives are upheld through the use of "shame rhetorics" which (re)produce "logics of sexual purity, coded 'correct' motherhood" (Adams 2016, 92). "Correct" motherhood, the "good mother," is a raced concept associated with following a cisgendered White heteronormative bourgeois life scripts (Adams 2016; Mann 2013). The bad (m)Other, then, is poor, unmarried, Black, and jobless (Bloom and Kilgore 2003; Roberts 2012). Being labeled as Bad (m)Others is an othering process through which marginalized women are constructed as so irrevocably different from "the good mother" that they must be shut out from motherhood via institutionalized surveillance, management, and punishment (Bloom and Kilgore 2003). The following analysis highlights moments where shame rhetorics are prevalent in HPs sensemaking of their patients.

Nurse Jane's baseline frustration with patients who become pregnant repeatedly suggests a general disregard and devaluation of the reproduction of her patients (who are almost all low-income and who are disproportionately Black). In describing her patients as "lazy," promiscuous (e.g., "they just keep doing it and doing it…"), and hyper-fertile (e.g., "they keep getting pregnant over and over…"), Nurse Jane draws on stereotypes about Black women (Ehrenreich 1993; Roberts 2017) to position her patients as Bad (m)Others who do not follow the White, bourgeois, heteronormative script. As she emphasizes that the clinic staff are "always trying to do whatever we can to get these people on birth control," Nurse Jane implies that her patients "have neither the right to become mothers nor the legitimacy to claim that their care work for dependent children and family members is meaningful" (Bloom and Kilgore 2003, 365–366).

Nurse Jane is vociferous about her frustration with two specific patients, Kye and Lee, who continue to reproduce despite their histories of drug use, sex work, incarceration, housing instability, and surveillance by foster care. In Nurse Jane's narrative, these patients are prototypical Bad (m)Others, as they exist completely outside the norms of private property ownership, respectable participation in labor markets, and middle-class lifestyles.

Similarly, Dr. Stacy suggests that by using drugs Rhea "not only killed her baby but also led to a lot of mental health issues for a lot of people" and that she was "so selfish" for becoming pregnant again soon after her stillbirth. While she acknowledges that drug use is "more complicated than that," by stating so forcefully that Rhea "killed" her baby, Dr. Stacy makes it evident that Rhea's actions constitute bad (m)Otherhood.

Nurse Jane's narrative demonstrates clearly how the character of the Bad (m)Other becomes violently, materially (re)produced in interpersonal interactions. Because she constructs her patients as Bad (m)Others who do not deserve to parent, Nurse Jane becomes conscripted into state efforts to forcibly control Kye's reproduction through court-ordered contraception. Here, basic bioethical principles of respect for patient autonomy and nonmaleficence have been abandoned (Roberts 1996).

Ehrenreich (1993) argues that "court-ordered treatment of women of color may constitute a coercive response to their acts of resistance to doctors' control of their reproduction" (Roberts 1996, 134). We contend that we should interpret Kye's court-mandated contraception in the same way, i.e., as a punitive response to her defiance of normative motherhood. While Kye is White, the systems which seek to control her should be regarded as White Supremacist systems, as women of color are disproportionately surveilled, disciplined, and assaulted by prison, foster care, and biomedical structures (Roberts 2017). When White mothers are affected by these systems, their punishment can be understood as a consequence of "acting too much like Black women" by deviating from the White, heteronormative, bourgeois script (Roberts 1992, 26).

Similarly, Dr. Scott's narrative focuses on a patient who would likely be cast as a Bad (m)Other in dominant narratives—Sarah is poor, unemployed, and has a history of drug use. Dr. Scott wishes that Sarah had not become pregnant again after her premature twins, but not because she feels her patient is incapable of being a mother. Instead, Dr. Scott felt concerned about the Sarah's health and upset that Sarah had to make the choice to terminate a pregnancy. Rather than portraying her as a Bad (m)Other, Dr. Scott represents Sarah's

desire to be a mother to her living children as one of the primary reasons she chose to end her pregnancy ("She *does* have the other kids. She does wanna go home"). To present Sarah as a Good Mother (or, at least, as a woman who deserves to have and raise children) despite dominant narratives which position patients like Sarah as Bad (m)Others, Dr. Scott needed other ways to characterize her patient. In the next section, we argue that Dr. Scott accomplished this by casting Sarah as a victim.

The Patient as Victim

A key difference between Nurse Jane and Dr. Stacy's constructions of their patients and Dr. Scott's portrayal of Sarah was the degree of agency narrators attributed to their patients. Patients in Nurse Jane's narrative were quite active; they become pregnant "over and over and over and over again," steal other patients' urine, and defy a court order. In Dr. Stacy's narrative, patients are also constructed as agents—particularly in contrast to their healthcare providers, as we discuss further in the next section. Instead, in Dr. Scott's narrative, Sarah is presented as powerless. She is often marked grammatically as the passive object of others' actions ("She'd been told"; "no one had given her"; "we've gotten her asleep"). Dr. Scott emphasized Sarah's lack of resources, her disability, and other constraints in her life ("She can't get a job … [she] is permanently disabled"; "She just gave up"; "[Sarah] had a lot of insecurities"). Dr. Scott positions Sarah as a Victim, a character who "is narrated as [an] innocent and (sometimes) powerless victim of a stronger, more forceful tyrant. When narrated as powerless, the victim is vulnerable and might require rescuing" (Monrouxe and Rees 2017, 308).

Dr. Scott's portrayal of Sarah reflects a "victim" genre of political stories used to counter Neoliberal dominant narratives that suggest poverty stems from personal failings, such as laziness and psychological dependency (Polletta 2008a). Dr. Scott emphasizes, "There's so many different places someone could have intervened in her [Sarah's] life" and "at one point could someone have intervened . . . that would have fixed [Sarah] ever going down that path?" In this story, Sarah is a defenseless Victim who needs to be rescued by others; she is an object to be fixed rather than an agent in her own right. Because Dr. Scott presents Sarah as a Victim who deserves

sympathy and intervention, she can avoid casting Sarah as a Bad (m) Other who can be held to account for her situation. Constructing Sarah as a Victim is, in other words, an exculpatory move which frees Sarah of blame or responsibility.

However, while perhaps less explicitly than the Good Mother and Bad (m)Other characters, the Victim figure is also tied to DNs of White Supremacy and Western Modernity. Historically, these DNs have described people racialized as Black[2] as having limited sentience and agency and, therefore, dependent on White people and scientific technologies to "save" them (Sastry 2014). Razack (2007) argues that stories which cast Black people solely as victims and bearers of suffering simultaneously objectify Black 'victims' and provide a source of pleasure and moral satisfaction for White people. In such stories, White people—under the guise of empathy—often imagine themselves in the place of the Black 'victim,' so that the focus of the story becomes the White person's imagined pain rather than the lived experiences and subjectivities of Black people themselves: "the nearer you bring the pain, the more the pain and the subject who is experiencing it disappears, leaving the witness in its place" (Razack 2007, 377). This pattern is evident towards the end of Dr. Scott's narrative when she imagines how much pain she *herself* would have to be in to use crack cocaine. In foregrounding her own fantasies about "how crappy" a patient's life must be for them to think that using crack cocaine is a "good idea," Dr. Scott "begins to feel for [her]self rather than for those whom this exercise in imagination presumably is designed to reach" (Hartman 1997, 19). Most importantly, through this discourse Sarah is positioned as an object to be intervened upon by an unspecified "someone" rather than as an agent who acts and makes choices within marginalizing structures. Consequently, through her well intentioned efforts to argue for more resources for patients like Sarah, Dr. Scott reinforces oppressive narratives which position people of color as less capable and sentient than Whites.

2 While Dr. Scott never shares Sarah's race, crack cocaine is a highly racialized drug and is typically associated with Black people, whereas powder cocaine is associated with Whites (and carries a much lesser prison sentence) (Roberts 1991). Therefore, while I do not know Sarah's race, we can understand how Sarah's story as a person who used crack fits within larger narratives about Black people.

In contrast, Dr. Stacy and Nurse Jane do not portray their patients as Victims devoid of voice or agency. However, their constructions of their patients are hardly empowering. In the next section, we argue that Nurse Jane and Dr. Stacy used evidence of their patients' agency to construct them as adversaries.

The Patient as Adversary, the Provider as Victim

Dr. Scott's patient is rendered blameless within her narrative because she is constructed as an agency-less Victim. In contrast, Dr. Stacy and Nurse Jane construct their patients as active agents and, in doing so, create opportunities for them to be cast as Bad (m)Others who should be held responsible for their own and others' suffering. Constructing patients as active agents also positions them as violators of the dominant "biomedical" set of social norms which guide clinical interactions, in which patients are supposed to be "patient," quiet, obedient, and subservient to healthcare providers—especially physicians (Cushing and Metcalfe, 2007).

This becomes especially problematic within the context of Neoliberal and Patriarchal depictions of power. Within such narratives, power is typically conceived of as coercive, a zero-sum game in which one actor can exercise their power over others through suppression or domination (Banerjee 1988). This conception of power suggests that, if patients have more power, healthcare providers necessarily have less power and may become vulnerable to domination from tyrannical patients.

This dynamic plays out in Nurse Jane and Dr. Stacy's narratives. Dr. Stacy repeatedly emphasizes her own helplessness and the helplessness of other HPs ("I carry those scars … for something that I don't have control over"; "you can't do anything about it"). She also highlights her powerlessness by grammatically positioning herself as a passive object who is pushed by others' actions ("she was the trigger for me ending up in therapy"; "it's still something that doesn't make me feel great") and by describing herself as a viewer who can only witness, but not intervene, in the world around her ("what it's like to watch a patient die in front of your eyes"; "I have sat in a room and watched nurses sob"). Dr. Stacy further emphasizes how her behaviors, particularly her emotional displays, are constrained by

norms and rules about how HPs should act ("You're allowed to show some emotion …"; "As the attending, you're really supposed to …"; "And now it's my job to say …").

Contrastingly, Dr. Stacy constructs her patients as quite agentive. She describes her patients as actively making choices which have real consequences ("It's because patients did something that they really shouldn't have done"; "Those decisions that she made, not only killed her baby but also led to a lot of mental health issues for a lot of people taking care of them"). In Dr. Stacy's narrative, patients have the power to write articles which (negatively) define what it means to be a physician, to sue doctors who have done nothing wrong, and to inflict mental anguish upon their HPs. While a great deal has been written about the power of physicians (Brody 1994; Starr 1982), Dr. Stacy suggests that doctors are at the mercy of litigious patients and slanderous writers, as well as dominant cultural narratives which dictate how physicians can(not) express emotion.

Nurse Jane's narrative also conveys a sense of collective victimization experienced by HPs. For instance, her use of the pronoun "we" discursively constructs an adversarial relationship wherein the clinic staff are a cohesive group engaged in an ongoing struggle *against* the patients. What's more, Nurse Jane seems to indicate the patients are *winning* this struggle. Even though the staff are constantly trying to "do whatever we can to get these people on birth control," patients "keep getting pregnant."

Framing patients as adversaries, particularly when there is a focus on in-group (provider) and out-group (patient) power struggles, forecloses opportunities for collaboration and partnership between patients and HPs. Here, then, patient autonomy is not an ethical principle for building meaningful and just relationships, but a tool for casting these patients as enemies. Furthermore, this characterization of patients as autonomous adversaries detracts attention from structural injustices. Dr. Stacy insists that the poor health outcomes she witnesses are usually "not the fault of a system" but are "just personally difficult situations," such as patients using drugs or "going into the woods" to give birth. This framing ignores that drug misuse may be related to lack of support services or treatment programs,

and that patients may wish to avoid a medicalized birth experience because they are wary of institutionalized medical oppression (Anderson, 2017). In sum, the figure of the Patient Adversary makes it difficult for HPs to understand patients compassionately, to recognize the structural causes of health inequities, or to advocate for structural change and social justice.

DISCUSSION

In this article, our goal has been to understand healthcare providers' (HPs') stories as power-infused rhetorical texts and to illuminate the political implications of HPs' constructions of themselves, their patients, and issues within the healthcare system. Through a Critical Narrative Analysis, we found that the issue of agency was central to participants' constructions of their patients as story characters. Through analyzing and critiquing HPs' stories, we do not aim to castigate or condemn individual participants. In fact, we believe that Dr. Stacy, Dr. Scott, and Nurse Jane work hard to be kind, compassionate, and professional HPs. Rather, our aim is to highlight how these individual stories, when told in the context of a highly unequal society, can reflect and perpetuate oppressive dominant narratives (DNs). By contextualizing participants' stories within the DNs of Western Modernity, White Supremacy, and Neoliberalism, we can begin to understand why individuals might tell their stories in the ways that they do and how these stories could be narrated differently (Woodiwiss 2017).

Using characters drawn from DNs—such as the Bad (m)Other and the Victim—is a way to make personal stories recognizable and persuasive to listeners (Polletta 2008a). Listeners may evaluate the credibility of stories by comparing them to stories they've heard before (Polletta 2008a, 27). Therefore, one strategy for telling stories that are rhetorically powerful is to craft personal narratives that resonate with stories that are familiar to one's audience (Polletta 2008a). Because Western Modernity, White Supremacy, and Neoliberalism are dominant stories in the U.S., narrators can be limited by the frameworks these DNs provide (Woodiwiss 2017). This is to say that, rather than blaming individual HPs, it is important to recognize that their stories are constrained by and told in response to the DNs

that are currently circulating within their cultural environment (Woodiwiss 2017).

It is vital to look beyond these DNs and their manifestations within participants' personal stories and to ask whether better stories could be told about motherhood, patients, providers, and healthcare systems (Woodiwiss 2017). We suggest that reframing these stories using the notion of co-active power could be useful. Co-active power is an alternative way of conceptualizing power, moving from framing power as domination (power-over) to power as arising through relationship building and recognition of human interconnectedness (power-with) (Whipps 2014).

A co-active power perspective enables narrators (like our participants) to emphasize that both patients' and HPs' actions are constrained by cultural and structural formations. For example, Dr. Stacy articulates how the cultural expectation that HPs remain stoic and emotionally detached (Monrouxe 2009) makes it difficult for her to empathize with patients like Rhea. While framing Rhea's choice to have another baby as selfish, she also clarifies, "It's more complicated than that, and addiction is a big deal. But it's hard not to feel that way. Because everybody cares about what the patient experiences when something horrible happens. Nobody really cares about what the providers feel." Thus, the lack of attention and acknowledgement of providers' emotional pain within DNs makes it difficult for Dr. Stacy to appreciate complexity and nuances in the lives of patients like Rhea. Rather than blaming Rhea for her pain, however, viewing power as co-active might enable Dr. Stacy to acknowledge that both HPs and patients face structural and cultural marginalization.

Adopting a co-active power perspective would also enable HPs to recognize that patients can be victims of oppression while also being agents who act with creativity and resilience (Banerjee 1988). Integrating this perspective might help HPs reimagine the patient-provider relationship as one in which "responsibility, voice, and authority" are shared as HPs and patients "take action together … and work to enhance the circular nature of their relationship" (Whipps 2014, 416). Rather than regarding patients' voices or actions as threats to HPs' status or power, then, these stories could catalyze reflection

upon the ways in which patients' voices and actions challenge HPs' worldviews and how they might work to pursue shared goals in the face of such challenges.

These narratives could also be reframed to promote structural changes that would support economic security, housing stability, addiction treatment, mental health care for patients and HPs, racial equity, and the right to parent children in safe communities. While these kinds of stories may be harder to tell and potentially less persuasive within the U.S.'s current cultural context—in which oppressive DNs remain dominant—they would echo and support the narratives shared by activists within the RJM movement. Reproductive justice advocates have told narratives that center the needs to protect human rights, shift to relational understandings of power, and change economic and political structures to support reproductive health (Ross et al. 2017). RJM activists and organizations such as Staceyann Chin (2009), Keeonna Harris (2019), and Forward Together (2019) have told stories that offer examples for how reproductive justice inflected narratives may be crafted.

We hope that this method of critically analyzing narratives emphasizes the importance and consequences of sensemaking around "Motherhood" even throughout everyday interaction. We must take seriously how the use of shame rhetorics have impact on the material lives of Black women and implement more racially just conceptions of motherhood in our daily lives. The practice of conceptualizing racially just motherhood must include advocating for policy changes in institutions that devalue and police Black motherhood as Bad (m)Otherhood (i.e. the foster care, welfare, and healthcare systems) (Gillman 2014; Robert 2017). The field of medical education, in particular, should consider how current methods of birth control counseling manifest racist shame rhetorics. Other authors in this special issue provide further exemplars of this practice. With this in mind, we conclude this article with a retelling of Nurse Jane's story about Kye which we hope acts as a "Counterstory" to oppressive dominant narratives (Delgado 1989; Martinez 2014). "Counterstory" is a methodology of Critical Race Theory which emphasizes that an understanding of racism must privilege the embodied and experiential knowledge of people of color (Martinez 2014). Counterstories allow

for "challenging the status quo with regard to institutionalized prejudices against racial minorities" (Martinez 2014, 37).

We encourage the use of Counterstories among HPs and researchers, who are witnesses of stories turned bearers of stories. By creating Counterstories, HPs and researchers can channel their social authority towards re-storying how marginalized mothers move through an unjust system. This act of Counterstorying allows HPs to subversively highlight the tensions, strength, power, and beauty (m)Others know and, thereby, become more generous witnesses and just bearers of reproductive stories themselves.

Thus, we offer a possibility for Kye's Counterstory:

> Kye is a woman who deeply wanted to be a mother. She would not give up, even as she was told motherhood was not for her. Her children were taken from her because she could not prove that she would raise them in a White middle-class lifestyle. A judge ordered her to take contraception, and her doctor was ordered to administer it. But Kye would not give up on having, raising, and loving a child. She stole the urine of another patient, pretended it was hers, so that she could have a positive pregnancy test and evade her court-mandated contraception. She found a way to resist the system that tried to control her, that tried to deny her right to motherhood.
>
> We want a better world for women like Kye. Treatment, not imprisonment. Food, shelter, and community, rather than punishment. A world where Kye would be supported so that she could build a safe and loving home for herself and her children. A world in which what that home looks like has manifestations beyond White middle-class lifestyles. A world which holds reverence for Kye's strength, rather than attempting to stifle it. We will keep fighting for that world.

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