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A Rhetoric of Respect: A Theoretical Heuristic for Improving Communication Between Health Practitioners and Black Women

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Research Article

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Abstract

Black women in the United States die from pregnancy-related causes at far higher rates than white women, even when complications occur at similar or lower rates. Disparities research rarely engages the history of medical racism, and the disrespect Black women describe in clinical encounters is seldom examined as a rhetorical problem. This article proposes a rhetoric of respect, a theoretical heuristic for changing how practitioners communicate with Black patients. Drawing on the philosophical distinction between directive and evaluative respect, the framework holds that persuasion without respect is coercion and identifies three tenets: acknowledgment, deference, and reciprocity. Using a Black feminist epistemological approach, the author analyzes interviews with Black women about their experiences with OBGYNs, treating participants' experience as wisdom rather than data awaiting interpretation. Close readings of four narratives show how dismissed concerns and pressured consent reflect recognition without acknowledgment, and how each tenet could have changed those encounters. The article also considers the framework's use in other settings of unequal privilege and consequence.

Introduction: The Ongoing Problem of Maternal Health Disparities

The problem of Black maternal health disparities is personal to me. Immediately after delivering my first child, I suffered prolonged hemorrhaging and had to undergo an emergency life-saving procedure to stop the bleeding. While I have very little memory of what happened after the delivery, recalling it continues to disturb my husband who was present and conscious for the entire ordeal. The morning before, I was prompted to visit the hospital by unexpected hemorrhaging. I had already experienced the issue which landed me in the prenatal wing of the hospital for two weeks the month before, as it was a sign of premature labor. My husband and I explained my medical history when we arrived at the hospital. I was admitted to the maternity ward and connected to a contraction-detecting device and a fetal heart rate monitor. After about two hours, the doctor checked the readings from both devices and informed me that I was not having contractions. Having experienced identical symptoms the month before, I explained that I felt contractions more in my back than my abdomen and suggested the contraction detector or tocodynamometer be placed on my lower back. The attending physician dismissed my suggestion, declared that I was not in labor, and had me discharged. I was back home that afternoon, in intermittent pain and constant anxiety. By the time I returned to the hospital later that evening, I was further along in the labor process than I intended to be. I received an epidural when almost fully dilated and after my daughter was born, continued to bleed out until surgeons intervened.

Throughout the process, my concerns were dismissed, and my insight was ignored. Despite my medical history and the fact that I was presently bleeding, the attending physician insisted that there was nothing wrong and that I was not in labor. The blood that only four weeks prior had meant a two-week stay in the hospital now was considered completely normal and nothing to worry about. My experience with contractions presenting in a different area of my body was overruled by numbers on a machine. The doctors and nurses could not or would not interfere with the sensor or its calculations by moving it to where I felt the most pain. To receive care for my labor and delivery, I had to wait until my cervix provided

irrefutable proof that I was indeed in labor. Proof that the previous physician did not even look for. I still do not know why the second doctor took me seriously when the first one did not. I can only wonder what would have happened if the first doctor had admitted me for labor and delivery, or worse, if the second doctor would have dismissed me because of the same calculations as the first. The tocodynamometer never provided proof of contractions.

My goal in this paper is to offer a theoretical heuristic for actively shifting paradigmatic rhetoric regarding Black maternal health from that which fails to acknowledge race's social influence on medicine or its most marginalized patients to those that exercise respectful ways of working with patients toward better health outcomes. At the time, I did not realize that what I was going through was reflective of a larger crisis, but I have since learned that disparities in health between Black and white patients have been apparent for decades. It turns out that my experience is not unique. Black women suffer from some of the worst health statistics across multiple categories. The least of these disparities is life expectancy, where White women live an average of 3 years longer than Black women (Xu et al, 2022). When it comes to childbirth, Black women are about 3.5 times as likely to die in childbirth (Hoyert, 2025). And the maternal mortality rates have been increasing for the past decade. Over the last three years the maternal mortality rate for Black women has increased by 48%, from 37.3 deaths per 100,000 births to 55.3 (Hoyert, 2025). In addition to being more likely to die in childbirth, Black women are also much more likely to die from pregnancy related complications up to a year after being pregnant, whether or not they delivered a child. And being pregnant is most risky for expectant mothers after the age of 40, where the rate of deaths per 100,000 is 191 to the average 65.7 and white women's, 53.9. In other words, Black women over 40 who get pregnant are 2.91 times more likely than the average rate and 3.55 times more likely than white women to die from complications related to their pregnancy (Creanga, 2017). The data shows that Black women are dying to be mothers and the problem is getting worse not better.

What makes the significance of these statistics more painful is that Black women experience fairly similar prevalence rates for the complications and health emergencies that kill us, meaning we do not necessarily experience pregnancy related complications at significantly higher rates, we just die much more often. Tucker et al (2007) found that while Black women experience pregnancy related complications at around the same rate as white women, they die from these complications 2–3 times more often; in the case of my complication, post-partum hemorrhage, Black women die at a rate of 3.3 to 1. For example, the prevalence rate for the postpartum hemorrhage that almost killed me is relatively common among Black and white, but white women actually experience it more often. The prevalence ratio Black – white for postpartum hemorrhage is .8 to 1; however, the rates of death per case of postpartum hemorrhage are 3.3 to 1. This difference between prevalence and mortality shows that Black women are less likely to experience this complication but over 3 times more likely to die from it. As horrible as that realization is, the information was much less shocking to me than it might be to others because of my experience with the disrespectful disregard for my perspective that I described at the top of the essay. The information hurt so much because it was not surprising, partially because it felt like a reprisal of the same message about Black women that has been circulating since this country's inception. The message is that our lives and experiences do not hold equal value to those of white

women. That message came through in my experience which I can only characterize as dangerously disrespectful.

The problem of socially-situated health disparities bears consequences across racial and economic lines, as famously wealthy and well educated Black women like Serena Williams and Dr. Tressie McMillan Cottom have recounted (McMillan Cottom, 2019; Porteé, 2022). Whether a Black woman has a Ph.D. or a G.E.D., she is more likely to experience substandard health outcomes than her white counterpart. The causes of health disparities among Black Americans, like those of wealth and general safety, are multifaceted but can ultimately be traced back to the transatlantic slave trade and African colonization. Disparities research rarely acknowledges historical context in a meaningful way, however. When one considers the history of medical racism and understands part of that history to be a matter of institutionally sanctioned disrespect of Black women for the purpose of chattel slavery and economic satisfaction, the need to intervene in a paradigm of communication with Black women that is founded on a complete disregard for their humanity becomes clear.

In what follows, I will show how a rhetoric of respect includes rhetorical actions that demonstrate respect for a patient. I will begin by describing the tenets that constitute the framework and then demonstrate how each tenet operates in practice. I explicate these rhetorical moves, or lack thereof, through a close reading of the excerpts from interview transcripts. Through a rhetorical analysis of the experiences of Black women at the OBGYN's office or delivery room, I will illustrate how each construction leads to disrespectful encounters and go further to describe how actions guided by a rhetoric of respect would counteract or prevent such instances of disrespect. To support this analysis I establish and detail the concept of a rhetoric of respect: a framework and paradigm for deliberate behaviors that ensure respectful, and therefore rhetorical, interactions between parties of differing levels of privilege, like the relationship between doctors and their more marginalized patients. In interviews with Black women who have shared their experiences, I was able to identify major areas for rhetorical intervention and a rhetoric of respect approach to interactions — which I will detail in what follows. First, through a review of relevant literature, I will show that a rhetoric of respect involves actions that must be enacted in dealings with patients regardless of how that patient is constructed in the collective imagination. After fully explicating the framework, I will demonstrate what disrespect and respect look like in practice, drawing from the narrative experiences of the Black women I interviewed for this study.

Defining Respect

Directive and Evaluative Respect

Respect is characterized in philosophical literature from two perspectives: either by deeming a person as worthy of respect or by determining that a person is obliged to show respect to another. When respect is defined by the person receiving it, questions of individual intrinsic worth and intellectual autonomy shape the conversation. These questions lay at the heart of evaluative respect or respect that must be earned. When defined as the duty of the person paying respect, the concept is reduced to a moral principle at the

core of directive respect or the mandate to respect a person regardless of their respect-worthiness. In both instances, respect is understood both as a feeling and as an action.

Immanuel Kant (1971) uses the phrase “respect for every other man” to describe an acknowledgement of the innate value of each individual and how they should be treated as an end and not a means. Kant asserts that in human interactions, each individual must be treated as valuable without the need to contribute to some other agenda or cause, as an end in themselves. The idea that individuals contain inherent value and must be treated accordingly is continued by Kenneth Henley (1977), who argues that individuals are valuable in ways that cannot be reasoned, but also do not need to be. For Steven Hudson (1980), the kind of respect Henley is describing would be called “directive-respect,” a kind of respect that may have different qualities but on the whole is not considered “earned or merited” (p.70). He points to a difference in the verbs attached to the term respect to differentiate directive respect from “evaluative respect” which is “the sort of thing which is or is not merited” (p. 72). Directive respect, Hudson asserts, can be demanded. A person has a right to demand respect for certain ideals, like the inherent value of an individual. In fact, to demand and to direct could be used synonymously. But one cannot demand evaluative respect. Instead, one commands evaluative respect by displaying certain qualities that are valued by others and evaluated to be respect-worthy. Hudson (1980) also differentiates between having respect and showing respect, or the feeling of respect versus acting respectfully. Directives necessitate action, not feeling. One may feel respectful of the institution of marriage, or one may not, but refusing to participate in an extramarital affair shows respect for the institution, regardless of any evaluative respect one may or may not have for their partner.

In the contexts of health and medicine, the difference between having respect and showing respect have life and death consequences. In “What does respect mean? Exploring Moral Obligation of Health Professionals to Respect Patients” Beach et al. (2007) are also careful to point out that respect has both a “cognitive dimension” and a “behavioral dimension” (692). They offer a concept of “respect as recognition of the unconditional value of patients as persons” (692). Again, Kant’s original conceptualization of respect returns to remind us that acknowledgement of another person as subjective directs us to respect them, without any reference to merit or accomplishment. In contrast to Beach et al. (2007) who seem to promote the attitude of respect over the actions and behaviors that reflect respect, noting that “actions and behaviors… are not a sufficient substitute for having a genuine attitude of respect,” I would argue that actions and behaviors are the only way respect can be demonstrated and felt by the individual who is being respected (694). As a rhetorical concept, the use of respect can be much more focused and situationally adaptable. When enacted as a tool for coming to an agreement on treatment and behavior, as in the context of healthcare, respect has the potential to bring doctors and their most vulnerable patients together for a common purpose: improving the health outcomes of Black women. The bottom line is that all patients are owed directive respect which must be shown through action.

Theoretical Framework: A Rhetoric of Respect

I propose the term rhetoric of respect to describe an approach to agreement in interactions between women's health practitioners and their patients. A rhetoric of respect refers to a set of rhetorical tenets that comprise a way of coming to agreement between doctors and patients. The tenets of this rhetorical framework are acknowledgment, deference, and reciprocity. In my search for iterations of respect in cultural and scholarly literature, I found that respect – defined in this context as "Deferential regard or esteem felt or shown towards a person, thing, or quality" (2010, OED, #10) – is enacted through the three specific rhetorical positions of acknowledgment, deference, and reciprocity. Each of these positions shapes the trajectory of interactions between interlocutors in different ways that all add up to a way of acting that demonstrates respect.

As a rhetorical concept, respect is appropriate because it highlights areas of contention and addresses the cause as opposed to the symptom. Previous scholarship in the Rhetoric of Health and Medicine that comes the closest to focusing on respect as a rhetorical action comes from Cathryn Molloy's (2019) *Rhetorical Ethos in Health and Medicine* which outlines how patients establish ethos with physicians in situations where their ethos has been negatively affected by stigma or kakoethos related to mental illness or bias toward women. Ethos and kakoethos, as Molloy (2019) explains them, are absolutely at play in interactions between Black women and their doctors; however, as she also admits, racial bias and prejudice play a role in these interactions, and there is nothing a Black woman can or should be expected to do to convince their doctor not to discriminate against them. Directive respect, however, overrules ethos and kakoethos to demand respect for a patient regardless of any personal evaluations one may have regarding their character, culture, or behaviors. A rhetoric of respect places the responsibility for establishing a productive relationship with Black patients back onto the practitioner

I define rhetoric as the structure and practice by which progress is made toward agreement. It is meaning-making and involves persuasion, but we need to be careful about the who, how, and why of persuasion because *persuasion without respect is coercion*. The inclination to persuade patients without coming to agreement is inherently disrespectful because of its failure to treat the person as an end in itself and not a means to an end. In the pursuit of healing, doctors often treat their patients and their bodies as a means to that end, without acknowledging the material reality of experiencing their current dis-ease. The patient's agreement is necessary for these interactions not to be coercive, and true agreement necessitates respect. In short, doctors' lack of respect for patients is a refusal to be truly rhetorical. Only through *acknowledgement* of the inherent worth of the patient as they are, and not as the doctor might want them to be, followed in turn by acts and language of *deference* and *reciprocity* can doctors put respect into rhetorical action. Showing respect then is what makes conversations between doctors and patients persuasive rather than coercive.

Three Tenets of a Rhetoric of Respect

Acknowledgement

A rhetoric of respect begins with the action of acknowledgment. Acknowledgement makes reciprocity and deference possible because it is the foundation upon which the other two concepts rest. For Hyde (2005), acknowledgement makes way for “conscientia” or “knowing together:”

Acknowledgement… is a capacity of consciousness that enables us to be open to the world of people, places and things so that we can admit its wonders into our minds and then admit to others the understanding we have gained and that we believe is worth sharing. (23)

The key word in the above quote is “enables.” As a matter of rhetorical significance, acknowledgement is the beginning, and it establishes a field of play, as it were. In the process of coming to agreement, acknowledgment is something owed to another simply as a human being, the failure of which “reveals the failure of one’s own humanity” (Cavell, 1999, p. 430). Cavell’s (1999) understanding of acknowledgement parallels Kant’s “respect for every other man” in that it connects acknowledgement of an “other” with one’s own capacity for “human reason” (p. 49). Thus, one’s capacity for acknowledgement of others is directly correlated with their own inherent value. In other words, as the old and well known African proverb goes, “I am because *we* are.”

Acknowledgement should not be confused with recognition, however, or the idea of identifying something that is already known to the subject. Moreover, acknowledgement is more than checking a mental box or even offering verbal articulation of agreement with a set of facts. As a rhetorical concept, acknowledgement involves not only recognition of another person as inherently valuable but also an establishment of behavior shaped by that reality. In other words, one does not simply remind oneself that another person has inherent worth independent of any particular values we might put upon them. That is only the first step. The next step is to make sure one’s demeanor and actions toward another always begin and end with that acknowledgement.

Most recently, ACOG published their statement of policy on “Racism and Obstetrics and Gynecology” (2022). The following excerpt serves as a recognition of a race as a strictly social construct: “Racism, not race, drives health inequities and leads to adverse health outcomes” (n.p). Their statement defines race as a social category and explicitly renounces the rhetorical use of race as a risk factor. It also calls for “acknowledgment of the historical context from which modern health inequities grew” as a starting point and goes on to talk about the need “to work to overhaul unjust systems.” This statement by itself is still only recognition. Whether or not it serves as a true acknowledgement remains to be seen in individual interactions with OBGYNs and the outputs of health disparities research.

In a rhetoric of respect, acknowledgement begins the process of agreement by limiting the scope of deliberations to a certain version of reality, one where the patient and doctor have established their positionality and determined the rules of engagement together. For each decision made, a practitioner should be able to say, “After acknowledging X, we decided to adjust our approach in Y way which led to Z as our best option,” or something of that sort. The key here is that acknowledgement becomes the entry point for agreement, not the end. The next two tenets of a rhetoric of respect are not simultaneously

necessary but also not mutually exclusive. In other words, a rhetoric of respect does not need to display all three tenets, but it must begin with acknowledgment and move into deference, reciprocity, or both.

Deference

The second tenet of a rhetoric of respect is no more or less important than the third, but it does necessarily come after acknowledgement. I propose deference as a rhetorical action in the pursuit of agreement between doctors and patients. Deference is defined in the OED as "Submission to the acknowledged superior claims, skill, judgment, or other qualities, of another" (p. 2). In many cultures, deference is automatically paid to the elders of a society because their experience and wisdom are highly valued. It occurs as just one way to show respect. To defer to the position of another means letting go of the need to be the authority or dominant participant in an interaction. Thus, even the most disciplinarian mother may bow her head and lower her tone when contradicted by her own maternal authority-figure (i.e., Grandma). In the field of Rhetoric, deference has been reduced to little more than a positive framing of someone else's belief or argument (Varpio, 2018). In legal studies, judicial deference, refers to the tendency for judges to defer to previous interpretations of a law or statute. The legal context of deference is more relevant to what I propose than the rhetorical one; however, I will argue that the attitude and action of deference operate rhetorically in healthcare interactions.

Not to be confused with reverence, which functions almost entirely attitudinally, deference requires a pulling back of authority, something I understand will be difficult for doctors to do, as their ethos is largely built on the idea that their training and expertise grant them more authority over matters of health and medicine. Nevertheless, the rhetorical act of deference, operating as deferential language and rules of engagement, puts the patient in the authoritative position. I assert that because ultimately a patient has much more at stake in the success of any interventions meant to sustain their life and health, doctors should defer rhetorically to their decision-making when attempting to come to agreement about what actions to take.

Deference in this context does not mean allowing the patient to dictate the course of treatment. It does, however, mean engaging in deferential language. This deferential language will likely begin as verbal acknowledgement of the patient's perspective, concerns, and ideas about the health issue at hand. It cannot end there, though. Deference must be acted out in practice, meaning that the patient is able to engage in good-faith efforts to understand what options are viable for a person in their position without feeling like they need to coerce or trick their doctor into ordering certain tests or avoiding certain treatment plans. For each decision made, a practitioner ought to be able to say "Acknowledging that my patient experiences X, although I think the issue is Y, we have decided to also investigate the possibility of Z." The key is not to do what the patient demands, but to defer to their perspective of the situation and consider the possibility that despite a lack of formal theoretical knowledge, a patient has experiential knowledge of their condition that carries more weight epistemologically, particularly from a Black feminist perspective. In this sense, deference to the patient is a Black feminist epistemological and rhetorical practice.

Reciprocity

Reciprocity tends to describe a give-and-take relationship between the researcher and the subject of their research. In “The Rhetorician as an Agent for Social Change,” Ellen Cushman (1996) provides a “self-reflexive rhetoric” of reciprocity where researchers establish rules of engagement for a reciprocal relationship with the communities they observe and analyze (p.16). Drawing on Bourdieu (1990), Cushman emphasizes that unless researchers are self-aware and self-critical about their positionality in a given research situation, they run the risk of developing oppressive power dynamics. Katrina Powell and Pamela Takayoshi (2003) propose, “understanding the relationship between researcher and research community as a contextualized process of negotiation and renegotiation” (p. 396). For them and Cushman, the bounds and quality of reciprocity are co-constituted between two parties. In the same way Cushman (1996), Powell and Takayoshi (2003) are attempting to avoid a “missionary activist” self-perception through reciprocity, doctors can actively avoid paternalistic behaviors through purposeful, reciprocal rhetoric (p. 13).

The first step is always acknowledgement. Cushman (1996) describes a two-way acknowledgement, both of the other and of self. This acknowledgement is both a recognition and an establishment of equal standing. The self-reflexive establishment of equal standing is the part of reciprocity that may be a special challenge for doctors because it specifically requires that the practitioner humanize themselves along with their patients. In some cases, this self-reflective acknowledgement could be a recognition of personal implicit bias or privilege. For the purposes of agreement between a doctor and patient, reciprocity means matching the energy of the patient beyond expected professionalism. In other words, if a patient has taken the time and energy to provide copious details about their condition as they see it, reciprocity dictates that the practitioner apply equal consideration in trying to understand those details. It also means being as open to receive as one is open to give. The assumption that the doctor does all the giving in their relationship with a patient creates an unequal power dynamic between the two, causing some patients to experience a loss of agency, or a silencing.

Methods

The research question that precipitated this IRB approved study (IRB Reference #1521587-1)

was as follows: *What lessons can be learned from Black women’s experiences with OBGYNs, and how might OBGYNs effectively employ rhetorics that treat Black patients in ways that patients perceive positively?* To answer that question, I conducted a rhetorical analysis of Black women’s narrative constructions of race and its role in their health care. In total, this study examines interviews from 10 Black women, over the age of 18, from various socio-economic backgrounds and geographic areas around the United States. In this essay, I focus on four participants, three of whom I have quoted at length.

I applied a Black feminist epistemological perspective in the design of my study as well as my analysis of the interviews because I wanted to find wisdom, not just knowledge. For the purposes of this study, a I looked to Collins' (2002) four tenets of a Black feminist epistemology: (1) personal experience as a criterion for meaning; (2) dialogue to validate knowledge claims; (3) ethics of care; (4) ethics of accountability. Understanding the importance of wisdom in Black feminist epistemology boils down to personal experience. As Collins (2002) notes, the difference between education or intelligence and wisdom comes by way of experience. For this study, the personal experiences of these women paired with their general knowledge of history make for the kind of wisdom needed to effectively improve health care and outcomes for Black women.

This research diverges from the norm in its privileging of personal experience as a criterion of knowledge production that is not only intelligent, but also wise, and not as data simply waiting to be interpreted. By engaging in dialogue, I was able to validate the knowledge claims I had already formed regarding respect as rhetorical action. Accordingly, I asked the women to interpret their own situations and experiences. They provided their own reassessment of their situations within the larger historical contexts of Black women's health care in the United States. I interviewed them so they could turn the knowledge produced by scholars, doctors and myself into wisdom that can change behaviors. Although I am foregrounding their expertise as Black women over my own as a researcher or technical communicator, I did disclose my own experience and positionality as a way of situating my ethos in the interaction.

The reader will notice that I quote the participants included in this paper at length, with limited editing on my part. All names are pseudonyms. This choice is a reflection of the epistemological position I have just described. It may have been easier for a more disinterested researcher to cut and paste different parts of their stories together in ways that may be more easily digestible for an academic audience, but I am not a disinterested researcher. An ethics of care and accountability requires a level of connectedness, emotional attachment, and empathy in the production of knowledge. In the context of this study, that meant that I would not separate the positionality and feelings that brought me to the work from the work itself. In the writing of this paper, ethics of care and accountability meant that I would not frame these women's stories to fit an academic lens, but instead mold my own academic lens to carefully present the wisdom they brought to the problem of disrespectful health care. I asked for the participants' analysis before applying my own. Key questions that asked participants to analyze their own experience included, "How do you see your experience fitting into the larger history as you understand it?," and "What advice would you give your doctor or other doctors that intend to treat Black women?"Providing the opportunity for participants to take a critical look at their own narrative not only privileged their perspective as knowledge and experience that combined to make wisdom, but also provided an opportunity to validate those knowledge claims through additional dialogue. The women I interviewed were not only able to contextualize and re-interpret their experience, but also leverage their insights into actionable takeaways for practicing OBGYNs.

Results

Samantha

Samantha's experience reflects a lack of all three tenets of rhetorical respect. Acknowledgement of Samantha's expertise as a woman living in her own body and as scientist, at any point during her pregnancy, would have changed the dynamic of her experience, one that was marked by a lack of deference and reciprocity. Samantha was pregnant with her second child when her OBGYN diagnosed her with gestational diabetes. She was cognizant of the diagnosis and took time to understand what the numbers they cited for it meant in a larger context.

Let's say a normal [HbA1C] range is like 5.7 and below. Mine was like 5.8 or 5.9… So it was slightly elevated, But I passed all the other [tests]. So they're like, yeah you have gestational diabetes… And then it kind of just started this ongoing issue related to the management of diabetes.

Samantha went on to describe the actions she was directed to take and the OBGYN's disposition toward her situation.

They wanted me to check my blood sugar three times a day, every day. And so I was doing that… it didn't matter what I ate, my body would handle it fine. But my fasting blood sugars were always elevated by one or two points. I went on their diet, actually, my sugars went up, my fasting sugar went up. So whatever the diet that they recommend, well it just wasn't working. You know there was like, try eating snacks at night, try doing this, try doing that, try not eating this at dinner.

When none of the dietary strategies proved efficacious, her physician prescribed insulin.

So I went on insulin. And I took insulin for I think two or three days and it didn't do anything; there was no change in my fasting blood sugar. So then they were like ok we just need to up the dose, you're not getting enough. So I increase the dose. The night I increased the dose, that next morning my fasting blood sugar was down by like two points; it was in the range they wanted by like again one or two points, like a very small decrease. During that day I just got incredibly sick. I guess my sugar dropped out. I thought I was gonna either pass out or fall and take a nap. And it's the kind of nap where I felt like I might not wake up…

One of the things they say is that if you feel unwell, take your blood sugar, see if it's low. And my blood sugar was in the 80's or 70s; it was low. But when I told them, they're like 'well a normal person would have felt fine. They would not have experienced what you felt, so just keep taking the insulin' (BW3, 1:02)

Up until this point, Samantha followed all the instructions her doctor gave. She followed the diet plan and she took the insulin; she increased the dosage when directed to do so. But at the point where she expressed dis-ease with the treatment, her concerns were dismissed. Her practitioners did not reciprocate her open-mindedness or willingness to listen. They should have moved as quickly to consider alternative treatments or diagnoses as Samantha was to adopt whatever treatment was prescribed to her.

A statement that reflects reciprocity may have sounded something like, “I see that you reported these levels as causing discomfort and the symptoms you describe sound like a low-blood sugar episode. Although most people would not experience what you did, let’s consider different parameters for you.” This statement does not immediately retreat from insulin as a treatment for diabetes, but it acknowledges Samantha’s perspective and reciprocates her effort to find a solution. Because her practitioners did not acknowledge or reciprocate her energy and instead continued to push for the original treatment plan, Samantha responded with her own refusal:

Yeah, that’s a big hell no… No, I will not be doing that. So, I took myself off. And they were very displeased with that… But they kept insisting that I keep meeting with the clinic, and they’re like ‘you don’t want to take your insulin?” No, it made me sick. And they’re just like ‘you really need it.’

Despite the displeasure of her OBGYN and their colleagues, Samantha refused to continue taking the insulin and began, “trying to figure something else out” because as she boasted in the interview,

I’m a whole scientist. I plotted my numbers and they were going down. It never got in the range they wanted, let’s say they wanted a 95 and I was getting 96 and 97, where before I was maybe a 99 which depending on what doctor you see… under 99 is fine.

Samantha’s confidence in her own analytical ability may not have been convincing to her diabetes clinic doctors, but their refusal to consider that her normal may be different than someone else’s normal damaged their credibility with her in turn.

The gestational diabetes clinic failed to acknowledge Samantha by disregarding her communicated experience and refusing to reciprocate her efforts to investigate the issue more deeply. When Samantha expressed that her insulin caused an adverse reaction, instead of trusting her testimony, the clinic ignored her concerns and reiterated their position. To acknowledge Samantha as deserving of deference and reciprocity would have required a change in actions, but no such respect was paid, either by the clinic or her OBGYN. Thus, despite all the changes and treatments she submitted to, Samantha could not even get the clinic to consider a different way of interpreting her fasting blood sugar numbers. In a reciprocal agreement, Samantha would not have been the only one trying to “figure something out:” her healthcare providers would have considered other possibilities with her. Samantha showed deference throughout the beginning of her ordeal, but when it became clear that her respectful actions would not be returned in kind, she stopped.

Natalie

Natalie’s experience was a mix of being at once valued for her perspective and also dismissed as unqualified. Natalie’s story provides another example of the difference between recognition and acknowledgement. As a mother having a fourth child, she had a wealth of experiential knowledge to share and she was asked to participate in a training group to give other practitioners some perspective

of being a Black pregnant woman. However, when the time came to take a different action in deference to that perspective, her doctor failed to take actions that were shaped by Natalie's reality. While her participation in this group helped Natalie grow more confident in her own voice, before this experience, she expressed not knowing how to assert her agency. However, in her fourth pregnancy, she recognized mental health symptoms that she knew were anxiety and depression and shared those symptoms with her OBGYN. She recounted:

So I had neonatal depression with the third. And I knew what it was, right? I had postpartum anxiety with the first. And I kind of knew that that might be a thing that could happen. So I was aware of it with the third. Then when it happened. You know, I talked to my OB, and it was very much like, you're on your fourth child, just suck it up.

Natalie immediately saw her own experience within the larger context of Medicine's abuse of Black women because she studies Black women in her own research. She's well aware of the history and recounted several events in the middle of her story.

Natalie's account was so imbued with intersecting stressors and situations that it is difficult to include many direct quotes that do not contain several ellipses. On the one hand, she was a professor in a department where the chair was male, white, and did not even have small children in his extended family. In contrast, Natalie had given birth to 4 children in 5 years. She was well versed in the systemic abuse of Black women. This background information is relevant because when her OB expressed concern over not being able to detect her fourth fetus's heartbeat, it stands to reason that the news exacerbated an already stress-filled situation. Natalie was experiencing anxiety and depression before she had reason to worry about her unborn child's survival. She even apologized during the interview for being "all over the place with this story." In acknowledging this context, I am being more respectful of Natalie's situation than her OBGYN was. Natalie continues her narrative:

This is so long winded, but it's just fucking crazy. The ultrasound tech is talking so much she's trying to find the baby's heartbeat on the monitor, right, she can't find the baby's heartbeat. And, and so we're in this room for 45 minutes… and we're in this small ultrasound room with the tech, who turns out to be [related to a powerful and famously conservative and anti-abortion politician]. I'm in the small ultrasound, they're not hearing my baby's heartbeat. And I don't even feel like I can even articulate what's rolling through my head because I know her politics, right. And I've also, you know, know her having her cousin's thoughts. I'm not gonna say that they're exactly hers. But it was just enough for me to be like, I just need to shut up, right.

Essentially, Natalie was in this emotionally and physically intense situation and had to contend with the political beliefs of her ultrasound tech at such a vulnerable moment. Acknowledgment on the part of the ultrasound tech would have meant contending with the fact that political alignments are a matter of life and death for some people and that they should not be discussed in a professional, medical atmosphere so casually. Instead, when Natalie was trying to sort out a mess of competing thoughts and concerns,

one of those concerns was whether her OBGYN office was a safe place to make decisions about her own body and future.

It turned out that her OBGYN's heart rate monitor was ineffective at detecting her baby's heartbeat. When she went to the hospital later, the heartbeat was strong. However, that incongruity did not stop her OBGYN from making the same observation at her next visit and this time emphasizing that the baby was in mortal peril. Recognition of the error did not result in a change of behavior – a gross failure of acknowledgement.

After they get me back into the room. And they call my husband, it takes him maybe like 20 minutes to get it to get to the office. And when he comes in my OB is at the tail end of telling me all the things that are wrong with the baby and all the things that could go wrong with this birth. And then Gary walks in, and [the OB] says, we're sending her to the hospital, your baby's not good. And then walks out. And I have a breakdown, right? So she's not explaining whatever it was to Gary, right. He just comes in, where she's [already] explained, you know, all the stuff, but those are her exact words 'your baby's not good'.

Natalie's OBGYN failed her in so many ways, all of which may have been avoided if the OBGYN had been purposely respectful in her practice. Acknowledgement of Natalie's situation should have steered her physician toward more considerate language. In Natalie's case, the OBGYN did not necessarily disbelieve her or disregard her experience as much as she refused to let it alter her approach. In some ways, that position is worse. It reflects the larger disciplinary dissonance in the OBGYN field that keeps stopping at recognition. Natalie's OBGYN recognized that her experience was valuable, but failed to acknowledge Natalie's position in the way she communicated with Natalie.

Bernice

The disrespect Bernice experienced was not incidental. She experienced her issue across multiple practitioners. For Bernice, the OBGYN's problem was that they did not acknowledge her position. Acknowledgement is to recognition as listening is to hearing. In the same way one can hear something but not be listening enough to respond appropriately, a person may recognize something without that recognition leading to an appropriate response. In Bernice's case, her practitioners may have recognized that Bernice was averse to having a hysterectomy, but such recognitions did not lead to an adjustment in approach which would have constituted true acknowledgment. This failure to acknowledge Bernice's perspective led to multiple instances of practitioners failing to reciprocate Bernice's efforts to find a better solution. One practitioner even refuses deference by trying to sneak in a full hysterectomy for what was meant to be a much different procedure.

Bernice had just switched OBGYNs a second time when she learned that she had fibroids. Upon her first meeting with the third new doctor, she was informed almost in passing, 'You know you have fibroids, right?' To which Bernice responded "No, no one has ever told me that."

That was the first time, despite you now having gone to my gynecologist regularly once per year, sometimes twice a year because… I'd had an irregular pap smear years ago, and so I actually went more often than the normal recommended frequency. So all this time, this previous gynecologist had never mentioned fibroids to me.

This initial realization that Bernice's second OBGYN did not share crucial information with her reflects a lack of reciprocity. Again, reciprocity involves a give-and-take relationship where both parties give and receive in equal measure. The term also refers to matching the actions and energy of the other in a given communicative situation. Bernice's first doctor failed to give her the appropriate level of information despite Bernice's efforts to build a rapport with him.

Bernice had a myomectomy to remove the fibroids, and she did so knowing that they would come back in approximately three to five years. She also knew she did not want a hysterectomy. Her original OBGYN appeared to defer her judgment on the matter. However, the surgeon was a different story. Before her procedure, the surgeon asked her to sign a waiver allowing him to perform a hysterectomy if he deemed it was medically necessary. Despite his admonishments, she refused to sign the waiver. She details the situation below:

You know, we did the pre surgery, consults, console meeting, and he talked me through what they were going to do. And then he was like, I'd like you to sign this consent form to elect to allow me to perform a hysterectomy while you're under general anesthesia if I see any reason why I should have to do that. You know, my knee jerk reaction when the doctor hands you something the sign is like, *Okay, I'll sign it*. But something made me pause and go, I'm gonna think about this. And then I went home. And I thought about it, and I was like, I don't have to sign this, I'm not gonna sign this. And so I told him… I'm sorry, I'm not consenting to that. You're gonna have to perform the myomectomy. I'm not consenting to hysterectomy at all, under any circumstances. And when I got out of anesthesia, and he came to do a follow up visit… He actually low key complained about how long it took, he was like, wow, there were a lot more in there than I thought. And I thought this would be an hour, it really took like three hours to get all of them out. Then, later… One of his resident students, or whatever they're called, kind of, like on the sly was like, I did a good job. He was basically like, 'you did the right thing by not signing that consent form, because he would have taken the fuck out of that uterus, if you had given him any opportunity to do that, just to make his golf game. You know, just because he was like, I scheduled this for an hour and it's gonna take too long, so just get the whole thing out.

This surgeon's repeated attempts to go around Bernice's authority over her own body represent a disrespectful degree of disregard for Bernice's autonomy. Not only did he try to refuse to acknowledge her positionality as the decision-making party in the situation, but he also failed to defer to the authority that positionality imbued. Reciprocity is not the issue here, but acknowledgement and deference are.

Ten years later, her fibroids were back and bigger than ever before. She knew this would happen, but unlike the first set of fibroids, these were negatively affecting her quality of life:

I could feel them becoming bigger and way bigger than they've been and more, you know, just interfering with my comfort and my periods are really heavy and they were just becoming a nuisance. So I started to, you know, went and found another gynecologist. I found a couple gynecologists who were very old, very dismissive. At that time I was about 40. When I started meeting with this new set of gynecologists trying to find somebody who could give me an answer. I just was trying to figure out what my options were and every one of them were just like, 'oh, just have a hysterectomy'.

Bernice had misgivings about having a hysterectomy and found the dismissive attitude of the OBGYNs she met disturbing.

My mother had had a hysterectomy when she was in her 40s and she also had fibroids. And I was speaking to a coworker at the time who had had a hysterectomy. And basically every woman I knew that had had a hysterectomy were [sic] saying 'don't get a hysterectomy. Whatever you do, just don't do it. It's not worth it.' That was kind of pushing me to just keep asking for opinions and asking for more opinions.

Bernice's connection to other Black women framed her dilemma as more than an instance of fibroids. She began to notice the pattern of dissatisfaction with the common treatment for them.

Hoping things would change, she met with a younger Black woman OBGYN, but found her demeanor to be the most disturbing of those she had met. This physician dismissed her experience and displayed a shocking callousness when discussing the possibility of removing Bernice's uterus, fallopian tubes, and ovaries.

I'm trying to explain to her that I was getting a lot of heartburn from my fibroids and she sort of condescendingly tells me that's not possible because your uterus is down here. And I'm like, lady, I know where my uterus is. I don't need an anatomy lesson! I'm telling you it's growing upwards into my stomach. And she was like 'we'll have to do an ultrasound to determine that.' And I said no, you actually don't; you can feel it. And I laid back on the table and I was like, put your hand right here. You can feel it through my skin. So then she goes ok… well, we'll get the ultrasound and we'll look at the results. And then she ordered me a transvaginal ultrasound! Even though I pointed out physically where the fibroid was, which was in my [upper] abdomen.

Bernice felt like she had to do the doctor's job because the OBGYN was being "sloppy." Moreover, she felt like she had to defend her body against an unwanted procedure. Once the results of the ultrasound came in, the OBGYN followed the same procedure as the ones before, but with a relish that Bernice did not appreciate.

She very quickly was like, you should just get a hysterectomy. Look, you're 41. Get a hysterectomy. They're super easy. And she literally said these words, "They're my favorite surgery to perform. They're just so easy and you know fine and you'll be just on your way. And no problem. And I was just sitting there, aghast. Like this is getting ghoulish and absurd.

At this point, Bernice started doing research on the effects of pre-menopausal hysterectomies on mice and finding there was some correlation with dementia. She also found interesting studies on the uterus's role in immunity and other bodily functions. In essence, her reproductive organs were becoming more valuable to her, the more doctors insisted on removing them.

Finally, Bernice returned to the original OBGYN that helped her. Insurance issues made her switch providers, but she fixed that issue and returned to the only doctor who had shown her a modicum of respect. Bernice felt acknowledged by this doctor, mentioning that he empathized with her.

So I went back to the great gynecologist that I met when I first moved to LA when I switched my insurance and he was he is a white man, one of the best bedside manner and I've ever had in a doctor and he listened to me very carefully and he empathized with me and he said, you absolutely should never get a hysterectomy. He's like "I've been practicing for. He's probably been practicing for 30, maybe 40 years. He's like, I can't count the amount of children I've [delivered] after a myomectomy. I can count on one hand how many hysterectomies I have performed because I don't do them. They are usually highly unnecessary and they are only necessary in life threatening cases."... I'm like tearing up because like, I feel like this guy, like, saved my whole life. But then he says, You know, "I think you're actually a great candidate for a new procedure called … uterine fibroid embolization."

Out of 5 or 6 OBGYNs, only one bothered to provide any alternative to a hysterectomy. Only one acknowledged her humanity and deferred to her ownership of her own body. It may be tempting to accuse Bernice of simply liking the doctor who agreed with her, but a rebuttal to that point would be to ask why Bernice should tolerate being in disagreement with her physician? Bernice has given birth to a child since this period in her life. If she would have let even one physician overrule her authority over her own body, her child would not exist.

Bernice's story reveals layers upon layers of disrespect. From her first OBGYN's failure to disclose that she had fibroids to the OBGYN who described a hysterectomy as her favorite surgery, Bernice's experience shows that the advice from 'experts' like those on the Today show's webseries to change doctors if you do not get the care you deserve are not helpful. Bernice saw multiple doctors, and all but one treated her with disrespect. Only one OBGYN put as much effort into finding an acceptable treatment for Bernice as she did for herself. Only one put Bernice's health above their own convenience. The surgeon who wanted to perform a hysterectomy so he could make his golf game could not have acknowledged her as an inherently valuable person if he was willing to remove her organs against her wishes in the interest of time. I am not arguing that women never need hysterectomies or that subjective experience is necessarily more valid than a physician's expertise, but I do posit that practicing a rhetoric of respect would have steered her OBGYNs away from trying to force the procedure on her.

Instead, acknowledgement of her positionality as a Black woman, and the history that shapes her experience would have required a more tactful approach that included looking into alternative procedures. Her OBGYN could have googled 'new fibroid treatments' and that would have been an act of

deference. Instead, looking through an analytical lens that already identifies her racialized body was inherently risky, her doctors chose what they felt was the path of least resistance.

Discussion:The Scope and Limits of a Rhetoric of Respect

As with many rhetorical concepts, the limits and scope are defined by elements of the rhetorical situation, like audience, author, and purpose. Obviously, everyone wants to be respected all the time, but applying a rhetoric of respect is especially necessary in specific situations. I see a rhetoric of respect as being most appropriate, or needed, in situations where one party has more privilege, and the other party has more at stake in the success of their interaction. Other examples might include the relationship between police and the people they detain or arrest, and also the relationship between legislators and their constituents. In each of these situations, like the relationship between doctors and their patients, one party has significant privilege and authoritative ethos, while the other is in the position to deal with the consequences of whatever the outcome of their interaction is. For example, the relationship between researcher and community partner or research subject is such that one party enjoys more institutional privilege, but the outcome of their research may have the most effect on the research subject or community partner. Cushman (1996) practices a rhetoric of respect in her work where she argues for reciprocity in the relationships between researchers and the communities they study or and work with. In describing her own reciprocal relationship with people in the community she was studying, she recounts the ways she put herself at the service of the community by providing writing help and access to university resources, and also how the community gave her access and helped her validate, or invalidate, her theories and analyses. She acknowledged their perspective as valuable as an end in itself, as opposed to a means to her research, abandoning her own theories if her research subjects rejected them and deferring to their position. Not only is Cushman's work a great example of how a rhetoric of respect can work in practice, but also of why a rhetoric of respect works especially well in situations where privilege and consequence have as seemingly inverse relationship as it relates to the parties involved.

A rhetoric of respect operates especially well in those situations characterized by unequal levels of privilege because the operative notion of respect is directive as opposed to evaluative. Both parties are responsible for showing respect, in any situation. However, in situations where privilege allows for a lack of acknowledgement, deference, and reciprocity, applying a rhetoric of respect becomes a deliberate practice of interpersonal social justice work. A rhetoric of respect is most closely modeled on Hudson's (1980) directive respect, the kind of respect that is expected because we are all human beings and that must be asserted in situations where social dynamics put that reality into question. In other words, this type of respect is most important when the understanding that it puts forth, namely the inherent value of individuals as individuals, could be otherwise disregarded in favor of other social paradigms or rhetorical screens, like racist essentialism or colorblindness.

To illustrate, let us consider Katrina's experience with her OBGYN. Katrina was experiencing severe bleeding and debilitating pain from uterine fibroids, and she agreed to have a hysterectomy to remove her uterus. However, when the day for her surgery came, her anesthesiologist described a different

procedure than what Katrina had agreed to. When her doctor was called in to discuss the discrepancy, the OBGYN's response was to take advantage of Katrina's vulnerable position as a person in severe pain who was in need of the surgery she came in to have. Katrina recounts the conversation:

She comes in and she's like, "you always ask too many questions. You always…" like very accusatory, very angry, 'you ask too many questions'… I said well but you know you and I never discussed my cervix. I felt like it had been enough for me to take in that I've been a perfectly healthy woman and now you're saying – you know, it's one thing for me to wrap my mind around, okay I'm going to lose my uterus. And then you're telling me my cervix? My fallopian tubes, like *no, this is not okay. I should have been informed of this.* She brings out a form and she says, "well here it says… that if the senior doctor determines that these other things need to be extracted –" if it's absolutely necessary, but this man [the anesthesiologist] is coming to me with the knowledge that all these items, these body parts, are going to be removed. That's two different things. I'm no dummy…"You ask too many questions, you get the surgery and add that other surgery, you get it today or you go."

In other words, after admonishing Katrina for questioning the procedure, the OBGYN gave her an ultimatum, one that she was only able to give because of her privileged position as the physician and the one with access to the resources Katrina needed. That privilege gave the OBGYN permission to disregard Katrina's concerns and force her to submit or deal with the debilitating consequences of not having the procedure she needed. If Bernice's story is any indication, Katrina's OBGYN may have just found it more convenient to take out the whole system. Afterall, two of Bernice's doctors admitted that removing all the parts was much easier than just removing one part or just the fibroids. Remember, it was one of her doctor's "favorite surgeries to perform because it's so easy" (Bernice). Their positionality as doctors allows them to prioritize their own convenience over their patient's quality of life; a rhetoric of respect does not. Hyde's (2005) commentary on acknowledgement echoes what Katrina and Bernice seemed to feel about their relationship with their doctor: "Remaining unacknowledged is a slight to one's being" (p. 26) He goes on to describe the state of mind caused by this betrayal: "Such disruption can move a person into a state of anxious wonder about his or her existence: 'What am I, what am I failing to do, what should I do?'" (p. 26). In one way or another, almost every woman I spoke to wound up asking herself similar questions, and their responses to their negative experiences were often bound up with the answers. For Katrina who now has a good talk with every female member of her family about women's health care "to teach them how to advocate for themselves." The answer was that she failed to ask the right questions or advocate for herself enough. She wants her family members to learn to make themselves acknowledged. Although her experience was a direct result of her doctor's failure to acknowledge her, the "state of anxious wonder" their failure produced led her to believe that her ordeal was in some way her own fault.

I will repeat this statement because it bears repeating: *persuasion without respect is coercion* and Katrina's experience demonstrates the coercive turn persuasion can take in situations with an unequal power balance. A rhetoric of respect in this case would have begun with Katrina's OBGYN acknowledging Katrina's aversion to having a full hysterectomy and moving forward accordingly. That

acknowledgement may not mean avoiding a conversation around having a full hysterectomy, but it would require that the main reason be more relevant than the doctor's convenience. Remember, acknowledgement in this case requires more than an internal recognition that Katrina does not want her cervix, ovaries, or fallopian tubes removed; it also requires that the OBGYNs decision making process at least consider removing those as options, unless absolutely necessary. Practicing deference is evidence of this level of acknowledgement. Using language like "I understand that you do not want to have those parts removed, so we will do everything we can to avoid that," shows deference to Katrina's position as the person with the most to lose without relinquishing the doctor's ethos as an expert.

Further, this type of deferential language indicates an action that represents reciprocity between the doctor and the patient. In this case, the doctor is promising to put as much care into considering all the possible approaches to the patient's care as the patient is. When a doctor expects to receive information, reverence, and obedience from patients, or trust, it is only reasonable that they reciprocate those observances. This reciprocity is a matter of respect. Refusing to give Katrina all the information was a refusal to reciprocate the observances the OBGYN demanded from Katrina. Telling Katrina that she "asked too many questions" was a way of saying she did not deserve the information she was seeking, a way of shutting down avenues of reciprocity. Conversely, to apply reciprocity would have meant observing the same edict to provide comprehensive information and return the reverence and obedience normally accorded to doctors because of their social privilege.

Conclusion

To summarize and conclude, the historical and contemporary treatment of Black women in medicine has been and continues to be disrespectful in its failure to acknowledge the social positionality of being Black in the US, its refusal to defer to the perspective of its most vulnerable patients (i.e., Black and Brown women), and practitioners' failure to reciprocate the good faith efforts their patients put forth toward finding a solution to their health problem. These demonstrations of disrespect often occur in interpersonal interactions between doctors and their Black women patients as a failure to listen to a patient's perspective or to look for alternative treatments when the first one proposed proves ineffective or problematic for the patient, as it did for Samantha. They can also come in the form of insensitive or unprofessional behavior as was the case for Natalie. And in their most horrendous forms, this disrespect can manifest as outright aggression toward Black women when they are in extremely vulnerable positions, as happened with Bernice and Katrina. Disrespect can most easily occur in situations where one party is afforded more privilege than the other. The unequal power dynamic makes it easy to recognize rather than acknowledge, or to flat out ignore the other's position or perspective. Power does that, and unwritten rules of civility allow that. A deliberately applied rhetoric of respect does not.

A rhetoric of respect purposefully inserts the active application of acknowledgment, deference, and reciprocity into situations where one party could neglect to do those things. Exercising a rhetoric of respect is a choice that reflects a commitment to equity. In a health and medicine context, a rhetoric of respect represents a tool for operating under a new paradigm. A directive respect for the value of people

as people supports a new understanding of race as a social predicament that shapes a person's experience of reality. A rhetoric of respect demands acknowledgment of that reality and offers guiding tenets for operating within it.

Acknowledgement as a prerequisite for respect is an appropriate starting point for any rhetorical negotiation between parties of inverse privilege and stake in the success of the negotiation. In situations where one party could very easily revert to old, disrespectful paradigms, a rhetoric of respect offers a framework for purposeful intervention in those old paradigmatic patterns. While rhetorical respect must always begin with acknowledgment and should also involve some configuration of deference and reciprocity, a rhetoric of respect need not end there. This theoretical heuristic should not be static in its constitution but dynamic and adaptable to different social situations. I look forward to seeing other scholars take this framework up and add appropriate amendments as their local situations call for.

Declarations

Author Contribution

V.J. wrote the main manuscript and reference section. There are no additional author contributions.

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