HOW SOCIAL FORCES DON A WHITE COAT:
THE SOCIAL CONTEXT OF CHILDBIRTH MANAGEMENT IN METRO DETROIT

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ABSTRACT

HOW SOCIAL FORCES DON A WHITE COAT: THE SOCIAL CONTEXT OF CHILDBIRTH MANAGEMENT IN METRO DETROIT

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Childbirth is both a biological and a cultural phenomenon—a life event universally experienced by women, and yet, "accomplished in strikingly different ways by different groups of people" (Jordan 1993:3). Childbirth acts as a point of intersection between biology and social values; the way in which a particular group approaches birth serves as an index of the cultural context in which it is practiced. Through a cross-cultural examination of childbirth, Jordan (1993) identified several "biosocial features," including local conceptualizations of birth, preparation for birth, birth territory, the use of medication and technology, attendants, and the locus of decision-making power, as culturally-variable traits that distinguish the social nature of birthing systems. American biomedicalized childbirth inherently creates a dynamic of stratified power through the use of obstetrical interventions, the authority and exclusive ownership of medical knowledge, and preparation for birth throughout prenatal care (Davis-Floyd 1992; Jordan 1993; Martin 1987; Van Hollen 2003; Wendland 2007). As a result, the process of decision-making during childbirth management crystallizes hierarchies of interaction and can be used as a tool by which to investigate the influence of social stratification on medical care and patient autonomy.

This dissertation presents the findings of a qualitative research study of childbirth management in Metro Detroit conducted from 2012-2014. Using findings from one-one-one patient interviews and participant observation in prenatal outpatient clinics and hospital labor and

delivery units, I use the locus of decision-making power within obstetrical practice as a metric by which to investigate the impact of salient cultural variables on the experience of expectant women receiving prenatal and peripartum care in Southeast Michigan. In doing so, I explore pregnancy experiences among urban and suburban expectant mothers, examining the creation and maintenance of authoritative hierarchies through the use of obstetrical tools and techniques, and how sociocultural context impacts the level of agency achieved by local expectant mothers in the decision-making process. Through the use of medical designations, such as "risk," the focused emphasis on pathology, and the absence of cooperative decision-making discussions during prenatal care, I posit that the structure of American obstetrics not only generates a dynamic of interaction that limits the individual autonomy of expectant mothers, but also that such stratified authority is particularly pronounced among disenfranchised groups of expectant mothers receiving care in Detroit. Furthermore, I argue that the perceived objectivity of biomedicine veils the influence of socio-cultural context on obstetrical practice and physician perspectives, such that hegemonic social ideologies relating to race, gender, and class can effectively infiltrate institutionalized birthing practices and contribute to a broader discourse on patient morality and responsibility.

In memory of my grandfather, Luiz Valente Boffi, PhD, who taught me to see the science in nature and the beauty in life.

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Introduction

Childbirth lies at a point of intersection between biology and social values. For decades, cultural anthropologists have studied the practices and techniques utilized during birth, and in doing so, have demonstrated that childbirth and the way in which it is approached by both expectant mothers and birthing attendants is greatly influenced by the context in which it takes place (Davis-Floyd 1992; Han 2013; Hunter 2012; Jordan 1993; Walzer Leavitt 1983; Martin 1987; Sargent and Stark 1989; Van Hollen 2003; Wendland 2007). Similarly, American medicine is a unique cultural system; how we practice medicine in the United States is intricately linked with broader societal beliefs. Cultural values of individuality, productivity, morality, and responsibility are embedded within the framework of the medical institution. As a result, examining the obstetrical management of childbirth investigates both the current narrative of American childbirth, as well as the broader medical reality of a highly technical and increasingly depersonalized health care system.

In her cross-cultural examination of birth among four cultures, Brigitte Jordan (1993) created an analytic framework with which to explore the cultural uniqueness of birthing practices, identifying several “biosocial features” of birth that vary considerably based on context—local conceptualizations of birth, preparation for birth, birth territory, the use of medication and technology, attendants, and the locus of decision-making power. In her examination of hospital births in the United States, Jordan found there to be an inherent hierarchy of authority in decision-making that stratifies agency between the physician and the laboring woman based upon possession of specialized medical knowledge, with the physician obviously favored in this dynamic. Thus, because biomedicalized birth operates on medically based knowledge, the obstetrician and medical staff necessarily hold a position of power over the laboring woman in the choices made about birthing options and interventions. However, there is need for additional investigation as to how such power is achieved and maintained in everyday pregnancy-related clinical interactions. What characteristics of American obstetrical care cultivate this stratification of power and how do they shape the experience of expectant mothers? Additionally, there have been few anthropological explorations of the role of socio-cultural dynamics in birth-related decision-making and whether or not a woman's social background alters her level of autonomy in this process.

Stemming from this background, I chose to investigate the social context of childbirth decision-making in Metro Detroit, examining the roles of both patient and physician in labor and delivery management and various factors that either limited or encouraged particular birthing choices. In doing so, I wanted to investigate the impact of diverse socio-economic context on the process of decision-making and patient autonomy. In this dissertation, I present the findings of an ethnographic research study conducted from 2012-2014, which examined childbirth management and birth-related decision-making in a Detroit-based hospital system. Focusing on social features of obstetrical care, I explore the individual experiences of prenatal and peripartum care among urban and suburban expectant mothers receiving care in Metro Detroit. While there have been a multitude of ethnographies examining cultural systems of birth, there have been few to compare childbirth experiences between diverse socio-cultural communities *within* the United States. Thus, this research project is unique in examining two cultural subgroups within very close geographic proximity and presents the opportunity to further isolate the role of specific cultural and socioeconomic variables as they affect dynamics of power in obstetrical management.

Summary of Dissertation Chapters

In this Chapter 1, I situate my research question within the broader literature on the Anthropology of Childbirth. Utilizing Critical-Interpretive, Marxist, and Foucauldian theoretical approaches, I outline Brigitte Jordan's "biosocial features" of birth, demonstrating the cultural uniqueness of Western biomedicalized birth and the potential social and political implications that result from particular obstetric techniques. In doing so, I aim to both identify gaps in the reproductive anthropology literature and also provide the background necessary to interpret the particular decision-making dynamics observed in this research study.

Chapter 2 addresses the position of racial/ethnic identity within biomedicine, examining how it is interpreted and invoked by the medical community. In this literature review, I outline several theoretical approaches to racial health disparities, including the racial-genetic, health-behavior, socioeconomic status, psychosocial stress, and structural-constructivist models. Using examples of racial health disparities in the Detroit region, I demonstrate the various ways that race has been used and misunderstood in medicine and how such false interpretations of race have meaningful impact on minority health experiences. I also introduce intersectionality theory as a key analytic tool for interpreting the varied birthing experiences of the expectant women participating in this research study, arguing that the interplay of race/ethnicity, class, and gender must be considered in the analysis of childbirth in diverse socioeconomic settings.

In Chapter 3, I introduce the historical context of Detroit, as well as the city's current social climate, in order to demonstrate the socioeconomic divide that exists between the recruited research participant populations. Following this introduction, I describe the various project field sites, detailing physical aspects of each site and the process by which I gained access as a researcher. Additionally, I briefly discuss my position as the researcher, which addresses my liminal perspective as a dually-enrolled medical and anthropology student. I then outline the qualitative methodological techniques employed in this study, including participant observation, close-ended surveys, and in-person interviews, and also provide selected demographic information of the survey and interview participants. I conclude by reviewing the data analysis process.

In this Chapter 4, I aim to address the pervasiveness of medical authority and knowledge in local conceptualizations of childbirth in the Metro Detroit region. Using narratives from expectant mothers I interviewed, I explore how managing pregnancy is transformed into "managing pathology" within the structure of obstetrical prenatal care. Using Foucauldian theory, I explore the process of patient standardization within obstetrical care as observed in prenatal clinical interactions, and how this homogenization supports the pervasiveness and perceived importance of "medical risk." Finally, I consider how "risk" is differentially assigned by clinicians based upon social constructions of "normal," finding that socially marginalized patient populations in Detroit are often labeled as "high risk," by using somewhat unclear clinical parameters.

In this Chapter 5, I review narratives of decision-making among the interview participants, examining the role of medical authoritative knowledge, technological interventions, and the architectural structure of the hospital in shaping the decision-making process. Based on observational findings and results from participant interviews, I explore the variable roles of patients and their obstetricians in decision-making, identifying specific examples of social factors that appear to be particularly influential in the process. Additionally, I investigate the differential power dynamics between outpatient and inpatient medical settings, as it impacts patient autonomy and agency.

In this Chapter 6, I narrow the focus of the research question to examine the impact of the specific socioeconomic stratification of Metro Detroit, as context for the urban participants' childbirth experiences. I retell the stories of the low-income, minority women in this study who experienced discrimination when interacting with medical personnel in their pregnancy-related care, arguing that both race/ethnicity and insurance status appear to be the primary impetus for their unequal treatment. Lastly, I discuss the contrasting environments of the urban and suburban hospital institutions, citing the overwhelming volume of patients and practicing physicians observed at the urban hospital as contributing to depersonalized doctor-patient interactions. I argue that the framework of American obstetrics fosters this type of practice and may even encourage the employment of racial and class discrimination in the medical care of disenfranchised patient populations.

Chapter 7 presents a discussion of the various conceptual and theoretical conclusions addressed by this research project. In considering various tools and techniques of obstetrical practice, I review the ways in which participant autonomy in birth-related decisions was impacted by socio-cultural context and relate these findings to a broader discussion of American obstetrical practice. Using Foucault's concept of "biopower", I discuss the use of terms such as "medical necessity" and "risk," arguing that these conceptual tools affect both individual patient autonomy, while also serving the purpose of population control by implementating of dominant social order through neutralized medical terminology. I further expand upon the notion of stratified medical space, as introduced in Chapter 5, as a means of establishing differential levels of patient autonomy, as a result of the medical environment (inpatient vs. outpatient care). I also consider the significance of socioeconomic stratification in the Metro Detroit region, not only in the course of not only birth-related decision-making, but also in health care experiences, generally, arguing that insurance status, in particular, serves as a proxy for racial identity that facilitates and justifies the incorporation of prejudice in biomedical practice. Lastly, I use a Marxist perspective to examine the relationship between the obstetrician and laboring woman, positing that depersonalized health care cultivates a disconnect in clinical interactions, while also servicing broader economic interests of the medical institution. I conclude by identifying potential avenues for change in prenatal care and medical education that could potentiate a more egalitarian form of birth-related decision-making in obstetrics.

Chapter 1: American Childbirth Culture: biosocial features of birth and decision-making

In constructing an ethnography of childbirth in the Metro Detroit region, this research study draws upon the wealth of anthropological literature on the cultural roots of birth-related practices. Childbirth is both a biological and a cultural phenomenon—a life event universally experienced by women, and yet, "accomplished in strikingly different ways by different groups of people" (Jordan 1993:3). Approaching childbirth as a cultural production reveals it to be a potential vehicle for social ideologies relating to race, gender, and class. Furthermore, it is an excellent example of the United States biomedical system as a cultural construction embedded with social conceptualizations of normality and morality. Thus, utilizing anthropological techniques to analyze childbirth practice makes possible an assessment of the complex socio-cultural and economic dynamics of Metro Detroit that impact the experience of expectant women participating in this research study.

Through a cross-cultural examination of childbirth, Jordan (1993) identified "biosocial features" of birth (local conceptualizations of birth, preparation for birth, birth territory, the use of medication and technology, attendants, and the locus of decision-making power) as culturally-variable traits that distinguish the nature of birthing systems. Using various theoretical models, including the Critical-Interpretive approach, Marxist, and Foucauldian theory, this literature review examines the culturally-variable biosocial features of American childbirth in order to provide a comprehensive understanding of how both micro- and macro-level structures of influence powerfully shape the everyday life of obstetrical practice (Jordan 1993), while also identifying gaps in disciplinary knowledge that will be addressed in the findings of this research study.

Local Conceptualizations of Birth

Social perceptions of birth are unique to each cultural context. As such, the collective image of birth among Americans varies greatly from other birthing systems around the world. Most importantly, this image carries with it an ideological status of "normal" that determines what is the "right" or acceptable way to give birth (Jordan 1993:48). In the United States, birth is viewed as a "medical event," with clearly defined roles of mother as "patient" and attendant as "doctor" (Jordan 1993: 49). This philosophical construct rationalizes medically-managed birth as necessary, yet this arrangement is anything but natural (Jordan 1993). Indeed, the essence of biomedical systems is that their structures are believed to be grounded in "objectivity," when in actuality, they are the result of deep-seated socio-cultural values (Rhodes 1996; Hepburn 1988). Thus, equipped with an "aura of factuality," biomedical functions are perceived as free of culture, effectively obscuring the influence of societal values and beliefs (Rhodes 1996:166).

To break through the guise of "objectivity" in biomedical practice, Scheper-Hughes and Lock (1987) propose the "mindful body" theory, which utilizes a "deconstructed" framework of the body—the individual body, the body social, and the body politic—to better identify "the cultural sources and meanings of health and illness" (Scheper-Hughes and Lock 1987:8). The social body denotes how the body represents and can be used to reflect dominant social structures. The body politic represents forms of control enacted by biomedicine at both the individual and collective level—how hegemonic ideologies are conspicuously produced and reinforced through the body (Ginsburg and Rapp 1991; Scheper-Hughes and Lock 1987). In understanding local conceptualizations of birth, the individual body is essential, in that it represents the manifestation of social values in embodied experience (Scheper-Hughes and Lock 1987). Cartesian dualism, or mind-body separation, is a fundamental part of the individual body as experienced in Western society. This philosophical distinction relegates intellectual and physiologic processes to entirely different realms, resulting in a significant disconnect between the physical and metaphysical self. Given its tangible nature and measurability, the physical body is the focus of Western medicine (Scheper-Hughes and Lock 1987:9). The absence of social, interactional, and emotional experiences in medical discourse transforms the body; it becomes external to itself, as if it were operating independently from the mind—like a machine (Davis-Floyd 1992). This paradigm constructs American perceptions of childbirth as a mechanistically driven endeavor, devoid of individual contribution on the part of the laboring woman (Davis-Floyd 1992:49). This technocratic model of birth frames the female body as "an abnormal, unpredictable, and inherently defective machine" in need of maintenance and repair through the technical expertise of the physician (Davis-Floyd 1992:53). Body-as-machine denotes a loss of control on the part of the woman, rendering the physical body something altogether foreign from the "self," a conceptualization that greatly influences expectations of and approaches to birth.

Similarly, within a modern capitalist setting "the body acquires a dualistic phenomenology of both a thing and my being, body and 'soul'," such that it is rendered an object in and of itself (Taussig 1980:4). The body, as describe in medical language, is fragmented and dehumanized—a collection of organs and abstract components, rather than a complex human being (Sharp 2000). The contractions of labor are not characterized as an amalgamation of organic synergy, mental focus, and emotional determination; they are the mechanical function of a disembodied uterus, distinct from the body within which it resides. According to Marx, a commodity is an "object outside us, a thing that satisfies human wants of some sort or another," namely through its utility or value (Tucker 1978:303). Clearly, the body-as-machine paradigm necessitates the body be distinct from the individual self, and thus, it and its products become potential commodities. Capitalist motivation to accumulate wealth (i.e. commodities) permeates the structure and function of the biomedical institution, such that clinical practice serves as a means of fulfilling these economic interests. Therefore, a biomedical birth becomes a source of potential wealth for the system—the woman and her unborn child commodities. Routine sonograms further segment the body in new and unusual ways, while simultaneously "fetishiz[ing] the fetus [and] displacing the mother" (Sharp 2000:300). As commodities of the biomedical institution, notions of personhood and ownership pertaining to the mother *and* the fetus are renegotiated through terms of "property" (Lock and Nyugen 2010). This bodily transformation of woman to commodity and physician to laborer presents a striking dynamic of interaction within the cultural system of medicine. However, there is limited investigation as to how these economic structures manifest in both the doctor-patient relationship and obstetrical practice as a whole. As is demonstrated through Marxist theory, the capitalist framework of American labor inherently changes the relationship between laborer and their work. Therefore, we may assume a similar transformation must occur between physician ("laborer") and patient ("work"). Thus, the capitalist milieu of American obstetrics must necessarily shape the intimate relationship that involves birthing decision-making, a topic that warrants more attentive philosophical investigation and will be further explored in discussing the findings of this research study.

Birth Territory and Preparation

Once entirely a "women's affair," at the start of the 20th Century, about half of American births were performed by male obstetricians (Walzer Leavitt 1983; Walzer Leavitt 1987). A historical analysis of American childbirth makes clear the important social transformations that lead to and came as a result of the move to the hospital. The transition from domestic, midwife-attended births to hospital births demonstrates how the underlying patriarchy of the American medical system has "convinc[ed] women of the defectiveness and danger inherent in their specifically female functions" (Davis-Floyd 1992:53). Within the hospital exists a unique way of seeing, writing, and speaking about the body that creates a distinct medical culture (Good 1994). Thus, the move from home to hospital birth dictates that "the dominant culture related to childbirth has become hospital culture," which is largely inaccessible to the birthing mother (Lewallen 2011:4). Furthermore, ideological constructs of childbirth as a "dangerous" and potentially life-threatening endeavor legitimates the hospital as the only appropriate, and therefore, responsible location to give birth (DeJoy 2010). Safety and unpredictability characterize childbirth in the minds of young American women, who often believe medical knowledge and technology to be the panacea for preventing pregnancy-related complications (DeJoy 2010). Thus, the "healing" of "pathological" pregnancies through the accomplishment of hospital birth "reaffirms the integrity of an implicit construction of reality and its enveloping symbolic order," such that the structures of medicalization, professionalization, and sexism present within the dominance of obstetrics is neutralized as an inherent reality of birth (Comaroff 1982:52).

In the United States, preparation for birth consists largely of identifying and managing pathology through prenatal care visits (Jordan 1993). These visits act as a means of socialization for the birthing mother, in which she is introduced to medical culture and what her expected role will be in a biomedical setting. Similarly, in this model, the only culturally "appropriate" location to give birth is the hospital, a social standard that is predicated on the aforementioned conceptualizations of pregnancy as “pathological” (Jordan 1993; Hahn 1987). The location in which birth takes place is crucial to the dynamics between participants because it “inevitably takes place on somebody’s territory” (Jordan 1993:67). It goes without saying that a hospital birth, with all of its technological accoutrements, is within the physician’s domain (Jordan 1993).

In general, medical settings are strange and unusual places to those outside of the medical profession, yet this lack of familiarity is not exclusive to the patient experience. In the hospital especially, there exists unique symbolic practices that reflect the social arrangements of the medical staff and those they treat (Good 1994). This can be seen in the symbolic costumes of health care workers—the distinct blue of hospital scrubs, white coats of varying length based on level of training, or the traditional netted caps and protective booties commonly worn by surgeons (Katz 1981). The language with which the staff communicate is entirely unique, colored by the Latin basis of medical lexicon and dotted with the agreed upon abbreviations and acronyms for various conditions or patient presentations. Even the title “doctor” injects of level of ceremony and formality within the ordinary interactions navigated by medical professionals, patients, and family. All these acts, beliefs, and practices reflect an established hierarchy of social interactions that is not only ubiquitous throughout Western medical practice, but also unconsciously accepted as a normal, seemingly natural arrangement within medicine. Medical reality is, just as Byron Good (1994) described, a unique cultural system, in and of itself, complete with it’s own version of seeing, speaking, and writing. Indeed, the outpatient setting is decidedly much closer to the everyday interactions of the general community, whereas the hospital exists almost as an independent, isolated cultural system. The hospital is a place where sick people go—a realm of fear, uncertainty, illness, and even death. It is important to note that medical professionals do not necessarily share this perspective. Thus, it can be assumed that the hospital setting is much more completely the “territory” of the doctor than an outpatient clinic may be. Indeed, the level of hierarchy is graduated between differential hospital settings. As a result, their control over decisions in labor and delivery could potentially increase when the laboring mother is transplanted into an entirely unfamiliar and potentially unnerving space occupied by other “sick” patients.

Medical settings also serve the purpose of surveillance. Regular prenatal visits consist of continued monitoring and documentation of various medical parameters, including fetal heart tones, blood pressure, and blood sugar levels. Prenatal care is focused on the prevention of pathology in pregnancy, driven by the possibility of maternal or fetal demise. This creates an impossible pressure on the mother to comply with medical advice or face the potential circumstance in which she is deemed responsible for her death or the death of her fetus. Thus, prenatal visits impart an expectation of unquestionable adherence to medical protocol in order to be considered a “good” or moral mother, thus legitimating the need for invasive acts of surveillance throughout the duration of pregnancy (Bessett 2010). Failure to follow prenatal guidelines, for whatever reason, leads to perceptions of the patient as either “difficult” or “problematic.” As an example, failing to use prenatal vitamins being conflated as medical “noncompliance.” The misuse or improper use of medications most commonly occurs among low-income, minority patients, thus the designation of “noncompliant” further cements notions of irresponsibility and immorality to already disenfranchised populations (Das and Das 2006). In this way, surveillance during the prenatal period is a powerful tool of control and maintenance of the existing social order.

Yet, how does this process of medical acculturation actually take place? How do obstetricians come to hold such authority over individual women’s physiologic and emotional status and by what means? Furthermore, how does the impact of the “pregnancy as pathology” mindset translate into the lived experience of an expectant mother? In what ways does the omnipresence of pathology in prenatal care shape the autonomy of expectant mothers and the decisions they make?

The Use of Medication and Technology

In a physical and philosophical sense, medications and technology alter the natural progression of labor and delivery. In this way, obstetrical interventions are “visible and manipulable” artifacts of a particular birthing system’s “way of doing birth” (Jordan 1993:81). Based on the various forms of intervention (episiotomy, pitocin, forceps, vacuum aspiration, cesarean preparation, etc.), it is evident that birth is “a product of technology” in most Western medical contexts (Jordan 1993).

A fundamental tenet of the technocratic model of birth “holds that some degree of intervention is necessary in *all* births” (Davis-Floyd 1992:57, emphasis in original). It is here, in the use of medical interventions, that the body-as-machine paradigm becomes a visible reality. The physical segregation of the mother into her upper (emotional) half and lower (mechanical) half is mirrored throughout various obstetrical procedures, including anesthetization through epidural, draping below the waist during delivery, and the lithotomy position, which obscures the mother’s view of her lower half (Martin 1987). The mechanistic model of birth is a product-driven endeavor, in which the labor of the disembodied uterus is described as having either “efficient” or “inefficient” contractions (Martin 1987). As a result, many laboring women experience a “splitting between self and body,” which reflects the characteristic individual body of American society (Martin 1987:84; Scheper-Hughes and Lock 1987).

Wendland (2007) contends that the increasing use of interventions and surgical delivery is such that the mother's presence "vanishes" during the birthing process. Cesarean section, in particular, embodies the complete transformation of pregnancy into a pathologic process, removing any previous forms of physical contribution available to the mother during the course of her labor and delivery. Obstetricians identify the use of cesarean sections as primarily designed to avoid poor outcomes, but research of the medical literature demonstrates that the use of "vaginal birth and cesarean surgery [is] socially constructed…under the rubric of evidence-based medicine in consonance with wider narratives of birth" (Wendland 2007:224). Wendland argues that it is the "social milieu" of biomedical practice—a time-constrained, economy-driven society—that is the underlying motivation for the use of interventions (Wendland 2007:208). Technology also serves a sociological purpose, in that the frequency with which it is used in medical practice bolsters the status of the hospital institution as advanced in its specialized knowledge and technical skills (Davis-Floyd 1992).

In this view, social constructions of birth, in addition to objective scientific practice, determine which technology is employed and when. This point is exemplified in ethnographic research of biomedical birthing technologies in other cultures, such as the utilization of pitocin and epidural anesthesia among Southern Indian women (Van Hollen 2003). In India, strong uterine contractions and pain are perceived as essential to a successful birth, which, in part, explains the ubiquitous use of pitocin as a tool for labor augmentation and the relative paucity of epidurals for pain control (Van Hollen 2003). Such examples epitomize Jordan's assertion that "the technology of birth tells us something about the local definition of the event" and that birthing interventions "are the visible, practical constraints on which the shape of the system rests" (Jordan 1993:82-87). Thus, the use of technology and pharmaceutical interventions during the course of labor and delivery can tell us much about the contextual variables that influence birthing decision-making. Given this observation, this research project asked what socio-cultural factors might be identifiable sources of influence among expectant mothers and practicing obstetricians in the Metro Detroit area; what individual and collective dynamics either encourage or discourage the use of particular interventions or medication in local delivery settings?

In examining the administration of medications and technological interventions in labor and delivery, it is important to recognize the significance of the pharmaceutical industry on the structure of the American medical institution. Capitalizing on the commoditization of birthing mother's bodies, pharmaceutical usage during birth demonstrates the infiltration of economic interests into obstetrical practice. Pharmaceuticals, like other commodities, have a "social life," such that they have become "powerful technical devices and cultural symbols" that "acquire a status and force in society" (Van der Geest, et al. 1996:156). During birth, pharmaceuticals are generally used for two functions: to relieve pain or to speed the progress of labor (Jordan 1993). The latter causes the most impactful alteration of a woman's birthing experience, essentially removing much of her natural bodily contribution to the progression of labor. Like many pharmaceuticals, pitocin is used mainly for the purpose of making labor more "efficient." Obstetrical practice exists within a culture of "time famine," and the institutional pressures to increase productivity encourage obstetricians to make birth more "efficient" (Vukovic 1999). Pharmaceuticals, like pitocin, become "time-saving commodities" that increase one's ability to produce (Vukovic 1999:51-52). How does this relationship of commodification and efficiency play out in the context of American childbirth? Are obstetrical interventions that augment labor (e.g. pitocin) in fact used to meet the demand of a "time famine?" And how is the use of such interventions understood and interpreted by expectant mothers?

An important point to note is that all forms of technology are not necessarily disenfranchising, and can even, in some instances, become empowering. Feminist rhetoric promoting natural or "alternative" birthing options often criticizes technology as "inherently patriarchal," which may frame "some women's use appreciation of technology as indicative of a kind of false consciousness, a violation of their true (essential) nature" (Beckett 2005:259). Thus, it is important to consider the structure of decision-making within obstetrical contexts, in order to fully assess women's individual and collective autonomy in this process. Indeed, women do not necessarily perceive the use of technology as universally disempowering, rather many see epidurals, pitocin, and cesarean sections as tools they may utilize to render control over their labor and delivery experience (Beckett 2005). There is clearly need for more nuanced investigation as to how expectant mothers perceive birthing interventions, that considers the use of technology as both a potentially autonomous choice on the part of the laboring woman, while also contingent upon the existing framework of medical authority and social constructions of pregnancy as pathological.

Attendants and the Locus of Decision-Making Power

These biosocial features of birth all contribute to the stratification of decision-making power in American obstetrics. Biomedically-moderated birth creates a dynamic in which a position of power is attained by the possession of specialized medical knowledge, which is largely inaccessible to the birthing mother (Jordan 1997). Within the hospital setting, physicians inherently occupy a hierarchical position of authority in the birthing process due to their exclusive "ownership" of such medical knowledge (Jordan 1997). The management of labor and delivery ultimately depends upon those who are a part of it—"the doing of birth is inseparable from the persons who participate in its production" (Jordan 1993:60). The laboring mother's role as "patient" grants her little, if any, autonomy in most biomedical birthing contexts (Jordan 1993). As such, decision-making in childbirth management crystallizes hierarchies of power inherent in the biomedical system.

However, the same hierarchies are not evident in midwife-attended births. Indeed, the possession of specialized knowledge does not necessitate the formation of power hierarchies. Ethnographic data suggests that biomedically-trained midwives do not impart the same power differentials with their own patients during home births, instead continuing to employ a "horizontally distributed knowledge modality," in which knowledge is "consensually constructed and socially reproduced at the community level" (Sesia 1997:410). Similarly, Davis-Floyd and Davis (1996) found that American midwives credited much of their decision-making efforts to their intuition, despite being well-versed in biomedical technologies. It is the hospital institution—fundamentally based on hierarchical structures—that facilitates the stratification of authority between patient and physician. Indeed the role of laboring mother is dictated by their birth attendant, and within biomedical institutions, "the doctor has a vested interest in preserving the ignorance of his patient, for it preserves and enhances his own power" and the power of the medical system (DiGiacomo 1987:339).

Thus, the setting of decision-making is particularly important in determining the distribution of power during labor and delivery and is an important component of an expectant mother's autonomy. When and where do decision-making discussions between obstetricians and expectant women take place? What information is the focus and how is it exchanged? How do expectant mothers reach a decision about birthing interventions and how do they communicate their choices?

Yet, the idea of “choice” as a readily available luxury for all birthing mothers clearly fails to address the lack of agency attainable for socially and economically disadvantaged women. Knowledge is one of the only means of gaining agency during a biomedically-managed birth, and generally, that knowledge is focused on biomedical and technical aspects of birth, rather than the inherent knowledge of embodied experience. As a result, disenfranchised women are often even more limited in the options available to them within a hospital-based birthing setting (Lazarus 1997). Instead, what exists is an illusion of choice. Low-income women often lack the variety of options afforded to birthing mothers from a dominant social strata. Indeed, ethnographic evidence demonstrates that low-income women are willing to go to great lengths to receive adequate prenatal care, yet limitations, such as transportation, Medicaid acceptance, and appointment scheduling, regularly delay or prevent them from doing so (Mullings and Wali 2001). Constrained by these barriers, low-income minority women often end up in crowded, overbooked clinics, facing long wait times, discriminatory treatment from medical staff, and poorly-communicated care (Lazarus 1997; Mulling and Wali 2001). Thus, we ask if the inherent stratification of power in biomedicalized birth may be more pronounced among disenfranchised communities of women, including the low-income, minority population of Detroit. This dissertation will explore what disadvantages low-income, minority expectant mothers actually experience when interacting with the health care system and how these factors impact their autonomy, both individually and as a greater community.

Conclusion

Childbirth and the way it is understood, approached, and managed within the Western medical system is not only indicative of its definition as a cultural phenomenon, but also of the socially-constructed nature of medical systems, in general. Using an epistemological lens, we can see that dominant social ideologies are embedded within medical knowledge, though often obscured by the presumed objectivity of medical science. Given this background of anthropological literature, this dissertation approaches the question of childbirth decision-making as a component of a larger medical cultural system, acknowledging both the societal dynamics of influence, as well as the will of individual expectant mothers and practicing obstetricians. However, there is an additional layer of complexity to this investigation of sociocultural context in birth-related decision-making in Metro Detroit: the issue of race. In the following background chapter, I will further consider the context of this research question by examining the cultural construction of race within biomedicine as it relates to racial health disparities.

Chapter 2: Racial Health Disparities in America: how do we address “race?”

If we are to understand childbirth as a product of socio-cultural context, then we must necessarily consider the varied identities of expectant mothers, as both women and members of particular economic and social strata. Birth is a highly variable experience, due largely in part to the previously outlined biosocial features of childbirth, identified by Brigitte Jordan. Yet, what individual and collective factors relating to women's social position impact their birthing experience? Does racial identity or socioeconomic status play a role in obstetrical management? And how do obstetricians perceive and approach patients from different social backgrounds? Given the high percentage of black citizens in the city of Detroit and the pronounced geographic and economic segregation of the Metro Detroit area, this chapter will examine the way in which socio-cultural identity—particularly race—is understood and utilized in a medical setting. Race, in and of itself, is highly complex both as a lived experience and as a constructed social identity. In general, poor health outcomes are disproportionately represented in African American communities. Indeed, black Americans experience greater incidence of disease morbidity and mortality in comparison to their white counterparts, especially if they are of lower class status (Dressler, et al. 2005; Williams and Collins 1995). These differences are collectively termed health disparities, wherein "disadvantaged social groups…systematically experience worse health or greater health risks than more advantaged social groups" (Braveman 2006:167). Accordingly, "race" and/or "ethnicity" have become key variables of interest in health-related research, yet these terms often lack a clear definition, which has lead to misconstrued understandings of the correlation between racial identity and physical traits (Dressler, et al. 2005). The resulting conflation of race as a biologically distinct category has caused many social science researchers to shy away from the investigation of race as it relates to health. Although it is not biologically significant, race *is* socially significant, as categorization within a particular racial group inherently exposes individuals to health risks, as a result of social and economic disadvantage (LaVeist 1996; Smedley and Smedley 2005). The issue is not with researchers choosing to examine race, but rather, with their definitions of it. Race is best understood as a social construct "used by members of society to explain perceived biological differences among humans" (Dressler, et al. 2005: 243). Thus, the label of "black" or "African American" is not a marker of biology, but rather an acknowledgement of social classification based on cultural values and beliefs (American Anthropological Association 1998). Often used interchangeably with race, "ethnicity" defines a community with shared ancestry, tradition, or beliefs, which may or may not include ethno-biological ideologies of race (Dressler, et al. 2005: 244). In an attempt to fully consider the multifaceted identities of expectant women in Metro Detroit, this literature review will examine five different models of understanding racial health disparities (racial-genetic, health-behavior, socioeconomic status, psychosocial stress, and structural-constructivist), as well as the way racial/ethnic identity is utilized within health care settings, as both a rationalization for variable health outcomes and a template for approach to particular minority patient populations (Dressler, et al. 2005). In doing so, this literature review outlines a more nuanced conceptualization of race; one in which American "blackness" is contingent upon long-standing institutions of oppression, such as slavery, as well as locally defined "ethnoracial categories"—framing "race" as both individually and collectively experienced, externally and internally defined, rigidly ascribed and contextually malleable.

Models for Understanding Racial Health Disparities

The task of understanding racial health disparities belongs to a myriad of disciplines, including medical research, public health, sociology, and medical anthropology. As would be expected, there is wide variety of theoretical approaches to understanding differential distributions of sickness and health. Dressler, et al. (2005) outline and critique five different models for used in medical research to investigate health disparities: the racial-genetic model proposes an explanation that equates differences in health with genetic variation, the health-behavior model emphasizes individual actions of racial/ethnic groups, the socioeconomic status (SES) model cites the overrepresentation of minorities in low SES groups, the psychosocial stress model focuses on the particular stresses experienced by minorities due to discrimination, and the structural-constructivist model considers the shared social structures of particular racial/ethnic groups in shaping human behavior and ideal health status. These models should be considered not only as academic methodologies, but also as representations of social and political ideologies (Dresseler, et al. 2005). Many of the presumptions inherent in these theories are based in popular conceptions of race, individuality, and notions of responsibility within health. Thus, in assessing their varied approach, one can elucidate the hegemonic social structures that motivated their ideological basis, as well as the justification of their continued use in the face of established scientific inaccuracy.

Race as Biology: the racial-genetic model

The racial-genetic model reflects the long-standing Western traditions of using racial taxonomy as a proxy for physically observed differences, as a means of categorizing diverse populations. The central tenet of this model presumes that racial groups are biologically and genetically distinct from one another. In actuality, there is greater genetic variation *within* racial groups than between them, thus, biological constructions of race are wholly unscientific and inaccurate (American Anthropological Association 1998). Surprisingly, this has not deterred research on health disparities from operating on conceptualizations of race as biologically determined (Cooper and David 1986; Goodman 2000). The persistence of race-as-biology paradigms may be best understood by framing race as an ideological construct. Race serves the purpose of defining an exotic "other" (Lock 1993). As such, the adoption of genetic theories of racial difference are "intimately linked to the development of the capitalist economy and associated exploration and exploitation of the globe by European expansionists" (Lock 1993:206-207). In providing a measurable distinction between "us" and "them," this concept's popularity is largely due to its affirmation of non-Europeans as inherently inferior. The power of physiologically or genetically distinct races is that it connotes biological determinism of particular non-physical traits, such as civility, intelligence, and morality. In doing so, biological constructions of race hold the power to neutralize political ideologies of racial "others" as scientific evidence. Perhaps one of the most famous examples of which is the "racial-cleansing" of Jews in Nazi Germany. The Nazi's believed races to be absolutely distinct biologically and used this premise to attach genetic predisposition for crime and disease to races deemed "inferior," framing race as simultaneously physical, behavioral, and moral (Proctor 1988).

Biomedicalizing Race

Such monstrous use of biological determinism seems an exaggerated point of comparison for current conceptualizations, but the modern treatment of race in biomedical sciences may be equally dangerous, in that it surreptitiously assigns existing prejudiced notions of morality and responsibility to minority groups through the use of seemingly "neutral" medical terminology. As a biological construct, race becomes the domain of medical science—a designation to be defined by physicians and the biomedical institution. Race becomes "objective" and “scientific”—a medical variable with which one can interpret health status. Thus, assigned racial identity can be used as a determinant for clinical approach. High rates of preterm labor in the black population is an example of such, where genetic variation in single nucleotide polymorphisms (SNPs) related to the premature rupture of membranes has been mapped in the black population and proposed as a indicator of preterm labor risk (Ferrand, et al. 2002). This study has effectively attempted to explain the high maternal mortality rate in the city of Detroit through biomedicalized means, which effectively forces the complexity of racial/ethnic identity into measurable and “objective” terms. Indeed, specialized protocols for the treatment of hypertension and even “genetically specific” pharmaceuticals have been developed for black patients as a result of this decidedly inaccurate racial-genetic model (Douglas, et al. 2003; Brody and Hunt 2006). Biomedicalizing race is a process of reification—a simplification of a complex physical, emotional, and social experience, such that race becomes a concrete and definable entity independent of the individual patient. As a result, racial identity is recruited as a biomedical commodity and potential source of economic gain for a variety of invested parties (Pollock 2013). In this way, African Americans simultaneously occupy two seemingly contradictory roles—a niche market for racially-targeted therapies and a “neglected population” (Pollock 2013). In assessing the failed pharmaceutical BiDil, a “racially-specific” drug for heart failure, Pollock (2013) argues that racialized pharmaceuticals invoke a form of biological citizenship, in which minority groups may “stake claims to social membership” in the U.S. health care system through their “damaged bodies.” As such, the seemingly defective bodies of the black community can at once call forth a moral imperative to act, while also present a point of potential profit for the medical institution (Pollock 2013).

Such efforts to develop biomedical solutions to health disparities reinforce biological simplification of racial identity in the mind of practicing physicians, which have both practical and ideological ramifications. Studying recommendations for cardiac intervention in simulated patients, Schulman, et al. (1999) found that, without any clear clinical indication, the least amount of cardiac catheterizations were recommended for black females. This may be be a form of "invidious discrimination," whereby heroic medical interventions "are used much less often among African American patients" (Brody and Hunt 2006:558) or a result of cultural perceptions of black bodies as being hardy and resilient. Either way, it is a translation of a social construct into a biological reality. Is the same differential approach to African American patients seen in the management of labor and delivery? How does racial identity alter an obstetrician's approach to prenatal and peripartum care, and in what way does perceived race/ethnicity influence obstetrical terminology?

If biological constructions of race influence a physician's perception of their patients, it similarly influences societal understandings of race. A racial-genetic approach to health disparities shapes collective understandings of race as finite, immutable, and inherent. Your health, whether you have a robust constitution or are predisposed to illness, is essentially physiologically inevitable. If race is biological and minorities have, by and large, poorer health status, then illness can be internalized as a personal and moral failing. In this way, race is transformed from a cultural product to an individualized understanding of self. Through its "scientific 'truthfulness,'" medicine legitimates biological constructions of race, effectively acting as a "pernicious way of constructing reality" (Lock 1993:203).

Racial Behaviors: the heath-behavior model

To its credit, the health-behavior model adds an environmental dimension to the discussion of health disparities, including diet, physical activity, smoking, and alcohol consumption, which counters the inherent biological nature of health status assumed by the racial-genetic model. However, the health-behavior model understands "behavior" as "voluntarily adopted [actions] by individuals" (Dressler, et al. 2005: 236). This perspective is problematic in two important ways. First, it assumes "behaviors" to be a matter of choice, rather than a result of circumstantial factors that either limit or encourage individual actions. Secondly, it designates poor health as the responsibility of the individual—as being a direct result of their actions.

Using an inaccurate version of Byron Good's "illness representations," Pickett, et al. (2013) attempt to posit an association between African American "beliefs" about hypertension and the "choices" they make during the course of their treatment, suggesting that "patients who are nonadherent…hold hypertension beliefs that are not consistent with the medically endorsed views of this disease," and thus, fail to follow their doctor-recommended treatment regimen (Pickett, et al. 2013:152). Using black participants from the Detroit area, the researchers argue that patients who believe their hypertension to be a result of stress or everyday exposure to racism had "less engagement in behaviors known to reduce or control [blood pressure]," concluding that providers must make an attempt at understanding patients' beliefs, so they are better able to coach them on the "correct" lifestyle choices (Pickett, et al. 2013:164). Only mentioning in passing the scarcity of grocery stores and lack of a safe environment for physical activity, their conclusion suggests that the disparate incidence of hypertension and its related complications within the black community are a direct result of their own behavior, which is motivated by beliefs that are “misinformed” and “unscientific.” They greatly downplay the significance of Detroit’s “grocery store desert,” a circumstance that results in both a physical absence of produce distributors *and* also a perceived lack of fresh food accessibility (Johnson 2012). In other words, the scarcity of major grocery chains in the inner city presents both a tangible barrier to attaining healthy foods, as well as producing a poor “observed food environment,” such that residents are limited in their dietary decisions in both a physical and a psychological way (Johnson 2012). Yet, Pickett, et al.’s discussion of Detroit health behaviors favors an individualistic construction of lifestyle choices, effectively negating the deeply entrenched context of inequality in the most basic of needs. In essence, they argue that black Detroiters are sick because they don’t know any better, and it is the role of the physician to reeducate them using “medically endorsed views of disease.”

Assigning blame is inherent in the health-behavior model’s approach to disparities. It assumes an almost utopian perspective of universal equitability in individual choice, such that those who make the apparent “wrong” choices are fundamentally the only responsible party for their poor health. This type of rhetoric is often seen in discussing reproductive health, particularly among African American women. Societal assertions that health status is the responsibility of the individual directly shapes welfare policy and the availability of social programs. Indeed, individual behaviors believed to lead directly to disease, such as smoking or poor diet, elicit strong public reactions that grant little sympathy or support for federally-backing health care costs (Gollust and Lynch 2011). Eating healthfully, avoiding tobacco and alcohol, and getting regular exercise certainly all have positive health effects. This is not the issue of contention. Rather, it is that these “unhealthy behaviors that arouse public scrutiny and blame…have become increasingly associated with low-status groups over time” (Gollust and

Lynch 2011:1088). Thus, racial stereotypes of poor behavior construct a social ideology of "deservingness" of health care, wherein minority groups are decidedly "undeserving" (Gollust and Lynch 2011).

Systemic Inequality and Race: the socioeconomic status model

The socioeconomic status (SES) model challenges both racial-genetic and health-behavior models, by explaining health disparities through the "over-representation of some racial and ethnic groups within lower socioeconomic statuses" (Dressler, et al. 2005:234). Instead of assessing individual traits or behaviors, the SES model focuses instead on systemic inequalities in minority resource accessibility. Many social science researchers have argued for a conceptual model that focuses on the "fundamental social determinants of health," such as social status, income, and education, as the only means by which health disparities can be appropriately understood and addressed (Syme 2008:456). In placing environment and social inequality at the center of health disparities discourse, this model shifts the core of the discussion away from "specific disease issues," displacing individualistic, biologically-determined explanations of health (Syme 2008:457). In doing so, the supposed biological inevitability of poor health in minority racial/ethnic groups is discredited, such that there can be a critical "epistemology" of disease emergence and distribution among disadvantaged populations (Farmer 1999).

Lack of insurance coverage is an example of socioeconomic status that presents a serious obstacle to accessible health care in the American medical system. Uninsured patients have less consistent access to basic medical care, which causes them to experience a greater incidence of chronic illness, poorer maintenance of chronic illnesses, and more frequent misuse of medication (Becker 2001). In addition to transient care accessibility, uninsured patients are often subject to tedious bureaucratic regulations and prejudiced service while accessing available social programs, as well as significant gaps in care, increasing the likelihood of chronic illness exacerbation and potential hospitalization (Becker 2004). The SES model complicates the suggestion of autonomous health decision-making proposed by the health-behavior model, by treating social inequalities, such as insurance status, as meaningful components of minority health care experience. Rather than assuming individual volition, there is instead a focus on large-scale oppression.

One of the most startling examples of health disparities across the globe is maternal mortality. Having one of the highest maternal mortality ratios among industrialized nations, the United States is no exception (McCool, et al. 2013). Given that black women are almost three times more likely than white women to die as a result of pregnancy-related complications and that the majority of these deaths are largely preventable through routine screening, adequate nutrition, and technological intervention, the U.S. maternal morality ratio is nothing short of a human rights failure (Bryant 2010; Coeytaux 2011). The fact that socioeconomic inequality literally determines who lives or dies demonstrates just how deeply this stratification is embedded within our social consciousness. Any assessment of maternal health that does not account for the systematic depravation of social and economic resources in minority populations is not only entirely incomplete, but also irresponsible.

Indeed, “complications of pregnancy often begin even before a woman becomes pregnant, when many women are uninsured and lack affordable access to primary care, including contraceptive services and information” (Coeytaux 2011:190). Poor access to educational reproductive services substantially impedes reproductive autonomy for young women (Johnson and Snow 1982). In a study of reproductive knowledge in Detroit females, Johnson and Snow

(1982) found that most of the women had little to no understanding of their menstrual cycle, which is essential information for successful contraceptive usage and preventing unwanted pregnancies. This study highlights the early beginnings of poor health care accessibility among minority patients, which, accumulated over the course of a lifetime, leads to increased disease morbidity and mortality. Through the perspective of the racial-genetic model, research on maternal morality would focus on the frequency of variant genetic alleles among African American women. The health-behavior model would assess black women's alcohol consumption, rates of STDs, "beliefs" about pregnancy and contraception, and motivations behind their "choice" to forgo prenatal care. These approaches, quite apparently, present a portrait of human experience that lacks attention to the impact societal power differentials on patient health. It is the socioeconomic status model that exposes the role of long-standing systematic inequalities in health status and the provision of care, by questioning not what the individual has done wrong, but how our society has failed.

Employing Intersectionality Theory

Inequitable resource accessibility is not the result of isolated experiences of either racial, class, or gender discrimination. Rather, all of these parameters interact and reinforce one another. Intersectionality theory accounts for systemic inequalities relating to race, gender, and class, but instead of viewing them as stagnant forms of oppression, it describes them as working "within a context of mutually constructing systems" (Collins 2000). In examining disparities, such as maternal or infant mortality, it must be understood that "discrimination based on poverty…gender, race, and ethnicity overlap, but they are not the same" (Lane 2008:19)—that gender, race, and class differences impact individuals and communities in cooperation with each other. Thus, the combined effects of being a low-income, minority female in the United States have bred a particularly injurious environment. In considering the context of childbirth in Metro Detroit, this dissertation must necessarily employ intersectionality theory, in an attempt to understand the unique experience of expectant women from, often times, vastly different social circumstances. Biomedical management of birth has been criticized as a tool for disempowering women during labor and delivery (Browner and Press 1996; Davis-Floyd 1992; Jordan 1997; Martin 1987), but there is need for a more nuanced understanding of the particular ways it operates in different economic and racial contexts. For instance, the standardization inherent in prenatal care homogenizes women into a "one-size-fits-all" template, which selectively favors women belonging to the dominant social strata (Sagrestano and Finerman 2012). Furthermore, ethnographic evidence suggests that Medicaid-based regulations during the prenatal period requires pregnant mothers to undergo a variety of medical interventions and counseling, in essence, "making themselves vulnerable to the state by divulging both intimate and banal details of their lives" (Bridges 2011:43). Thus, experience with prenatal care is highly dependent on the racial identity *and* class background of the pregnant female, a principle which drives the theoretical basis of this research investigation. Therefore, group subjugation is not simply the result of capitalist interests, patriarchal dominance, or racial oppression, but rather a product resulting from the interaction of all three. Thus, it is not appropriate to envision gender, class, and racial inequalities as mutually exclusive, but rather as working in concert. In assessing this complex relationship, this chapter will first begin by examining the various models by which race is understood not only as a biological variable, but how it is used to explain disparate health outcomes among minority populations. In doing so, it will demonstrate the social role of medicalized racial/ethnic identity as a means by which inequality and oppressive social practices can be couched in seemingly apolitical rhetoric, like “genetic predisposition” and “health behaviors.” Most importantly, this chapter will question whether the pronounced racial and economic stratification of the Metro Detroit area plays a role in the experience of local expectant mothers in their obstetrical care.

Medicalizing Discrimination: the psychosocial stress model

The SES model does not provide a full explanation for the dramatically greater incidence of poor health outcomes among racial minorities. For example, the *prevalence* of pregnancy complications is not as disparate among minorities as the *fatality* of such complications (Coeytaux 2011; Tucker 2007). Essentially, even when there is equal prevalence of a particular complication, minority women more often die from these complications that their white counterparts, indicating that there is an additional dimension, aside from socioeconomic status, in the generation of poorer health outcomes (Coeytaux 2011; Singh 2010; Tucker 2007). The psychosocial stress model adopts race and discriminatory stress as its central tenet. It argues that the “singular experience” of being an African American in the United States “generates a particular configuration of stressors that in turn is associated with health and disease” (Dressler, et al. 2005:241). By focusing on the experience of racial minorities within the specific historical context of post-slavery America, the psychosocial stress model achieves a level of exploration of which the socioeconomic status model falls short.

Within this model exist two different types of approach: the first simply describes racism as an overall negative effect on health, while the second makes the distinction between institutionalized and perceived racism (Dressler, et al. 2005). The first approach characterizes a unique group of “stressors” that impact African Americans (unstable support systems, high-crime neighborhoods, and economic hardship) as a result of institutionalized racism (Rosenthal and Lobel 2011). Given its history, Detroit provides an excellent example of how social stratification can manifest as harmful effects on health. Food insufficiency is an example of a "situational stressor" that impacts African American communities disproportionately and creates a measurable level of "psychological distress" among residents (Ajrouch, et al. 2010:171). Continued anxiety as a result of this stress is likely detrimental to emotional and physical well being. Indeed, the incidence of depressive symptoms among Detroit women is strongly correlated with the amount of situational "stressors" experienced (Schulz, et al. 2006). In such circumstances, social support, either formally through food stamps or informally through familial and community networks, are believed to provide a significant beneficial response among residents (Ajrouch, et al. 2010). Unfortunately, the lack of police infrastructure and funding for neighborhood safety measures leads to high rates of violent crime in many African American communities, which can, in turn, disrupt the stability of social support systems necessary for maintaining good mental health. One study found that the loss of a parent among black, female Detroiters resulted in substantial social and emotional instability, such as intermittent homelessness, which created periods of "acute stress" and compromised their overall health (Berman, et al. 2013). In this way, the psychological "stress" of living in low-income, crime-ridden areas has both an immediate impact, as well as eventual disadvantage for future generations.

Institutionalized racism resembles aspects of the socioeconomic status model, in that it describes large-scale inequalities in class, education, employment, and resource accessibility, yet it does so within the context of a racialized social order that necessarily places African Americans in a position of disempowerment (Dressler, et al. 2005). The concept of institutionalized racism provides a potential explanation for the existence of health disparities within a setting of ostensibly equitable resource accessibility. For example, higher rates of cesarean section, longer hospital stays, and greater incidence of adverse outcomes among black Medicaid enrollees cannot simply be interpreted through variable socioeconomic status, as they still experienced a greater amount of complications when compared to white enrollees with the same insurance coverage and financial eligibility (Zhang, et al. 2012).

Perceived racism refers to the "conscious perception of discriminatory acts and practices and the distress associated with that perception" (Dressler, et al. 2005:239). Perceived racism is a key component of the understanding of embodied experience of health and illness for African Americans, as it touches ever interaction they have in both a medical setting and in everyday life. Often souring interactions with health care personnel, perceived racism significantly impacts women's pregnancy experience and potentially their outcomes (Carty 2011; Rosenberg 2002). A study among women in the Saginaw area found that reported experience of perceived racial discrimination were "associated with lower self-reported physical health, mental health, and a higher likelihood of smoking," while also "marginally associated with lower birth-weight births" (Carty 2011:93). Repeatedly encountering circumstances of racial prejudice can have obvious cumulative effects on individual and collective health among minority patients. This dissertation explores whether or not perceived racism is experienced by expectant women receiving care in Metro Detroit. Thus, discrimination in health care interactions was addressed directly in interview questioning and used to assess the expectant mothers' overall perception of the presence or absence of prejudiced assumptions within the local hospital system.

Distinguishing Racial Experience: the structural-constructivist model

The structural-constructivist model presents a much more dynamic understanding of racial identity. Borrowing from Bourdieu's concept of "habitus" and "social field," it posits that human behavior is the result of both cultural constructions of reality, as well as shared meanings of social structure that dictate interaction within and between communities (Dressler, et al. 2005). In using this model, there is both an understanding of race/ethnicity as a social construct, as well as attention to how these constructions are made (Dressler, et al. 2005). Most importantly, it employs a more detailed understanding of the "goals and aspirations" implicit in a given social structure, as uniquely conceptualized *within* racial and ethnic communities (Dressler, et al 2005).

The first step in understanding the social construction of racial identities is to "establis[h] the fact of whiteness" (Hartigan 1997:495). In only describing the racial identity of minority groups, there is a definite omission of what constitutes white identity, which only serves to perpetuate assumptions of whiteness as a "relational identity" to "racial others" and obscures the necessity of white privilege in all forms of social interaction (Hartigan 1997:496). By acknowledging white identity as a social construction inherent in the creation of racial inequality, one can acknowledge both the routine discrimination of African Americans and how it manifests in subtle, and sometimes obvious, ways. It also makes the researcher aware that they, too, are examining the disenfranchisement of minorities through an inherently white perspective—that even the discourse on health disparities is conceptualized through the eyes of dominant racial groups. This is one of the great disadvantages of the psychosocial stress model: it assumes that minority communities view racial inequality through with the same perspective as the white majority. What constitutes a desired lifestyle is not dictated externally, but rather generated from within—the result of shared community beliefs—and an individual's proximity to that lifestyle, which is described as "cultural consonance" (Dressler, et al. 2005:242). In achieving cultural consonance, individuals have better self-perception of overall health, regardless of external social ideologies and structures of oppression (Dressler, et al. 2005). Thus, the structural-constructivist model presents an opportunity to explore the emicly constructed ideas of a "good life" from the perspective of the minority, rather than dictate what it should be in relation to white privilege (Dressler, et al 2005; Hartigan 1997).

As an example, social stigmatizations of pregnancy in teens or low-income women is not universally experienced by all. In actuality, whether a pregnancy is "good" or "bad" is highly dependent upon social context, whereby these labels "become affixed to pregnant women in and through their social interactions" (Neiterman 2013:336). For instance, pregnant teens may find ridicule at church, but feel free of judgment when among friends and family. Similarly, black women who are viewed as "welfare queens" in one setting simultaneously can be seen as loving mothers in another. To that same point, there are certainly instances when even the dominant types of "normal" pregnancies (i.e. white, middle-class women) can be stigmatizing, such as in professional work settings (Neiterman 2013). In essence, the social context in which she interacts shapes a woman's perception of her pregnancy, as well as the perception of others (Neiterman 2013). Thus, constructions of the pregnant body are both a result of a shared cultural reality, and also, the meaningful social structure unique to particular contexts. As an example of the structural-constructivist model, this phenomenon demonstrates that the "goals" and "aspirations" of particular social groups, including racial and ethnic groups, meaningfully shaping the experience of health and how it is understood (Dressler, et al. 2005).

Both the socioeconomic status and psychosocial stress models homogenize the experience of racial/ethnic minorities. The structural-constructivist model necessitates that one employs a truly ethnographic perspective, in order to establish the particular constructions of reality and life goals specific to various racial and ethnic communities. The preceding discussion of medicalized birth presents a blanket criticism of increased technology and intervention as universally disempowering. However, it fails to explore the instances in which medicalization can be considered a positive experience. This is not to dismiss the obvious ways in which biomedically-moderated births serve social, economic, and political agendas, but rather to acknowledge differential experiences within the system as potentially empowering. To that point, a study of teen mothers' experiences with obstetrical care showed that they alternately "embraced" and "rejected" medical care (Brubaker 2007). Access to formal medical care (often for the first time in their life), created an opportunity for young women to engage with the medical system, as well as provided a setting in which their socially stigmatized pregnancies were "normal" (Brubaker 2007). A similar inference can be made in the context of racial minority health, where counseling by physicians may serve to legitimate concerns about their health and provide access to services otherwise unavailable to them. In this way, medicalization can serve as a means of approximating their conceptions of a "good lifestyle" and achieving a greater level of "cultural consonance."

Conclusion

Understanding the context of childbirth in Metro Detroit necessitates consideration of the unique socioeconomic dynamics of the region. This dissertation attempts to investigate the way in which these cultural variables manifest in the experience of obstetrical care and the process of birth decision-making. The various models for approaching health disparities all provide insight into both the experience of being a racial minority in the United States, as well as commonly held misconceptions and stereotypes of marginalized patient communities. In masking systemic inequalities, biological models of race fail to address the role of socioeconomic stratification in the distribution of disease morbidity and mortality. In general, enlightened approaches to racial health disparities are informed by the notion of race as a dynamic categorization that invokes particular ideations at both the individual and collective level. It can be both an assigned trait and also malleable identity, powerfully imposing dominant structures of oppression, while also differential experience between individuals and communities. It is equally important to acknowledge constructions of health and racial experience as emically constructed within minority communities, as it is to be aware of institutionalized racism and ideological forms of oppression.

Knowing the intense level of racial and economic stratification and pervasiveness of poor health outcomes in the Metro Detroit region, consideration of medical conceptualizations of race, as presented in this literary review, adds needed context. In this dissertation, I use many of the conceptual tools provided by these theoretical models to both critique biomedical approaches to race, as well as construct my own analytic framework for understanding the unique community-defined identities within the Detroit population. In discussing childbirth decision-making among urban and suburban expectant mothers, I often refer to the ideological constructions of racial identity, as both determinants of individual patient autonomy and contributors to the broader societal perception of the city of Detroit, as a whole.

Chapter 3: Setting and Methods

Setting

Metro Detroit is an optimal field site in which to examine the role of sociocultural context in childbirth management, as it provides an incredibly diverse population of expectant mothers from a variety backgrounds. What makes Detroit ideal is that this intense level of socioeconomic stratification occurs within relatively close geographic proximity. This chapter will introduce the city of Detroit and the greater Metro Detroit area, employing a historical perspective to discuss the current sociocultural climate of the region.

Census and Segregation: Detroit, then and now

Just the mention of Detroit draws up a range of visual imagery, whether it's the 1960s race riots or the characteristic city skyline dotted with abandoned buildings and remnants of a booming twentieth century city; Detroit is infamous in its desperation. Yet, the catchy news media's story of a city's desolation fails to encompass the complex history that brought Detroit to this point. In order to understand the cultural dynamics of Southeast Michigan, one must address the long-standing geographic and socioeconomic inequality that has shaped the modern landscape of Detroit and it's surrounding suburbs, collectively known as Metro Detroit. Detroit's "urban crisis" began long before the current picture of crime, economic insolvency, and racialized angst. Following World War II, waves of southern African Americans migrated to urban areas in the Northern United States (Boustan 2010). These once predominantly white cities met the influx of black residents with resistance, and Detroit was no different. Discriminatory housing laws, loan regulation, and employment practices implemented a form of geographic segregation that further partitioned Detroiters into racial groups (Sugrue 2005). The outflow of white city residents, the historical phenomenon known as "white flight," followed a Supreme

Court ruling that sanctioned “Detroit-only” school integration, such that the surrounding suburban school districts were able to remain segregated in all but name (Meinke 2011). The resulting city landscape was markedly segregated, which “set into motion a chain reaction that reinforced patterns of racial inequality” and by 1967, two-thirds of the inner-city population was African American (Sugrue 2005). This racial and class discrimination has resulted in large-scale suburbanization and decentralization of the inner city, leaving the downtown area unstable and economically ravaged (Vojnovic and Darden 2013).

The largest city in Michigan, Detroit is located on the Southeast edge of the state, just minutes from the Canadian border. It is home to approximately 700,000 residents in less than 140 square miles (U.S. Census Bureau 2014). Perhaps one of the most salient characteristics of the Metro Detroit landscape is the marked geographic racial segregation between inner-city and suburban populations. Michigan is historically one of the most racially divided states in the nation, with over 80% of Detroit residents classified as African American by the 2014 U.S. Census Bureau and less than 15% among the rest of the state’s population (U.S. Census Bureau 2014). There is a similar distribution in Oakland County, an adjacent suburb just minutes from the Detroit city border, where approximately 77% of residents are identified as non-Hispanic white (U.S. Census Bureau 2014). The city and its surrounding area are also markedly segregated by class, epitomized in the rapid transition between the abandoned homes of Detroit’s eastern city limits and the lavish mansions of neighboring Grosse Pointe. Detroit’s neighbor, Oakland County, is also one of the wealthiest counties in the nation, where the median household income of over $100,000, annually, dwarfs the $27,000 reported for the city (U.S. Census Bureau 2014). Such gaps in socioeconomic status, along with crime and resource allocation, plague the well being of Detroit and the state overall. Amid outcry, the Governor appointed an

Emergency Financial Manager for the city, effectively removing governing power from the locally-elected officials. Despite having emerged from the largest municipal bankruptcy in history, there have been continued civic disputes. For example, the renegotiation of city workers' pensions to facilitate the bankruptcy settlement has put Detroit residents at odds with the rest of state and invoked familiar racialized dialogues about the city's present and future.

Site Locations

Given the intense segregation and stratification among the Metro Detroit population, the goal of this research project was to capture this striking socio-cultural division through the recruitment of two distinct participant groups from urban and suburban clinic locations. Thus, research study sites were chosen based on geographic location and a general representation of urban and suburban community demographics within the patient population. The primary sites were two outpatient prenatal care facilities, with hospital labor & delivery units acting as secondary research sites. The clinics selected for observation offer prenatal counseling services provided by board certified Obstetrician/Gynecologists (OBGYNs), in addition to routine gynecological care. Given that the focus of this research project was to examine dynamics of doctor-patient interaction within a biomedical setting, observation excluded "alternative" birthing settings, such as birthing centers or midwife-run care facilities.

As a medical student in training, I occupied a liminal state, as both an independent researcher and a compatriot among those within the medical establishment. I was granted a level of entrée beyond what I could have achieved solely as an anthropologist, simply because of my dual-affiliation with the College of Osteopathic Medicine. Although I did not wear the traditional white coat while observing, having a medical school ID badge and baseline familiarity with the general proceedings of the hospital was crucial in obtaining permission to observe in the labor and delivery unit. Also, I would argue that the medical staff, with whom I observed, felt a certain level of comfort in confiding in me the challenges of their jobs, which often times translated into frustration with their patients. They were correct in assuming I would have sympathy for those under the pressure of a grueling and often thankless profession; my personal experience working within the medical system has pushed me to the edge enough times to empathize with their plight. At the same time, I would like to think that being acquainted with medicine allowed me to critique patient care and the decision-making process in a more nuanced and informed way. In the same breath, I must acknowledge the inherent limitation of my status, in that achieving a truly neutral position as researcher was particularly challenging, given my experience as a medical student.

a.) Outpatient Prenatal Offices

i.) Urban

All clinic and hospital locations have been given pseudonyms to achieve confidentiality of the institutions and hospital system. There were two outpatient clinics chosen for observation, one in the urban setting, called “Metropolitan Clinic,” and one located in the suburbs—“Village Clinic.” Labor and delivery units at two hospitals were used as secondary observation sites; “Central Hospital” will refer to the urban hospital location, and “Outer Hospital” will refer to the suburban hospital. Each outpatient clinic services expectant mothers who will deliver at the hospital institution in the corresponding geographic location, and all four of these observational field sites operate under the same greater hospital system. The first point of research contact was initiated at Metropolitan Clinic through pre-field observation in downtown Detroit.

Metropolitan Clinic is located just outside of the Detroit city limits. Although situated in an ethnically diverse community, Metropolitan Clinic primarily serves African American patients living in and around the city of Detroit. Of particular importance was that Metropolitan Clinic serviced patients who would be delivering at Central Hospital, located in downtown Detroit. Situated in a strip mall alongside a grocery store and a few fast food restaurants, Metropolitan Clinic is small, clean, and well organized. As you enter, you come upon an enclosed reception area and adjacent waiting room lined with chairs. Through the door that separates the waiting area from the back of the clinic, there are six patient rooms along a single hallway. In addition to the patient rooms, there is a small, onsite lab for specimen analysis, a break room that housed patient records, and an office with two desks where the obstetricians completed paperwork in between visits. My observation sessions were primarily conducted with a single OBGYN, Dr. Smith[1], although throughout the course of the project, several other physicians allowed me to follow with them, as well. There were, in fact, a number of Arab women also being seen in this clinic, but due to cultural sensitivity surrounding gynecologic exams among the Arab community, these patients were excluded from observation and interview recruitment.

ii.) Suburban

Outer Hospital was chosen as the suburban prenatal site primarily because it is within the same hospital system as Central Hospital, and thus, offered continuity in hospital protocol, resources, and standard of care. Initial contact was made with an obstetrician practicing at Outer Hospital, who then agreed to my conducting observation at their outpatient practice—Village Clinic. This clinic lay in stark contrast to Metropolitan Clinic. Village Clinic had approximately

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[1] Names and personal identity of all participants have been changed to retain anonymity.

three times the office space as Metropolitan Clinic. In the waiting room, glossy mahogany chairs with plush cushions sat next to brochures for Botox and Juvederm, information from the dermatologists that shared the office space. There were approximately 20 patient rooms and generally 3-4 obstetricians seeing patients on any given day.

b.) Inpatient Labor and Delivery Units

i.) Urban

Observation of labor and delivery in the urban setting was conducted at Central Hospital, located among a larger complex of health care facilities in Detroit. Situated outside of the downtown area, Central is one of the largest hospitals in the city. The labor and delivery unit is located among the other hospital wards, roughly demarcated by double-doors, but similar in appearance to the other departments. Centrally located in the labor and delivery floor was what staff called "The Fishbowl," a u-shaped collection of computers and monitoring equipment. The individual delivery rooms formed a rectangle surrounding the Fishbowl. Only vaginal deliveries were sanctioned for the labor and delivery floor, while cesarean deliveries were moved to operating rooms in the basement of the hospital, where other surgeries were also performed. A separate ward was reserved for "high risk" deliveries and postpartum stay.

ii.) Suburban

In comparison, Outer Hospital is situated among a residential area of a Detroit suburb, belonging to the same hospital system as Central Hospital, but located approximately 40 miles outside of the Detroit city limits. The hospital, itself, is newly constructed. The labor and delivery unit is located in a secluded area and only vaguely resembles a standard hospital wing. Behind locked doors requiring identification for entrance, the labor and delivery unit was its own distinct center, seemingly a hybrid between a hotel lobby and a high-end medical center. The equivalent of Central Hospital's "Fishbowl" is an oblong desk, which discretely houses patient charts, computers, and standard monitoring equipment. On the labor and delivery floor, the look of a typical hospital is transformed through the use of wooden paneling and heavy doors. Behind the “welcome desk” is a u-shaped corridor of individual patient rooms surrounding the centrally located operating room, where the majority of cesarean deliveries took place. Indeed, the operating room was so obscure that I missed its entrance several times before distinguishing its door among the rest of the wood paneled walls.

Methods

In order to produce an ethnography of pregnancy and delivery in the Metro Detroit area, this research study employed qualitative methodology using observational techniques, a brief patient survey, and interviews to elicit individual experiences of expectant mothers, as well as larger interactional community and institutional dynamics of the local hospitals. In 2011, I began shadowing Obstetrician/Gynecologists (OBGYNs) practicing in Detroit. These sessions were for the purpose of familiarizing myself with the medical setting and establishing connections for future observation; no field notes were taken at the time. In October 2012, after having received approval from Michigan State University’s Institutional Review Board, I began initial fieldwork by observing at Metropolitan Clinic and Central Hospital, followed by subsequent observation at Village Clinic and Outer Hospital.

Participant Observation

In both urban and suburban locations, I followed obstetricians through the course of a standard clinic day, observing prenatal visits and patient charting. Prior to beginning any observation, I obtained verbal consent from the clinic staff to observe them. Additionally, I made a specific point to inform the staff that I was *not* acting as a medical student, but, instead, a graduate student conducting a research project. At the start of each observed prenatal visit, I introduced myself, briefly described the research project, and requested the patient's verbal consent for me to observe the appointment. During observation, I took handwritten field notes, designated by date, geographic location, clinic or hospital facility, and the start and finishing time of the observation session. Almost every expectant mother who agreed to my observation of their prenatal appointment also agreed to participate in the survey; thus, demographic data from the survey population are representative of the observational participants (see Table 1). Field notes included facility descriptions, number of patients observed, interactions and conversations observed, and information on practice guidelines, challenges, and limitations. Each individual observed patient interaction is labeled with the same demographic information: gravidity and parity status (number of pregnancies, term and preterm deliveries, abortions/miscarriages, and live children), current weeks gestation, and age.

Closed-ended Surveys

After the obstetrician finished his/her examination of the patient, I remained in the room to conduct a closed-ended survey with the patient. Surveys were conducted verbally and consisted of a brief set of patient demographics. Additional questions asked about women's previous labor experiences, any issues encountered in receiving prenatal care, missed prenatal visits, preferences for delivery (vaginal vs. cesarean, use of inductive drugs, and use of an epidural), and who they would describe as the primary decision-maker in labor and delivery. During the surveys, women usually offered anecdotal information and interesting reactions to the questions, which were also included as handwritten notes on the survey sheet. No identifiable patient information was recorded with the survey data. The survey was also used as a tool to recruit participants for in-person interviews. No participant recruitment was performed during hospital observations, as it would have been inappropriate in the context of an on-going labor and delivery.

Observational findings and survey information directed the further development of the research question, as well as the structure and content of patient interviews. Surveys helped identify pertinent issues surrounding the current state of pregnancy-related care within this hospital system and also helped corroborate or refute initial hypotheses. Additionally, this survey information was used to gather basic demographic information, such as age, parity, self-identified race/ethnicity, insurance status, and city of residence. Once compiled, this information was used as a point of comparison between the demographics of the observed clinic patient populations and the overall socio-economic stratification present between the suburban and urban areas of Metro Detroit.

From the 92 surveys (63 urban and 29 suburban) I conducted, 90% of the urban clinic population identified as African American or Black, and 93% of the suburban population identified as Caucasian or White. Furthermore, 85.5% of urban survey participants reported using Medicaid or a Medicaid/Managed Care Organization (MCO) as their primary form of insurance, while 100% of the suburban patients reported using private or employer-based insurance plans (Table 1). This reflects the policy of Village Clinic, which refused Medicaid patients in the practice. As such, the survey sample demographics roughly represented the overall geographic stratification of the greater Metro Detroit region (U.S. Census Bureau 2014).

Table 1. Demographic Information of Survey Participants

	Suburban Total: 29		Urban Total: 63		Total: 92	
	No.	%	No.	%	No.	%
Age						
Range:18 – 46, Median: 28						
18 – 25	1	4	33	52	34	37
26 – 30	12	41	15	24	27	29
30 – 35	10	35	11	18	21	23
36+	6	20	4	6	10	11
Weeks Gestation (at time of survey)						
Range: 6 – 40, Median: 28						
6 – 12	6	21	5	8	11	12
13 – 27	5	17	28	44	33	36
28 – 40	18	62	29	46	47	51
Unknown	0	0	1	2	1	1
Gravidity*						
Range: 1 – 11, Median: 2						
1 – 2	22	76	25	40	47	51
3 – 4	5	17	17	27	22	24
5 – 6	1	3.5	12	19	13	14
7+	1	3.5	9	14	10	11
Parity*						
Range: 0 – 7, Median: 1						
0 – 2	27	93	45	71	72	78
3 – 4	1	3.5	11	17	12	13
5 – 6	1	3.5	6	10	7	8
7+	0	0	1	2	1	1
Race/Ethnicity**						
Non-Hispanic White	27	93	2	3	29	32
African American or Black	1	3.5	57	90	58	63
Hispanic	1	3.5	0	0	1	1
Other	0	0	3	5	3	3
Missing***	0	0	1	2	1	1
Insurance Coverage						
Private or Employer-Based	29	100	8	13	37	40
Federally-funded	0	0	54	85.5	54	59
Unknown	0	0	1	1.5	1	1

*Gravidity refers to the total number of pregnancies, including the current pregnancy, miscarriages, abortions, and stillbirth. Parity refers to the number of living children

**Race/Ethnicity was self-identified by participants

***Race/Ethnicity was not asked of 1 woman who participated in a preliminary survey.

Patient Interviews

Following the conclusion of the survey, I recruited patients for participation in interviews. Women were invited to participate in an interview if they were over the age of 18, receiving obstetrical care in the respective clinic, had a viable pregnancy, and were not considering adoption or termination. Those who agreed to be interviewed were given an informational sheet with my contact information and details of the project. Some patients were interviewed onsite, immediately following the survey, while others provided their name and phone number and were contacted at a later date. I interviewed 30 expectant mothers—15 from the urban clinic site and 15 from the suburban clinic (see Table 2 for select demographic information). Interviews were performed both in-person and over the phone. All interviews were recorded. Following the conclusion of the interview, patient participants were asked whether or not they would be open to conducting a postpartum follow-up interview after their delivery, and all agreed. Participants were contacted 2-3 weeks following their original due dates. I was able to interview 8 of the 29 participants eligible for a postpartum follow-up, but was unable to contact 21, as they either had changed their number or chose not to respond.

While women readily agreed to participate, it was often challenging to complete the interviews, both in the urban and suburban clinic setting. Many women were difficult to get in contact with, often because their numbers had been changed or because they were unable to meet at a later time. In response to this obstacle, I increased the number of clinic observation days, followed up initial contact the next day with phone calls, and offered on-the-spot interviews with every willing participant. Interviewing women immediately following recruitment was particularly effective, but presented a few issues. Many patients had arranged transportation to and from the clinic, which prevented them from participating. Furthermore, I would often miss several hours of observation at the clinic on that day, as the patient and I would move to another location to conduct the interview.

Expectant mothers who were in their final trimester of the pregnancy (28-40 weeks) were preferentially selected for participation in an interview, as they had already received the majority of their prenatal care, and had likely started to construct an expectation for their labor and delivery experience. The median gestational age of the participants at the time of the interview was 33 weeks (See Table 2). Although the majority of suburban participants were in the third trimester, a handful of the urban participants were within the first few weeks of their pregnancy, primarily because recruitment at Metropolitan Clinic proved to be particularly difficult. All women were recruited and interviewed in the prenatal period, although one interview participant delivered unexpectedly at 28 weeks and was interviewed postpartum. Both nulliparous (first-time mothers) and multiparous (one or more previous deliveries) women were chosen for participation. Interview questions were adjusted slightly for women who had previously had babies, in order to include information about their prior experiences and how that might have affected their current views. Women who were involuntarily scheduled for a cesarean section were not included in the project. However, those who had come to this decision with their doctor prior to the interview were included. This determination was primarily based upon the woman’s obstetrical and medical history.

As an example, one survey participant had a history of multiple uterine surgeries and simply could not deliver vaginally and, therefore, was not included. In this case, she would not have been offered the option for a vaginal delivery by any obstetrician (or likely any midwife) and thus, was truly limited in her choice. However, mothers who had previous cesarean sections

Table 2. Demographic Information of Interview Participants

	Total: 30		Suburban Total: 15		Urban Total: 15	
	No.	%	No.	%	No.	%
Age						
Range: 21 – 26, Median: 30.5						
21 – 27	8	27	1	7	7	46.5
28 – 34	18	60	11	73	7	46.5
35 – 38	3	10	3	20	0	0
46	1	3	0	0	1	7
Weeks Gestation (at time of interview)						
Range: 6 – 40, Median: 33	3	10	0	0	3	20
6 – 12	5	17	0	0	5	33
13 – 27	21	70	15	100	6	40
28 – 40	1	3	0	0	1	7
Postpartum						
Gravidity*						
Range: 1 – 18, Median: 3						
1 – 2	14	47	9	60	5	33
3 – 4	11	37	5	33	6	40
5 +	5	16	1	7	4	27
Parity*						
Range: 0 – 6, Median: 1						
0 – 2	24	80	14	93	10	67
3 – 4	4	13	1	7	3	20
5 – 6	2	7	0	0	1	7
Race/Ethnicity**						
Non-Hispanic White	14	47	13	87	1	7
African American or Black	13	43	1	7	12	80
Hispanic	1	3	1	7	0	0
Other	2	7	0	0	2	13
Annual Income						
< $10,000	7	23	0	0	7	50
$11,000 - $20,000	3	10	0	0	3	20
$21,000 - $50,000	5	17	1	7	4	27
$51,000 - $70,000	4	13	3	20	1	7
$71,000 - $90,000	1	3	1	7	0	0
> $90,000	9	30	9	60	0	0

*Gravidity refers to the total number of pregnancies, including the current pregnancy, miscarriages, abortions, and stillbirth. Parity refers to the number of living children
**Race/Ethnicity was self-identified by participants

Table 2. (cont'd)

	Total: 30		Suburban Total: 15		Urban Total: 15	
	No.	**%**	**No.**	**%**	**No.**	**%**
Education						
< High School Diploma	5	17	0	0	5	33
Trade School	6	20	2	13	4	27
Some College/Associate's Degree	5	17	0	0	5	33
Bachelor's Degree	7	23	6	40	1	7
Graduate Education or Higher	6	20	6	40	0	0
Not Provided	1	3	1	7	0	0
Postpartum Follow-up Interview	8	27	4	27	3	20
N/A (interview conducted postpartum)	1	3	0	0	1	7

and had scheduled a repeat cesarean section were included because they were technically eligible to choose a vaginal birth, as they would technically have the ability to choose.

I also conducted three clinician interviews—two with obstetricians and one with a former labor and delivery nurse/lactation consultant. I had hoped to conduct more, but experienced great difficulty in recruiting obstetricians, even when using my medical school connections. All three interviews were with suburban practitioners and were recruited in the labor and delivery unit during lulls in the flurry of activity. During all practitioner interviews, there were several interruptions and various distractions. All of my attempts to schedule interviews either in clinic or at an alternate date were rejected. While I was only able to recruit three clinicians, the data collected from these interviews has still proven useful in adding a level of depth to discussions of institutional and bureaucratic dynamics at play in childbirth management and shall be used as a platform for future investigation.

Data Analysis

Data analysis was performed in an iterative fashion, as initial observational findings, survey information, and early patient interviews were used to continually develop the research question and goals of the study. All interview recordings were summarized using a standard template that mirrored both the interview structure and the larger theme of the research question. During review of field notes and transcription of recorded interviews, memoing was used to identify pertinent themes in participant responses and construct conceptual models for narrative evaluation (Bernard 2006:497-500). Categorical tables were developed for evaluating key questions within the interview structure and connecting participant responses to the identified conceptual models, including definitions of a "good" birth, preferences for labor and delivery, expectations for delivery, experiences with prenatal care, and perspectives on socioeconomic status and health (Bernard 2006). These initial tables were developed in an Excel spreadsheet, and used to group participants based on similar responses to each of the key interview questions. Commonalities among participant responses were further organized based on location of clinic, age, gravidity/parity, income, education, or previous obstetrical experiences, in order to identify patterns shared between respondents. As an example, the question, "Do you have or plan on creating a birth plan?" was grouped based on the answer "Yes" or "No." These subgroups were further divided based on different demographic information, one of which was whether or not this was the participant's first pregnancy. As a result, I found that most first time mothers were open to the prospect of a birth plan or had actively created one, and that most participants in their second pregnancy or beyond felt it was either unnecessary or unrealistic. Based on review of these tables, I returned to the interview summaries to further investigate participant responses within the broader context of their overall narrative, in addition to reviewing observational field notes and survey data to examine and address potential discrepancies in the findings.

Using these analytical techniques, I incorporated both rich narrative accounts and observed medical interactions to identify patterns in obstetrical practice related to decision-making. Both participant observation and in-person interviews were vital in data collection and analysis; the interviews provided a first-hand account of expectant mothers' perspectives and experiences, while observation allowed me to add my own perspective, as both an anthropologist and a medical student. The results of my data collection and analysis will be presented in the following three chapters.

Chapter 4: Managing Pathology: the construction of pregnancy knowledge, medical expertise, and "risk"

With the Enlightenment's birth of reason, death and disease no longer belonged to the "metaphysics of evil," and instead, became the purview of medical science and "rational thought" (Foucault 1994:196). Foucault marks the advent of anatomical dissection as a watershed moment, in which medicine gained a unique means by which to penetrate the body with what he calls "the medical gaze." The birth of "the medical gaze" marked an important philosophical shift, which concretized disease through the visibility of dissected corpses and restructured the medical approach to the individual patient as algorithmic and anatomically compartmentalized. For the first time, "man could constitute himself in his own eyes as an object of science" (Foucault 1994:197). Medicine had replaced religion as the arbiter of death, being able to interpret morbidity and mortality in a myriad of ways and, in doing so, potentially explain or delay its arrival (Foucault 1994). Through medical technology, obstetrics has similarly penetrated the female body and positioned itself as mediator of fetal well being or demise. Ultrasounds, blood panels, and amniocentesis are just a few of the techniques utilized by obstetricians that standardize the female body and render it malleable for technical interpretation by "the medical gaze." The very fabric of modern medicine is interwoven with pathological analysis. Thus, even when approaching a natural bodily transformation, such as pregnancy, medicine must necessarily employ an examination of death and disease. However, in its interpretation of disease, "the gaze" fails to see individual experiences of illness and, instead, sees it "as the endlessly reproducible pathological fact to be found in all patients suffering in a similar way" (Foucault 1994:97). Indeed, medical expertise, in its continued adherence to the scientific method and reproducibility, dictates a similar approach to all laboring women. As a result, "the gaze" homogenizes the patient and establishes powerful conceptions of "normal" that are constitutively reinforced through the biomedical system's seemingly objective dogma.

In exploring the process of decision-making during this research study, it became apparent that the influence of the "medical gaze" on biomedical expertise and the basis of pregnancy knowledge plays a significant role in determining the expectations of and options available to both individual women and the greater community of expectant mothers. This chapter will explore the generation and transmission of such knowledge in both formal and informal ways, using narrative accounts from patient interviews and findings from participant observation in prenatal clinics. In doing so, I argue that the construction of pregnancy knowledge importantly informs the birthing choices accessible to expectant mothers, by limiting the discussion of alternative birthing practices through the concept of "medical risk." Furthermore, I posit that the structure of prenatal visits and the transmission of formal obstetrical knowledge introduces notions of "risk" and "medical necessity" into the experience of pregnancy, which powerfully influences the approach taken by both women and clinicians in navigating pregnancy decision-making and management. Additionally, I explore the varied understandings and applications of "risk" in obstetrical practice, as well as the social implications of being designated as "high risk," which I argue is simultaneously disempowering for individual women and self-serving for obstetrical authority, through it's affirmation of biomedical necessity in the accomplishment of American childbirth.

Do you know what to expect when you're expecting?

Most women in this study said they had given very little consideration to pregnancy and the experience of childbirth until the moment they discovered they were pregnant. Of course, the occasional story from a friend or family member—maybe even a dramatic TV or movie portrayal—played a part in constructing a vague idea of what the experience might be like. Most of the women were familiar with the well-known symptoms (morning sickness, weight gain, insane food cravings)—that their body would endure a chaotic change—but for the most part, they simply responded that they just *"didn't know what to expect."*

Although, most of the interviewees identified very few specific expectations for their pregnancy, there were commonalities among the responses, including perceiving pregnancy as being difficult and uncomfortable physically, fear of labor pains, anxiety over the responsibility of parenthood, and general uncertainty about what could potentially happen. This may be because mainstream American childbirth practices have moved decidely out of the home and into the hospital, and as a result, there is a general lack of community discussion about birthing experiences and an even greater lack of first-hand encounters with childbirth (Jordan 1993). As Jordan (1993) described in her cross-cultural examination of childbirth, birthing knowledge is passed through both informal and formal means, with the United States most heavily relying on formal transmission of pregnancy knowledge through obstetrical practice. Though it may not detail the specific aspects of childbirth, such informal pregnancy knowledge provides women with a general picture of the most commonly practiced forms of childbirth within American culture. As an example, media depictions of childbirth figured prominently in the minds of expectant mothers in this study. Five of the interviewees specifically mentioned movies and TV shows, such a TLC's "A Baby Story," as giving them a general idea of what to expect for pregnancy and labor and delivery. Take, for example, an exchange between myself and Amy[2], a self-identified Hispanic woman, pregnant with her second child, and receiving her prenatal care at Village Clinic.

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[2] Names and personal identity of all participants have been changed to retain anonymity.

> *Emilia: With your first pregnancy, what did you kind of imagine? What were your expectations?*
>
> > *Amy: My expectations were a lot of pain. [laughs] Uh, a lot of pain. Um, difficult time trying to deliver. Just…craziness.*
>
> *Emilia: So you kind of had this picture of chaos—*
>
> > *Amy: Yeah.*
>
> *Emilia: Even before you delivered?*
>
> > *Amy: Yes.*
>
> *Emilia: Where do you think you get that from?*
>
> > *Amy: Uh, from movies. From my friends. Um, a lot of friends who delivered, probably within the year before me.*

Portrayals such as this, seen in popular movies like "Knocked Up" or "Juno," depict a scene of chaos, unintelligible screaming, and uncontrollable pain, and in doing so, powerfully generate a "narrative of pregnancy" that impacts the knowledge and expectations of the general population (Ellis West 2011). Not surprisingly, mainstream media representations of pregnancy are almost always in a hospital and biomedically-managed, which both reaffirms the necessity for technology in "normal" pregnancy, and also, further marginalizes "alternative" or natural birthing practices (Ellis West 2011). In such examples, women are typically depicted as out of control, unable to competently function throughout their labor and delivery, and dependent upon the medical staff to guide them through the process. In discussing their expectations for labor and delivery, the women I interviewed often referred to such popular characterizations of childbirth. For example, Beth, a self-identified white women, pregnant with her second child, and receiving care at Village Clinic, cited television shows about childbirth as having introduced her to the obstetrical tools frequently used during hospital deliveries.

> *"I mean, I kind of knew what [to expect] through watching TV shows or birthing videos. You know, things they might use, like forceps or a vacuum or you might need an episiotomy."*

Not only does the transmission of informal pregnancy knowledge familiarize expectant mothers with the particular interventions used in obstetrical practice, but it can also demonstrate a specific tone of uncertainty and lack of control on the part of the laboring woman. A response from Jill, a self-identified white woman, pregnant with her first child, and receiving care at Village Clinic, captures the expectation of unpredictability that often accompanies informal channels of pregnancy knowledge.

> *"I have this fear that because I'm tiny, the baby will be too big and won't fit and end up having a c-section and the epidural won't take. Anything that could go wrong is what I'm envisioning actually happening. I don't want to set my expectations high and then be completely disappointed."*

In perpetuating this idea of childbirth as helter-skelter, unpredictable, and necessitating technological mediation, there is limited opportunity for women to expect otherwise. Rather than viewing this characterization as one option for childbirth, most of the women simply saw this as the "normal" way to deliver a child.

In this way, media representations form a "cultural circuit," whereby fictionalized portrayals of childbirth may manifest into reality for expectant mothers (Ellis West 2011). It is important to epistemologically examine the means by which technology has become the dominant figure in media representations of childbirth, portraying the power and authority of biomedicalized models of birth as natural and objective, rather than symbolic forms of practice (Comaroff 1982; Good 1994). Indeed, the origination of this "cultural circuit" begins with the ubiquity of biomedical obstetrical concepts, both within and outside of medical settings. Women reported that even conversations with friends and family focused on technological interventions characteristic of obstetrical practice, like epidurals, c-sections, and induction. Indeed, biomedical forms of pregnancy knowledge permeate the content of informal community knowledge described by the women in this research study, as well as dominating formalized discussions of pregnancy and childbirth. It would seem that in dominating both the formal and informal circles of childbirth knowledge, biomedical expertise asserts its central role in the accomplishment of a "normal" childbirth, such that medical knowledge is valued as the ultimate authority in managing pregnancy.

Carrie is a 31-year-old, self-identified black female, pregnant with her first child, and receiving her prenatal care at Metropolitan Clinic. Carrie believed very strongly that pregnancy is a *"natural"* life event. With a shy smile on her face, she told me that she would even love to become a midwife one day. Carrie detailed specific preferences for her labor and delivery; she wanted to deliver vaginally and without pain medication. She hoped the doctors would allow her body to progress through labor without intervention and help maintain a relaxing and calm environment. If the option were available at her hospital, she would have even chosen to have a water birth. However, despite this being the first child for her and her husband, Carrie already assumed that her childbirth would likely be a *"medical, rushed experience"*—that the obstetrical staff would make her feel like, *"You're going to have a baby and it's scary."* She anticipated a lot of medical interventions and being *"talked into"* an epidural and the use of pitocin (a pharmaceutical used to both induce and strengthen uterine contractions): *"When you see it on TV or the stories I've heard, it's always like that…they're always ready for something to go wrong…they need to get these people in and out."*

Without ever having delivered a child, Carrie was already familiar with the most common types of biomedicalized birthing practices through informal channels of pregnancy knowledge.

As is demonstrated in her comments, even before she began engaging with pregnancy-related care, she already had been inundated with imagery of birthing practices that employ technology and medical intervention. Meanwhile, alternative birthing methods, such as home births or water births, have limited availability, even to women, like Carrie, who would be open to them. Most often, media representations focus on biomedical approaches to childbirth, and the options available to expectant mothers are generally narrowed to those acceptable within the biomedical model of birth.

Technological "Expertise:" social media and the transformation of informal pregnancy knowledge

Lisa, a 23-year-old, self-identified black woman receiving care at Metropolitan Clinic had approached this pregnancy with very particular goals for her birthing experience. When in the final weeks of her first pregnancy, she was told by her OBGYN that she would need to be induced because she was petite, and her baby was large. She agreed. Once the induction had begun, the labor didn't progress appropriately, according to the obstetricians. After the inductive drugs had been initiated, Lisa was also given an epidural, which numbed her so effectively from the waist down that she said she *"couldn't feel anything,"* including the contractions. She never progressed to active labor and ended up delivering via cesarean section. Her second delivery was also by cesarean section, though this time it was scheduled "electively." Following that delivery, she was told by a midwife on staff at Central Hospital that, should she decide to have another child, she could attempt a vaginal birth after cesarean (VBAC), an option previously unknown to Lisa. Having had her first child at the age of 18, Lisa felt that she hadn't really been informed of the options available to her for her second delivery; she had thought once she had a c-section, she must always have a c-section.

Armed with this new information, Lisa researched VBACs online and found several community forums dedicated to promoting the process. Encouraged by women's success stories and accounts of personal experiences, Lisa became determined to achieve a VBAC with her third delivery, even going so far as to switch obstetricians around her 28th week to find a clinician who would support her decision—*"Don't try to scare me out of something I really want to do."* At the time of the interview, her current OBGYN was on board with her decision, and she anticipated a successful VBAC delivery. During the interview, Lisa mentioned that she felt she had *"missed out"* on the actual experience of birthing her child, calling her previous deliveries *"boring."* She felt that having an induction or planned cesarean took the *"fun"* and *"anticipation"* out of her child's arrival. She desperately wanted to experience the feeling of contractions and delivering her child vaginally. What actually resulted during Lisa's delivery provides an interesting look into how the institutional dynamics of American hospitals impact women's delivery experiences and will be further explored in Chapter 6.

Lisa was just one of the many women in the study who had found social media, among other sources outside of prenatal care, to be helpful in providing information and alternative options for their pregnancy. What was most exciting about Lisa's experience was hearing that the positive stories from other women who had a VBAC delivery empowered her to attempt her own. Though not the focus of this dissertation, through the course of this research study it became clear that social media may potentially serve two important roles in childbirth. Firstly, it can serve as an accessible form of pregnancy information, particularly, for women with limited access to resources outside of prenatal care. For young mothers like Lisa, social media is a commonly used and generally accessible form of community conversation, potentially opening up a myriad of options, local resources, and information otherwise unknown and inaccessible to disenfranchised expectant mothers. Secondly, social media and community forums have the potential to legitimize experiential knowledge of childbirth in otherwise highly technical biomedical settings. Individual women's stories, including all the particular details and uncensored information of their experience, can be transmitted through community forums, and thus, become open to discussion and debate. Through the boom of social media and its power to influence public opinion, online community forums may challenge the dominance of medical expertise and obstetrical constructions of childbirth, by acknowledging the value of women's personal laboring accounts and experiences.

"Managing Pathology:" prenatal appointment structure and hierarchies of information

Aside from such informal sources of information, the first contact with an authority on pregnancy begins at the initial prenatal visit with an Obstetrician-Gynecologist (OBGYN). I use the word "authority" with purpose, as community forms of knowledge are routinely dismissed as anecdotal and unscientific within the realm of biomedicine. The breadth of literature on the anthropology of reproduction provides a well-established critique of biomedicalized birthing models as reinforcing notions of pregnancy and childbirth as potentially dangerous and inherently unpredictable—of the pervasive belief that laboring women's bodies are prone to dysfunction, needing constant surveillance and medical intervention (Davis-Floyd 1992; Jordan 1993; Martin 1987; Sargent and Stark 1989). Ethnographic analysis suggests that this technocratic model of childbirth inherently creates a dynamic of power based upon the possession of medical knowledge, and that power dynamics of decision-making become necessarily stratified between the expectant mother and her obstetrician (Davis-Floyd and Davis 1996; Hopkins 2000; Jordan 1997; Renne 2000; Sesia 1997). However, what may not be so obvious is that the very structure of the prenatal visit is an important means of producing pregnancy knowledge and enforcing such dynamics of power, by “educating” expectant mothers with the forms of information obstetricians consider important, while simultaneously calling attention to the insidious concept of “medical risk” and the potential for poor outcomes at every prenatal visit.

Take for example a typical prenatal visit I observed during this research project: Following check-in at the front desk and waiting to be called in for the appointment, the expectant mother is ushered back to a room, where a member of the nursing staff measures her weight and blood pressure, and collects a urine sample. The patient then waits in the consultation room to speak with the doctor—either fully clothed or half naked from the waist down if they will be having a pelvic exam. The OBGYN enters the room, greets the patient, and almost immediately begins performing the physical exam portion of the visit. Generally, one of the first tasks is to measure the fundal height of the uterus with a piece of disposable, paper measuring tape. The doctor then proceeds to listen to the fetal heart tones with a portable, hand-held doppler. The OBGYN may then check the lower legs for signs of swelling before proceeding with the pelvic exam, if necessary at that particular visit. All the while through the physical examination, the doctor runs through a checklist of common symptoms—*“Any pain? Cramping? Vaginal bleeding?”* After finishing the physical exam and symptom review, the OBGYN then moves on to discuss recent test results—perhaps a glucose tolerance test for gestational diabetes or the results of a recent blood panel or ultrasound. Finally, the doctor may offer a few sentences about what to expect at the next visit and then walks toward the door, asking whether the patient has any questions. All in all, the visits I observed lasted about 5 minutes or less, on average.

This routine is conducted with such regularity and rapidity, that the majority of women I interviewed could easily describe it with impressive consistency. Furthermore, 24 of the 30 expectant mothers interviewed described some form of medical information, testing, or screening as the primary topics of their prenatal visits. Given that biomedicalized birth considers pregnancy to be inherently dangerous, as argued at the beginning of this chapter, it is no surprise that the content of obstetrical prenatal care I observed focused solely on the management of pathology, rather than the management of pregnancy.

These observations are consistent with the standards of care in general obstetrical practice in the United States. For example, even within the standard Electronic Medical Record (EMR) template for prenatal visits, "pregnancy" is listed as one of the conditions under "problems list." Every guideline, benchmark, and standard of care is designed for the purpose of assuring "normalcy" and averting poor health outcomes. Measuring the fundal height of the uterus insures that the fetus is growing appropriately and acts as a screening tool for intrauterine growth restrictions and macrosomia, or an abnormally large fetus (ACOG 2015). Listening to fetal heart tones insures the general health and viability of the fetus (ACOG 2015). Urine samples are used to assess for protein and albumin in the urine, which are common signs of preeclampsia (ACOG 2015). In "managing pathology," biomedicine dictates what information is worth knowing and reviewing, guiding expectant mothers to focus their attention on biomedical aspects of care and quietly dismissing other forms of knowledge in the process. Here emerges a clear hierarchy of importance among the information covered in the prenatal visit; the physical portions of the exam—such as measuring the uterus, fetal heart tones, or reviewing lab results—are clearly given primacy. They are embraced as the most objective and reproducible parameters, and within the Western biomedical realm of the "medical gaze," are generally viewed as the most valuable source of information for the obstetrician in assessing “normalcy” in pregnancy. In the encounters I observed, the expectant mother’s subjective account of her corporeal and emotional experiences was usually secondary to the findings of the physical exam, imaging, and laboratory testing. Reflecting these tendencies, any discussion of emotional or mental well-being or even talk of the actual labor and delivery process was almost entirely absent in the routine prenatal care I observed in this study.

The lack of prenatal discussions about the emotional and social transformations accompanying pregnancy did not go unnoticed for many of the interview participants. For instance, Sarah, a white woman in her early thirties, pregnant with her third child, and receiving care at Village Clinic, found that much of the *“fun”* and *“excitement”* of her first pregnancy had dissolved into anxiety and uncertainty this time around. Although her first delivery was uncomplicated (delivered vaginally at 39 weeks and 4 days, using an epidural, no inductive drugs, and moderate to severe perineal tearing), she tells me that she and her husband have taken things more seriously with this pregnancy, discussing their plan of action should *“something happe[n]”* to her during labor and delivery. When asked whether or not she discussed any of these thoughts with her obstetrician, she replied:

> *“No, I don’t feel like [with the] OBGYN there’s any discussion of [the fact that] you’re bringing another human into the world and it’s going to change your life. It doesn’t really get discussed. As ironic as that is, you think [that’s] what you talk about. No, it’s much more of the black and white, cut and dry. Like ‘We’re watching your blood pressure. We’re watching your thyroid. We’re watching your weight.’”*

Although she wishes she was able to talk about such social and psychological aspects of her pregnancy with her obstetrician, Sarah did not view the absence of such discussions in her prenatal care as inappropriate, stating that talking about these fears is not the doctor's responsibility. Ultimately, she feels that time is extremely limited with your obstetrician and, therefore, there is simply no way to incorporate such discussions: *"You have your ten minute window, and that's what you've got. That's the way it is with our medical world."* Indeed, 8 of the women interviewed for this study specifically described a rushed, abbreviated prenatal experience during their appointments. Still, some mothers perceived the brevity of such visits as an affirmation of the health and "normalcy" of their pregnancy, as Amy did.

> *Emilia: Do you feel the communication is good? Do you feel like they're listening to you?*
>
> > *Amy: Most of the time. There's been a few times where I felt it was kind of rushed…I feel like it's probably because my first pregnancy was really easy. They had told me time after time, "You are the model pregnancy…No issues." Everything was great and so, I think probably because everything was perfect the first time, this time around it's just, "Okay. It's a good pregnancy and just keep on moving forward."*

The expediency with which obstetricians conduct prenatal visits is most certainly a result of the lack of time partitioned for patient interaction, but also seems to serve an important role in constructing a deliberate tone and structure of the prenatal interactions, one in which the valuable time of the clinician is reserved for discussing and averting pathological findings. Thus, expectant mothers may assume that discussions with the doctor should be limited to the abnormal or potentially harmful aspects of their pregnancy. Although pregnancy is a natural state for which women's bodies are designed, obstetricians may see their place in pregnancy-related care as "managing pathology," rather than "managing pregnancy." Yet because this is such a life-changing event, there are a myriad of other concerns and questions that are, unfortunately, not being addressed, particularly in populations where there are few supportive resources outside of formalized prenatal care. Not only can the focus on pathology virtually eliminate the discussion of various other non-medical aspects of pregnancy experience, but it also may create an environment in which there is a continuous vigilance for medical risk and uncertainty. In Chapter 5, I will further explore how this structure of pregnancy knowledge and "managing pathology" specifically impacts the decision-making process during prenatal and peripartum care.

Introducing Risk: medical expertise and homogenization

An important result of the prominence of pathology in obstetrical care is that, from the very first prenatal visit, the overall perception of pregnancy may be designated as one of uncertainty, where no one, not even the doctor can know what will happen during labor and delivery. Rather than defining the unexpected as a normal part of pregnancy, it instead provokes fear of potential health risks to the expectant mother and her unborn child. The weight of this sense of risk was felt strongly by most of the interviewed expectant mothers, with 22 of the 30 mentioning "risk" or "safety" explicitly during their interview. This dynamic is certainly problematic and places an unnecessary burden of fear and anxiety on the mother, as expressed in sentiments such as Beth's:

> *"I'm very realistic in terms of like, you are not going to have a…safe baby until that baby is out and breathing. Like, your whole pregnancy, every single time you go to the bathroom, you're looking for blood. Like, you never know what can happen and it's all out of your control. So, I mean, that's a fear every day—all day."*

It is evident that the pathological focus of obstetrical practice instills a level uneasiness into the everyday lived experience of expectant mothers. As, Sarah, articulated, this fear may stem largely from a more general perception of pregnancy as a risky endeavor, both for the health of the woman, but primarily for the well-being of her unborn child.

> *"When you first find out you're pregnant and being rattled by the fears—Are you going make it past this week and that week? And will you carry this baby to term? Throughout the pregnancy, there are all these different points of 'woo-hoo's' that you have to make it through. So, there's like a constant thread of fear there. You're growing another human being. Something could be wrong with it. You could lose it. Yeah, there's a risk there and the risk part of it may be more [whether you can] handle what could be."*

For one interview participant, Jane, a 28-year-old, self-identified white woman, receiving care at Village clinic, the framing of her pregnancy as riddled with medical risk was particularly prominent. Diagnosed with Type I Diabetes Mellitus over 10 year ago and working as a Nurse Practitioner, Jane was fully aware that, due to her diabetes, her pregnancy would be considered more complicated that an average woman's. She said that when she began receiving regular gynecologic care as a young woman, her OBGYN reiterated that, should she become pregnant, it would be *"very high risk."* Jane felt this pressure and anxiety was unnecessary: *"Okay, but yet, I do know some people who are fine with being pregnant and diabetic."* Ultimately, she ended up switching to a different prenatal care facility—Village Clinic—where she felt the environment was more relaxed. Still, she was advised to see a separate OBGYN who specialized in high-risk management. Early in her care, the high risk OBGYN informed Jane that, because of her diabetes, she would need to be induced toward the end of her pregnancy—that they would not *"let her go"* past 38 or 39 weeks gestation. When Jane began to question the need for induction, especially if the fetus's lungs were not yet mature, the OB told her that if her blood sugar was *"crazy,"* it was safer for the baby to be delivered, and *"if it's safer for the baby to come out than to stay in, then it's just safer, and this is what we'll do."* This confused Jane. She always had impeccable control of her blood sugar through the use of her insulin pump. Why had they already decided that her blood sugar would be out of control? When Jane pressed further, the OBGYN simply replied, *"We don't want to end up with a dead baby."* Jane was shocked by this statement, and had since been afraid to ask about the induction, instead hoping that if she didn't say anything, she would be able to avoid it altogether.

Through constantly invoking concepts of "risk," the hierarchy of decision-making was rigidly stratified for women interviewed in this study, such that the obstetrician could trump the choices of the expectant mother by mentioning potential harm to the fetus, even when the mother, like Jane, is familiar with medical practice. "Risk" was presented and exclusively interpreted by the obstetrician, yet the responsibility of avoiding that risk was most often left with the expectant mother. The result is a chilling effect; expectant mothers are discouraged from making autonomous decisions because they are not deemed qualified to interpret medical "risk," yet if they are to challenge the obstetrician's decision, the may be held personally responsible for any mother's most feared outcome: *"a dead baby."*

Jane's experience is an example of the pervasiveness of "risk" concepts in modern obstetrical practices. Obstetrical decision-making is supposedly based upon avoidance of risk and the determination of medical necessity—both concepts owned and understood by medical experts, yet only peripherally accessible to expectant mothers. Yet, I observed little discussion between obstetricians and patients as to what those risks could be and even less information given to women as to what the specific risks are—they simply exist. Jane's experience demonstrates how medical expertise can shape pregnancy knowledge and the philosophical approach to childbirth within obstetrics.

Perhaps the most interesting aspect of Jane's experience is that the obstetrical management had already been determined independent of what her actual health status may be at the end of her pregnancy (e.g. they wouldn't *"let her go"* past 38 or 39 weeks). This demonstrates an important aspect of biomedical constructions of pregnancy knowledge—standardization. In understanding the generation of obstetrical pregnancy knowledge, we must also understand the generation of biomedical expertise and its role in the socio-cultural construction of health. Lorna Rhodes (1996) describes a "close examination of practitioners" as a "promising direction" in the demystification of the cultural system of Western medical practice, specifically calling for a critical analysis of their work, the constructions of their professional identity, and their *knowledge*. In that spirit, next we will draw upon the introductory discussion of Foucault's "medical gaze," by critically examining medical expertise as it relates to the understanding and designation of risk within obstetrical care.

Danielle, a 27-year-old, self-identified black/multicultural woman, pregnant with her fifth child, and receiving her prenatal care at Metropolitan Clinic, found the standardized nature of her prenatal care to be frustrating. The day of our interview, Danielle had attended her 34th week prenatal appointment, at which time, she had expressed concern to her OBGYN that she was not gaining weight, as she had with her previous pregnancies. In response, he simply stated that it was *"normal during pregnancy."* Danielle felt her concerns were dismissed by the OBGYN, without him actually listening to and considering her complaint.

> *"I was so frustrated…Like, to me, I don't care if you are a man with a degree…You're not that woman. You don't know. You don't know what my body's*

> *going through. You don't know how I'm feeling…They do need to listen more. You just can't say, 'Well, that's normal in pregnancy.' It might be normal for one person, but it ain't normal for the next person. Because with my other four kids, I gained weight, but with this child, I didn't…He thinks, 'Oh, that's part of being pregnant.' No, it's not. When you have a baby, then you let me know."*

Unfortunately, Danielle's experience may not be at all uncommon in either obstetrics or in medicine, more generally. Standardization of patient care is a primary goal of biomedical practice—to identify patterns and use these patterns as templates for approach to each new patient, which is largely a result of the patient homogenization accomplished by "the gaze." Indeed, the characteristic focus of Western medicine on pathology is, in large part, a result of "pathological anatomy reduc[ing] the importance of clinical symptoms," such that the lived experience of individual expectant mothers gives way "in favour of massive geometry" (Foucault 1994:159). As a result, the individual woman and her bodily experience may be lost, homogenized into an image of what is considered, medically, to be a "normal" patient.

Who is actually at "high risk?"

In asserting standards of "normal," biomedicine also determines what is "abnormal," and in doing so, becomes capable of classifying individuals who deviate from the "standard" patient as irregular in a physical, and therefore, measurable, sense. In obstetrics, "high risk" is the medical designation most commonly attached to an "abnormal" pregnancy. As an example, women of Advanced Maternal Age (AMA) are generally given a blanket designation of "high risk," which applies both to the health of the fetus and to the individual woman (ACOG 2015). This designation is universally applied to the general population of expectant mothers above the age of 35. One might challenge this practice as faulty, not only in applying general population statistics to individuals, but also in representing medical risk as universal, without consideration of individual health status (Rockhill 2001). Indeed, you wouldn't expect two 55-year-old men to have the same risk for a myocardial infarction if one was obese with long-standing high blood pressure and the other was a vegetarian, marathon runner. Similarly, you wouldn't expect individual expectant mothers to be given a universal designation of "high risk" independent of their individual health status.

During my observation for this research project, obstetricians gave me several different responses to my question as to what would be considered a "high risk" pregnancy, ranging from a history of multiple miscarriages to home environment of the expectant mother. Though it may be used as an objective categorization, "risk" was variably defined and enacted by the obstetricians I observed. For example, when observing in the prenatal clinic, I asked one of the physicians whether or not a twin pregnancy would be considered "high risk:"

> *"Not necessarily, but it depends on what the doctor feels comfortable with. Some people say miscarriage is high risk or preterm labor or preeclampsia. It depends on whether or not mom or baby are at risk for fetal death or maternal death."*

This statement is contradictory in that it asserts that the "high risk" designation is both dependent on scientific evidence of "risk" of maternal or fetal demise, while simultaneously dependent on the physician's comfort with handling the pregnancy. What *is* evident is the recognition that evidence-based medicine, itself, is open to the interpretation of the individual physician.

This becomes particularly problematic when considering the opportunity for the obstetrician's individual biases to infiltrate their assessment. In my observations, factors like the patient's appearance, the way they talk, or even their health insurance appeared to consciously or subconsciously influence the physician's opinion of their lifestyle or assumed behaviors. In the case of pregnancy-related care, this can powerfully shape the actions taken by the clinician in the disbursement of their care. In a city like Detroit, where poverty and crime are widely publicized and sensationalized, it seems especially easy for such assumptions to color the perceptions clinicians and medical staff have of their patients.

Indeed, when I asked this same clinician about the high maternal and infant mortality among the Detroit population, he replied, *"This whole population is high risk,"* citing young age, multiple pregnancies, low socioeconomic status, drug use, and preterm delivery as among the factors that impact the health of expectant mothers in Detroit. This sort of blanket assessment is concerning, both in that it rationalizes homogenized approaches to prenatal care and is also seemingly interpreted by this physician as legitimate, allowing him to justifiably make and act on inferences about patients based on their presumed social background. This last point merits further exploration and will be expanded upon in Chapter 6, but for the purpose of this discussion, it is important to further explore how the idea of medical "risk" can easily transform into "race," especially when it relates to black women's reproduction.

Conclusion

Based on the narrative accounts of expectant mothers interviewed for this study, I have argued that both informal and formal transmission of pregnancy knowledge play an important role in constructing expectations for labor and delivery. While popular TV shows about childbirth and even community forums on social media provided additional information about what to expect when you are expecting, obstetrical care appeared to be the clear authoritative voice in the creation of local birthing knowledge. Indeed, I found the focus of prenatal visits on "managing pathology" to be particularly influential in the minds of expectant research participants, such that the very structure and tone of routine prenatal care powerfully shaped their perceptions of pregnancy and childbirth, as well as their perceived control in the process of labor and delivery. The concept of medical "risk" proved to be especially salient in prenatal care, with the avoidance of "risk" being the primary impetus for various obstetrical measures. However, I observed "risk" assessment as being highly variable among obstetricians, both enacted universally based on seemingly objective characteristics such as age, while also used to described presumed social background based on patient demographics.

Consequently, the generation and maintenance of biomedical forms of pregnancy knowledge reaches beyond the scientific constraints of evidence-based medicine and speaks more broadly to the societal authority of the medical institution. Biomedicine has the power to transform social identities into objective facts, and in doing so, is capable of reinforcing dominant social arrangements. When considering the position of racial identity within biomedicine, this capability to neutralize hegemonic ideologies as objective, is particularly troublesome, a concept which I will explore further in Chapter 6.

Chapter 5: Knowing What Questions to Ask: navigating the world of biomedicalized birth and the process of labor and delivery decision-making

It's the end of May 2013, and the days are becoming thick with the humid heat of a typical Michigan summer. The labor and delivery unit at Central Hospital is a flurry of activity. Several patients' names are scrawled in neat rows on a giant white board, listing room number, gestational age, cervical status, and the medications and interventions administered. The day begins with a scheduled cesarean section at 10 am. The methodical efficiency with which it's performed is impressive—the masked obstetricians give short, firm commands that are met with the scrub nurse's swift, slap of the requested surgical instrument into their gloved hands. Within 30 minutes of the first incision, they have delivered the baby. At 10:45 am, one of the obstetricians, with whom I am observing, and I leave the others to finish sewing up the gaping horizontal abdominal incision. We rush back up to the labor and delivery unit, as one of the patients there is close to delivery. From the centralized computer area where the medical staff gather, the readings from all the electronic fetal heart monitors and tocometers (the device to measure uterine contractions) on every patient can be observed and monitored. Our patient, a black woman in her early twenties, is 9 cm dilated and 100% effaced, meaning her cervix is ready for delivery, but the obstetrician notices some potentially ominous abnormalities on the fetal heart monitor. *"We're going see if we can have a baby,"* he says as we enter the patient's room. *"That's a contraction,"* the patient's mother tells her. This is her first pregnancy, and she is unable to feel them due to her epidural. The doctor stands at the end of the delivery bed with his fingers in her vagina; the entire room is silent, aside from the rhythmic ping of the monitors. Everyone in the room stares at the electric screens in anticipation of the next contraction—*"You can't help it. You just start bouncing your head to it,"* the nurse says with a smile. *"How am I doing?"* the patient asks the doctor. *"Making progress,"* he replies. *"Push the doctor's finger out,"* the nurse guides the patient as her next contraction gradually appears as a swooping hill on the monitor, *"I know it's hard because of the epidural."* A nurse anesthetist pops her head in to ask if a c-section will be necessary. *"We want to try vaginally,"* the doctor replies.

The above scenario is a description of a typical vaginal hospital delivery, as observed during this research project. As evidenced in this narrative, a myriad of social interactions take place during the course of labor and delivery, which are colored by cultural norms, the social status of physicians, and most importantly, the hierarchical process by which decisions are made regarding medical interventions. There has been a wealth of ethnographic analysis of the influence of culture on accepted forms of childbirth practice among various groups, many of which utilized international birthing experiences in order to examine the cultural uniqueness of American obstetrics (Browner 1996; Davis-Floyd 1992; Han 2013; Hunter 2012; Jordan 1993; Walzer Leavitt 1983; Martin 1987; Sargent and Stark 1993; Van Hollen 2003; Wenland 2007). However, there have been few in-depth explorations of the sociocultural dynamics at play during the decision-making process relating to obstetrical intervention and management. This chapter will unpack a few of the factors that impact the choices made by individual expectant mothers and their obstetricians, utilizing a comparative framework to contrast an idealized model of shared decision-making with a patriarchal, directive approach. Both this chapter and Chapter 6 will explore these dynamics as they unfold in both prenatal and peripartum obstetrical care. This chapter will specifically focus on individual doctor-patient interactions, while Chapter 6 will investigate the role of broader macro-level societal dynamics, including logistical parameters of the hospital institution and the potential influence of racial/ethnic identity and class status on peripartum care experiences.

A Brief Introduction to Obstetrical Interventions

This section will provide a very basic overview of three interventions commonly used in obstetrics. The goal is to familiarize the reader with these techniques, in order to better interpret the choices made by patients and clinicians. The majority of the medical information provided is cited from the American Congress of Obstetricians and Gynecologists (www.acog.org), while a limited amount is drawn from my knowledge as a 4th year medical student.

Cesarean Section

Perhaps the most well known of the three interventions is the cesarean section. In the simplest sense, a cesarean entails delivery of the fetus through an abdominal incision rather than through the vaginal canal. Abdominal surgery is a very extensive procedure, and cesarean deliveries are no different, carrying all the standard risks and potential complications of a regular surgery. Obviously, then, cesarean sections take place within the Operating Room and require an entirely new host of restrictions, protocol, and ritualistic practices (see Katz 1981). The most common use of a cesarean delivery is for an emergency situation where the mother, baby, or both are at risk. Certainly, this is often the case, but occasionally, it is not. Scheduled cesareans are routinely performed after the 39th week of gestation—performed "electively"—especially if the expectant mother has had a previous c-section. Once you have a cesarean section, the incision site makes the uterus more prone to rupture during contractions. Thus, some obstetricians believe having a vaginal birth after cesarean (VBAC) presents an increased medical risk, although it can be performed safely in most women. Indeed, a "previous cesarean delivery" is an acceptable diagnosis used by many obstetricians to justify a scheduled cesarean, with some physicians even refusing to perform VBAC deliveries.

Induction of labor

Although they are used with great frequency in hospital deliveries, inductive techniques, procedures, and medications are less familiar to the general public. Induction refers to the artificial initiation of labor, although some of these interventions are also used to augment physiologic labor changes that have already commenced. Techniques range from vaginal suppositories ("cervical ripening") to promote dilation of the cervix, artificially rupturing the amniotic sac, and administration of the drug pitocin. Pitocin is a homolog of a naturally occurring hormone—oxytocin—which is responsible for initiating and strengthening uterine contractions. Generally, pitocin is employed for the initiation of labor in women with a medical condition, such as preeclampsia or gestational diabetes, or in the postpartum period if there is excessive hemorrhage. According to the Federal Drug Administration, pitocin should not be used to initiate labor for an elective induction, as there are considerable risks to both the mother and the newborn. "Elective" inductions can be routinely scheduled once a woman reaches 39 weeks, as the fetus is believed to be fully developed and viable outside the womb at this stage of pregnancy. As with cesarean sections, "elective" inductions can be performed after 39 weeks without medical indication, which is generally documented with "patient choice" as the reasoning for induction (per Induction and Cesarean Scheduling Form from MHA Keystone OB Initiative, mha.org).

Epidurals or Spinals

Pain medication is another common intervention in biomedicalized birth, most often accomplished through an epidural. Other forms of analgesia, like morphine or demerol, can be administered intravenously, but are not utilized with nearly as much frequency. With an epidural, a needle is inserted into the lower back, and an anesthetic is administered just outside of the spinal cord. As a result, the entire lower half of the body is numbed, eliminating the laboring woman's pain, but also impeding her ability to move around. The loss of sensation is such that women require a catheter to be inserted in their bladder, assistance in positioning their limbs, and difficulty feeling uterine contractions, such that they quite often struggle to push adequately. There are very few reported complications as a result of the procedure, although it is widely recognized that they slow down the progress of labor and generate falsely abnormal readings on fetal heart monitors. This analysis will consider the various technological and pharmaceutical interventions available to laboring women in a typical American hospital birth and investigate the process by which expectant mothers and obstetricians choose to employ their use during labor and delivery.

A "Good" Birth: exploring mothers' preferences and concepts of shared decision-making

The process of medical decision-making can be extremely complicated and has rightly garnered the attention of social science researchers and medical personnel, alike. The model of shared decision-making is often touted as an idealized, cooperative framework for medical interactions (Charles, et al. 1997; Charles, et al. 1999). While there are potential issues within a shared decision-making model, I chose to employ this concept in my analysis as a counterpoint to the directive/paternalistic model, characteristic of traditional medical practices of the twentieth century (Charles, et al. 1997). In shared decision-making, there are necessarily at least two parties involved in the process—patient and physician—both of whom exchange information, such as medical knowledge/advice and patient preferences/expectations (Charles, et al. 1997).

From their discussion, the ultimate goal is for a consensus to be reached based on the input of both parties. Many of the studies conducted on medical decision-making focus largely on end-of-life care or otherwise emergent care needs, which can be viewed as clinical scenarios in which the directive influence of clinicians can be seemingly justified. Of course, pregnancy is most often not a life-threatening condition and entails long-term care over the course of 9 months. Therefore, the process of decision-making does not entail the same emergent needs of other clinical examples. Childbirth can, in theory, appropriately incorporate a comprehensive discussion of available options and interventions during the course of prenatal care.

Of the 30 women interviewed for this research project, 18 reported that their physician provided key information that guided their choices, and 19 stated that their doctors played a large role in making the decisions. Furthermore, 14 interviewees say they, themselves, were the ultimate decision-maker, while 12 specifically noted that the doctor's decision would trump their own should there be "medical necessity," "risk," or a question of "safety." Only 1 expectant mother stated that her doctor did not have any role in the decision-making process. Most of the women's sentiments on this topic can be summed up in the following quote from Wendy, a self-identified white woman, pregnant with her first child, and receiving care at Village Clinic, as she described her obstetrician's relationship to her labor and delivery decisions:

> *"I think it's cooperative, but I am not a doctor, and a lot of pregnant women think that, just because they're pregnant, they know what's best for their baby, and I know overall what's best for my baby. I know that he needs to be able to eat when he comes out at some point, and I know that he needs to fit through my birth canal or [be] pulled out through my stomach. I know the basic things, but the way of making those things happen, that's not my department. If I knew all those things, I wouldn't be going to a hospital."*

Wendy's comments reflect the widespread dynamic of obstetrical practice both observed in this research study and discussed among the ethnographic findings of reproductive anthropologists—that the loci of decision-making is based upon the possession of birthing knowledge, specifically medical birthing knowledge, and that women must necessarily depend on the information provided by their doctor in order to participate in that process. As such, in the prenatal interactions observed during this research project, the doctor clearly plays a central role in decision-making, either through provision of information, advice, or overt opinions. At the same time, only 9 of the 30 interviewees reported ever having been asked about *their* preferences for labor and delivery. Furthermore, of the 9 that said they *were* asked, the discussions they reported were limited to whether or not to schedule a repeat c-section or attempt a VBAC.

Thus, it seems that the idealized shared decision-making model was essentially non-existent for the women interviewed for this research study. The exchange of information they described was predominately unilateral—from physician to patient. Thus, the decision-making process during their prenatal discussions more closely resembled the classical directive/patriarchal model than a shared exchange. This absence of discussion of patient preferences would seem to necessarily result in stratified decision-making roles and the authoritative position of obstetricians within that relationship. What is most striking from these interviews is that many of the women genuinely believe themselves to be an equal partner in that process, while at the same time stating that they do not possess the knowledge base necessary to challenge obstetrical decisions. Rather than fully participate in decision-making, it seems these expectant mothers must trust their doctors to do what is in their "best interest." As such, the limited agency in decision-making among expectant mothers and continued lack of information necessary to challenge such hierarchies are firmly ingrained, yet unrecognized, within obstetrical practice. In this dissertation, I use this observed dynamic between patient and physician as the basis to examine sociocultural factors that limit and influence the choices made. In doing so, I wanted to be careful not to presume how interviewees felt about the use of various interventions. In order to achieve this goal, I began each interview with a simple, open-ended question: “What is your idea of a ‘good’ birth?”

This question allowed me to examine delivery experiences from a more emic perspective, in that it did not make assumptions about interviewees’ preferences based on their currently established plan for delivery. Lastly, this question presented an opportunity for the interviewees to describe a birthing experience different from what they had previously experienced or even what they expect their future experience to be. Given that alternative birthing practices are generally limited within biomedicine (see Chapter 1 and 4), this research project focused primarily on women’s preferences for key decisions surrounding the three previously discussed interventions and techniques used by obstetricians: cesarean delivery, use of inductive drugs and procedures, and delivery of pain management. These tools and techniques were chosen because they represent three frequently made decisions in almost every hospital delivery. Furthermore, their use impacts three visceral sensations of the childbirthing experience: the body’s progression through the phases of labor, the physical experience of contractions and cervical dilation, and the bodily delivery of a child by the mother through the vaginal canal (Davis-Floyd 1992; Jordan 1993; Martin 1987). Most importantly, these techniques individually and synergistically remove physical and emotional autonomy from the birthing mother, by either overriding her physical contribution through technological intervention or eliminating sensorial input through the numbing/sedative effects of the medications.

“Knowing what questions to ask:” medical knowledge and authoritative hierarchies

As Chapter 4 outlined in great detail, the ubiquitous presence of “risk” in medical practice sets a definitive tone for the course of prenatal care that often dictates the direction of obstetrical encounters and general approach of both patient and physician to the management of pregnancy. What seems most important about the concept of “medical risk” is that while it is discussed freely by both physician and patient, only one party is positioned to comprehend, and therefore, claim ownership of this terminology—which is, of course, the physician (Jordan 1993). Brigitte Jordan first discussed this “exclusive ownership” of “authoritative knowledge” as powerfully impacting the social interactions between laboring mother and obstetrician, such that the technical expertise of obstetrical tools and interventions “simultaneously defines and displays who should be seen as possessing authoritative knowledge and, consequently, legitimate decision-making power” (Jordan 1993:152). Indeed, this hierarchy of decision-making is achieved through the use of such techniques, which ultimately remove the “ownership” of the birthing process from the laboring woman and leaves it in the hands of the physician, the only medical staff member capable of fully utilizing any of these interventions (Jordan 1993). In this model, the physician reigns atop the authoritative hierarchy within a biomedically-managed childbirth, even above nurses or otherwise qualified medical faculty. The following birth story will demonstrate how these hierarchies can break down when technological interventions aren’t employed. In this case, the achievement of a birth without intervention powerfully influenced the experience of one laboring woman and her future approach toward and perspectives on birthing techniques.

When I asked Zoe what was her idea of a “good” birth, one of the first things she said was to *“do what feels good in the moment.”* A 31-year-old woman pregnant with her second child, Zoe described her first labor and delivery as an empowering experience. At just 34 weeks and 6 days, her water broke unexpectedly—about a month too early—such that when she arrived at Outer Hospital, her cervix was already 3-4 cm dilated, indicating that she had advanced quickly through the first stages of labor. Due to her early onset of labor, the hospital was not expecting her ,and as she quickly progressed, there was little time for the medical staff, especially the obstetrician to intervene. *“It’s crazy. It was so crazy. They weren’t ready [laughing]!”* The obstetrician on call that day was attending to another delivery, so during her labor, Zoe was mostly cared for by the nurse, who instructed her to stand under a running shower to ease the pain and use a birthing ball to help turn her baby to the appropriate position. Zoe didn’t have time to get an epidural or even have an intravenous (IV) line inserted, so she was able to walk around, lay in the most comfortable position, and move freely to work through the pain. She had arrived at the hospital around 1:30 pm and delivered her son by 4:30 pm. It was so fast that *“the doctor…just kind of, like, swung in at the last minute and was like, ‘Okay, let’s do this.’”* Although the early arrival of her baby was scary, she said the overall birthing experience was incredible: *“I wanted to go as natural as possible. Not to be able to say I went natural, but to…I don’t know…I felt like Superwoman after I had him. It was a really good feeling, and it was good to kind of, in a weird way, prove that to myself.”* In this case, because the usual technological interventions weren’t employed, the authoritative hierarchy dissolved. Zoe felt strong and capable, *“I’m not really scared of giving birth this time because I feel like I did it last time. So, I think I feel more confident going into this birthing experience.”*

In the absence of technological hierarchies, Zoe had effectively regained the ownership of her birth, even though it took place in a hospital institution with the assistance of biomedically-trained birthing staff. We can see a clear delineation of bodily ownership between Zoe's experience and the vaginal delivery narrative from the beginning of this chapter. It appears that the use of technological intervention is the primary differing variable between them. Using this example, it appears that obstetrical interventions, such as epidurals, effectively weaken the woman's control over her laboring body (i.e. *"How am I doing," "That's a contraction," "Push the doctor's fingers out").* Furthermore, the introduction of medical intervention commits the laboring mother and the medical staff to continued medical management of labor and delivery. This might be described as an iatrogenic cascade; once a medical intervention has been introduced, the natural physiologic progression of the body is interrupted—changed—such that continued medical intervention is necessary for the delivery to be realized. Thus, the use of technological intervention not only creates decision-making hierarchies, but is essential in their maintenance.

The acquisition and solitary possession of technical expertise is dependent upon the dominance of medical knowledge. Indeed, obstetrician-attended birth seems to necessarily function on the stratification of knowledge between patient and physician. Therefore, a fair conclusion might be that those who are least able to challenge the hierarchy of decision-making are most vulnerable to loss of autonomy. Women who have limited access to medical knowledge and technological expertise, such as low-income, low-literacy women, are especially powerless within this hierarchy, such that agency and control over the events during labor and delivery are considerably lessened. One of the expectant mothers interviewed for this research study, offered an interesting example of how access to medical knowledge can affect birthing experiences.

Pregnant with her third child, Grace, a self-identified white woman receiving care at Metropolitan Clinic, was anxiously awaiting her labor and delivery, uncertain of what might happen. Her first two children had been delivered via cesarean section. With her first birth, Grace had reached the full 40 weeks of gestation. When she arrived at her regularly scheduled prenatal appointment, they found her blood pressure was elevated. Although she had had a normal blood pressure throughout her entire pregnancy, the obstetrician suggested she be induced. Grace states that when advised to pursue induction, the obstetricians offered little explanation.

> *"It was just kind of, 'Your blood pressure is up. Let's go ahead and induce.' I know high blood pressure can be tricky and scary, so I just kind of went along with it and didn't question it too much…They did make it my decision, but I didn't feel like I knew my other options…It kind of felt like, 'This is what we need to do. Do you consent?' And I didn't stop and say, 'Well, what else can be done? Is there a possibility to wait? Can we do anything else? Can I just go to the hospital and wait to see if the blood pressure comes back down?' I didn't question it."*

Following induction, Grace labored for 17 hours with little progress; the doctors told her, *"'Okay, we're just going to go ahead and take you into c-section.'"* She told me that during the surgery, she bled profusely and became hysterical, and once the baby was delivered, they gave her a medication to help her calm down, but also caused her to lose consciousness: *"I was kind of traumatized that I was so out of it that I didn't remember anything of the first whole day after delivery."* The experience was very difficult for Grace: *"I was really hard on myself, and I felt like a failure of a mother because I didn't go into labor on my own. I had to be induced. I didn't break my water on my own. I didn't deliver on my own. I had to have a c-section, and* *then, I couldn't feed my baby. I never produced any milk. So, I felt like a horrible mom that couldn't do anything for my baby, and I got really depressed afterward."*

The traumatic experience of her first delivery affected the overall way she approached her next pregnancy, and the second time around, she tried to participate as much as possible in planning the birth. For example, she told her obstetricians that she wanted to have a c-section without general anesthesia, and thereby, avoided feeling the same post-operative fog: *"It went a lot better because I was more vocal."* However, Grace told me that her ideal birth would still be to deliver vaginally, but she didn't want to get her *"hopes up"* for a vaginal delivery, as her obstetricians were concerned that she would be at increased risk for post-partum hemorrhage.

During the interview, Grace told me how important having a general understanding and familiarity with medicine was in the experience of pregnancy. Since her last two deliveries, she had begun a professional course to become a Certified Nursing Assistant (CNA), a paraprofessional health care position that generally consists of a 6-week training program. With this increased knowledge, she felt that, in her most recent health care experiences, she *"[knew] what questions to ask."* In contrast to her previous deliveries, Grace told me that she felt more aware now that these are her decisions—that she feels entitled to be informed. As a result, she felt that with this pregnancy, she was able to express her preference for a vaginal delivery and more easily explore her options for delivery with her obstetrician.

> *"If I didn't know the right questions to ask, [I'm] almost like a pushover. The doctor already has his routine, knows what he's going to say, what he's going to do, and if you don't question it, then that's what's going to be done. Not necessarily the wrong thing to do, but you should be able to know the rest of the options."*

In reviewing the interviews from this study, it appears that stratification of medical knowledge could be largely responsible for the lack of preference-based discussions during the prenatal period. It seems that many of these expectant mothers, like Grace, simply did not know "what questions to ask," such that information necessary for an engaged discussion of the birthing process was never discussed or understood. Some anthropologists studying reproductive health have noted that prenatal visits are often the first consistent interaction with medical care for many low-income, minority women (Brubaker 2007). As a result, they are ill-equipped to navigate the dynamics of the doctor-patient relationship with the same ease as one who not only begins in a position of social privilege, but who has also had regular interactions with a doctor.

The ramifications of traumatic birthing experiences, like Grace's, have even farther-reaching effects in the lives of women. The expectant mothers I interviewed often said their previous deliveries greatly impacted their perspectives on pregnancy, and even themselves, as women and mothers. Several of the women who delivered via unplanned cesarean section described themselves as *"failures"* because they were unable to delivery vaginally. Others desperately wanted to experience the feeling of contractions or delivering vaginally. Aside from these anecdotal responses, this research study found birthing experiences to have a tangible impact on women's perspectives on decision-making in childbirth. Of the 22 interviewees asked about the prospect of formulating a birthing plan, 12 reported that they had already or anticipated creating one. Of the 10 who stated they did not have a birthing plan and had no intention of creating one, 6 had a previous cesarean section, all of which had been unplanned and emergent. Additionally, all 10 cited a lack of control over labor and delivery as the main reason why they chose not to pursue a birthing plan. These results were not associated with geographic location, level of education, or economic status; they were associated with previous traumatic birthing experiences. From these findings comes another answer as to why we should care about how a woman delivers—that a singular hospital experience can powerfully shape a woman's perspective of pregnancy, of bodily control, and of self.

Stratified Medical Space: delayed decisions and graduated hierarchies in medical settings

When I sat down to interview Michelle, a self-identified white woman in her late thirties, receiving care at Village Clinic, I was excited. She was funny, gregarious, and thoughtful in her responses, and even though I had just met her briefly in the clinic, I felt that we had established a surprisingly quick rapport. She was pregnant with her first child and described herself as sometimes "clueless" about different aspects of her pregnancy-related care. Despite that admission, when asked about her "good" birth, she detailed a very introspective response:

> *" I feel like, in general, your body is programmed to do what it's supposed to do…I think you kind of have to trust your body, but obviously, I trust medicine, too…[Induction] starts your labor when your body doesn't do it itself…I would rather my body goes into labor because I feel like when the baby's ready, then my body will do the right things."*

While Michelle was not entirely opposed to induction, and she felt she would be open to it, should she be past due or incredibly uncomfortable, she was generally unfamiliar with the various methods of induction and the overall process. Although she was already 33 weeks pregnant at the time of the interview, she had not yet discussed with her doctor the process of induction, risks associated with its use, or the options available to her should she choose to be induced. She also told me that none of the obstetricians had yet asked her about her labor and delivery preferences. When I interviewed her again after her delivery, Michelle described a birthing experience that hardly resembled the ideal she had described to me previously.

Michelle told me that when she arrived at her regular prenatal appointment at 40 weeks and 2 days, she was told that her cervix was potentially beginning to dilate (*"maybe 1 cm"*) and was offered the option of an elective induction. At this point, Michelle was already very uncomfortable and had been getting very little sleep. She was also given an ultrasound to determine the baby's size and whether the obstetrician would *"let her wait or go ahead with the induction."* The ultrasound measured the baby at 9 lbs, which concerned Michelle even more—what if the baby became too big if she chose to wait any longer? The overall discomfort she felt, the concern for her baby's size, and her excitement to meet her child led Michelle to agree to the induction. She was sent to the hospital labor and delivery unit that night.

When she arrived at the hospital, she was given what she described as *"a medication to help her cervix prepare for labor."* By the morning she was dilated to 5 cm, and the obstetricians began pitocin. After 13 hours of labor, Michelle was in incredible pain, both from the powerful contractions augmented by pitocin and the concurrent kidney stone that she was found to have during the course of the delivery. The pain had become unbearable when she began to feel the urge to push. The nurses noted that she was 9 cm, but she was told she *"wasn't allowed to"* push yet, as she wasn't *"ready."* At this point, the medical staff informed her that her cervix was beginning to swell and regress in its dilation. After two and a half hours of excruciating pain, despite continuous epidural administration, Michelle was desperate. It was at this point that the obstetrician informed her of their recommendation to deliver via cesarean section.

Although Michelle had been generally open to interventions, should the health of her baby be at risk, she had told me that she would ideally want to explore the available options and discuss the decision with her doctor before deciding to have a cesarean section. However, at the time she was asked to make this decision, her pain was so unbearable, that she felt she simply had no time to weigh her options, as she had originally planned. Indeed, she stated that had she been more comfortable at the time, she would have taken the opportunity to ask questions. Michelle said she felt completely out of control of her pain management and of the decision to proceed with a cesarean section. Although she specifically noted that the obstetricians *did* ask her to decide, she felt that the circumstances of her labor were such that she was left with no choice. She felt depressed and upset by the experience for weeks following the delivery and even became emotional, again, reliving the experience during our postpartum follow-up interview.

This birth story illustrates an important aspect of birthing dynamics that critically impacts the varied levels of power during decision-making—setting. This argument, drawn from Jordan's biosocial features of birth, posits that the physical space in which delivery takes place dictates the sociocultural practices and perspectives by which childbirth is approached and the interactional roles that various participants are assigned. What is so compelling in Jordan's discussion is the assertion that no matter the setting of the birth, it must necessarily belong to someone—must be someone's "territory" (Jordan 1993: 67). When considered in these terms, it is clear that the hospital labor and delivery unit must be the territory of the practicing obstetrician and medical staff, rather than that of the laboring woman. However, there are a myriad of medical settings in which obstetrical care is disbursed: free-standing prenatal clinics, in-hospital prenatal clinics, labor and delivery units, and postpartum care in either clinic or hospital. Each of these settings importantly inform sociocultural birthing practices in different ways, based on the unique environment in which they take place. Given this observation, a more precise way to conceptualize birthing settings, and medical settings more generally, would be to consider them as a conglomeration of distinct environments with distinct power structures, rather than one homogenized institution.

Each specific medical environment generates varying levels of patient and physician autonomy based on numerous characteristics of the practice, including the level of physician training and/or medical specialty, geographic setting, the patient volume seen on an average day, and whether or not it is set in the clinic (outpatient) or hospital (inpatient). This last variable—inpatient versus outpatient setting—greatly impacted the birthing decision-making observed during this research study, as many of the decisions related to obstetrical management were primarily made in the labor and delivery unit. This concept of variable medico-social dynamics based on setting and resultant hierarchies of authority in decision-making—what I'm calling stratified medical space—appears to be largely based upon the use of technology, atmosphere of emergency/illness, and the level of divergence from normal social dynamics, with the degree of all of these factors being inversely proportional to the level of patient autonomy achievable by the laboring mother. In other words, the environment and social arrangements of inpatient medical settings results in a greater level of power stratification between the patient and clinician.

This idea of stratified medical space—that every medical environment is differentially disempowering or culturally alienating to the patient—provides a useful lens for the examination of shared decision-making in labor and delivery, particularly when considering the discussion of labor and delivery preferences. For the purpose of this discussion, I use the term "preferences" to refer specifically to the three commonly used interventions described earlier in this chapter: cesarean section, induction, and pain management/epidurals. Very few of the women (9 out of 30) reported that they had been asked about their preferences by their obstetricians during their prenatal care visits. In the over 120 hours of participant observation conducted during this research study, I never witnessed a single discussion about labor and delivery practices or interventions that solicited the mother's thoughts, feelings, or preferences. Furthermore, many of the mothers who participated in postpartum interviews said they had not been asked their preferences at any point in their pregnancy-related care. As a result, the majority of decision-making discussions were left until the actual time of delivery.

As was demonstrated in Michelle's story, delivery is not the ideal time for contemplating birthing options, as the laboring woman is both emotionally and physically vulnerable. Discomfort, anxiety, and excitement were all common emotions felt by the expectant mothers interviewed for this research project. As can be seen in Michelle's anecdote, the decision to proceed with induction can be easily influenced by any one or all of these sensations. The main problem is that these decisions are not being discussed at a time when expectant mothers can fairly weigh the options, but rather are left until women are highly suggestible and more likely to favor induction. Furthermore, the ubiquity of "risk," so intricately embedded in the base of obstetrical knowledge and the prenatal environment, plays an important role in this process; the obstetrician's suggestion of induction plants in the mind of the expectant mother that it might be the best (or safest) course of action (see Chapter 7).

The concept of stratified medical space further suggests that there is potentially an additional level of disempowerment on the part of the laboring mother, being that she is in a foreign environment and surrounded by the unfamiliar social structures of the hospital. In the absence of prenatal discussion of preferences, decision-making effectively migrates from the relatively more neutral ground of the outpatient clinic to the highly stratified space of the inpatient labor and delivery unit. Any opportunity for discussion about various obstetrical interventions is essentially eliminated once the expectant mother arrives at the hospital—a dynamic that is largely a result of the unique characteristics of the inpatient environment. The pace of the work and the urgency of the situation, once in the hospital, seems to exclude the possibility for expectant mothers to discuss various interventions and gain the knowledge to "know what questions to ask" when the time to make such decisions finally comes. Take for example an interaction I observed between a medical resident and a laboring patient at Central Hospital, as recorded in my field notes:

> *Early this morning, a young, black woman arrived at the L&D unit in labor with her second child. The resident artificially ruptures her membranes (a form of induction) around 12:15 pm to help the labor progress further. At 1:30pm, the resident returns to her room to check her cervix for any further change. After telling the patient that she is 5-6 cm, she asks the patient if any one has talked to her about pitocin. When the patient responds that no, no one has talked to her about pitocin, the resident tells her that, if there is no further change in her cervix, they will begin pitocin. The patient looks at her blankly, and the resident leaves the room and puts in the order for pitocin.*

This scene was typical of the decision-making observed in the labor and delivery unit at Central Hospital. It clearly implies a lack of discussion about the various interventions during prenatal care. Due to the rapidity of patient interactions during labor, differential level of power and accessible knowledge, and physical vulnerability of the expectant mother, there is little opportunity for questions or discussion at the time of delivery. In my observations, there was simply no time to sit down and hash out the details of various interventions with patients when in the hospital labor and delivery units. Any autonomy the expectant mother may have had during their prenatal visits dissolved into the chaos of the hospital environment, where they are in a highly compromised position and radically limited in their mobility, tethered by intravenous lines or paralyzed by epidural administration.

Panopticon and Parity

To take this concept of stratified medical space one step further, let us consider the architectural structure of the hospital and it's impact on labor and delivery decision-making. Traditionally the layout of in-patient labor and delivery units consist of a centralized area of computers, monitoring equipment, and patient records, which also serves as a congregating point for the physicians and medical staff. This area—often called the "Fishbowl" or "Board room"—is generally surrounded by the patient rooms. In the labor and delivery unit, the Fishbowl is especially critical in the management of patient care, as the readings from monitoring equipment are displayed on a collection of large TVs, which provide data central to care decisions. Obstetricians are able to see how often and how strongly the laboring women are contracting. They can monitor the fetal heart rate for changes that may indicate potential harm. They can even tell when a woman has gotten up to use the bathroom by the absence of displayed readings when the monitors are removed. This technology essentially serves as a digitized projection of the laboring woman's bodily experience—a way of examining a patient without actually having to leave your seat.

Indeed, the labor and delivery unit echoes the theoretical concept of the Panopticon proposed by Foucault and applied in an ethnographic study of an inpatient psychiatric unit by Lorna Rhodes (Foucault 1984a; Rhodes 1991). Foucault argued that a uniquely inconspicuous form of societal discipline and power could be acquired through surveillance, and that such surveillance is achieved through the structural features common of so many civil institutions, namely prisons, schools, military barracks, and *hospitals* (Foucault 1984a; Rhodes 1991). The centrally located monitoring equipment surrounded by "cellular, partitioned" patient rooms in the labor and delivery unit strongly resembles the architectural features of the Panopticon and provides a means of confinement and constant surveillance of laboring women (Rhodes 1991:22). Through the translation of physical experience into graphic readings, individual laboring women are homogenized and approached through the standard template for managing a "normal" labor and delivery.

If we are to use the concept of stratified medical space to construct inpatient settings as environments of pronounced authoritative hierarchies between patient and provider, then the Fishbowl is the epicenter of such stratification. During field observation, the physicians, residents, and nurses spent the majority of their time in these centralized areas. As a result, the majority of information used to guide management decisions was based upon the technological readings from the monitoring equipment. If the internal device that measured uterine activity demonstrated weak contractions, the decision to start pitocin could be made, or if the fetal heart monitor showed consistent late decelerations[3] (a potential indicator of fetal distress), the obstetricians may consider forceps, vacuum, or a cesarean section to speed up the delivery. Most of the observed labor and delivery decisions were made in the Fishbowl before having examined the patient, and generally, without patient input. This observation was especially pronounced at Central Hospital, where the majority of patients were low-income, minority women from the

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[3] The term late deceleration refers to a slow decline in fetal heart rate with an equally slow return to a normal heart rate following a uterine contraction. Late decels, as they are often called, are generally ominous in that they can indicate fetal distress due to decreased oxygen supply from the placenta. However, some obstetrical interventions, like epidurals, can actually cause late decelerations in the absence of fetal distress.

Detroit area. Two examples from my field notes, taken during observation in the labor and delivery unit, illustrate this point:

> *With his hands on his hips, the obstetrician stands in the center of the Fishbowl staring at the screen displaying the reading from the internal fetal heart monitor of a patient who arrived after her water broke. She is in early labor—only 1-2 cm dilated. He appears to be concerned by the reading, noting late decelerations in the heart rate. He glances over at the board that lists various medical information about all the laboring women on the unit, like age, gravidity, parity, gestational age, and interventions administered during labor and delivery. Finally, he turns to the resident, "Yeah. She needs to be delivered. She's 40 weeks and has [late] decels. Induce her."*

> *One of the laboring women is having late decelerations with her contractions. The on-call obstetricians and a group of residents watch the monitor from the Fishbowl. After the third late deceleration occurs, the obstetrician calls down to notify the operating room that an emergency cesarean section may be necessary. They all continue to closely watch the fetal heart reading, but no one goes to the patient room to discuss, or even inform her, of this decision.*

In such examples, can we conclude that expectant mothers are explicitly included in the decision-making process? It would seem they are not—they are not even *physically* present at the time that many decisions are being made. In this way, the surveillance achieved by the labor and delivery unit panopticon further bolsters the authority and control obstetricians have over biomedicalized management of birth. Furthermore, in perpetuating this depersonalized construction of patient presentation, this technology supports the continued dominance of biomedicalized forms of birthing practices, reciprocally supporting the use of various interventions and seemingly justifying the homogenized template of obstetrical care.

Conclusion

In this chapter, I examined the idealized model of shared health care decision-making, which incorporates a cooperative discussion of information between patient and clinician, in order to explore the way in which labor and delivery choices are reached. In contrast to the classic patriarchal or directive medical decision-making approach, the shared model emphasizes an exchange of information between the two parties, including the discussion of patient preferences for various health care options. I considered the discussion of preferences surrounding three common labor and delivery interventions (cesarean sections, induction techniques, and epidurals) during interviews with expectant mothers and found that the majority of them had never been asked about their preferences during prenatal care. In analyzing these findings, I argued that the use of technology and pharmacologic interventions work to create and maintain stratification of power between clinician and patient during biomedically-managed births. In addition to the existing hierarchies inherent to hospital births, I found additional social factors, such as patient's level of education and degree of medical literacy, either served to limit or exacerbate the loss of autonomy on the part of the laboring woman. Finally, I discussed the potential impact of hospital architecture and inpatient medical settings, citing Foucault's Panopticon, finding that both the physical separation of patient and obstetrician during labor and delivery and the foreignness of the hospital environment contributed to the unequal share of decision-making power.

This chapter has largely drawn upon the watershed anthropological works of Jordan (1993) and Davis-Floyd (1992), relying heavily on their theoretical framework of authoritative birthing hierarchies. Through my analysis, it is clear that decision-making power is, indeed, unequally distributed between obstetrician and laboring woman. However, the methods with which medical authority is obtained and reinforced during prenatal and peripartum care are not always obvious. In this chapter, I have detailed just a few of these methods and, hopefully, contributed to the larger anthropological discussion on childbirth decision-making.

Chapter 6: “Baby Daddies” and Assembly Line Medicine: socio-economic stratification and childbirth decision-making

In the previous chapters, I used findings from this research project to outline a general ethnography of childbirth experiences in the Metro Detroit area. In doing so, my goal was to identify the interacting webs of community knowledge, medical expertise, social experiences, and authoritative hierarchies that inform and dictate the course of decision-making during pregnancy and childbirth management. In this chapter, I will take this analysis one step further and explore how the unique socioeconomic characteristics of the Metro Detroit region impacted the individual care experiences of the research participant population, and created contrasting institutional dynamics between Central and Outer Hospital. I will first analyze racial/ethnic and class discrimination experienced by study participants when interacting with pregnancy-related health care providers, examining how such encounters not only impacted their obstetrical care, but also how it may potentially influence the observed obstetricians' perspective of their patients. Then, I will discuss divergent environmental characteristics of Central and Outer Hospital, identifying factors, such as patient volume and the number of providers, as influencing the consistency of obstetrical care and the process of birth-related decision-making. Lastly, I explore the contribution of insurance coverage to the contrasting urban and suburban medical environments and examine the contribution of capitalist interests on the observed obstetrical framework of care. Based on these observations, I argue that the economic stratification and racial/ethnic segregation present between the urban and suburban field sites manifested both as differential care experiences among the individual research participants, and also through institutional characteristics of the respective hospital labor and delivery units.

“Who’s the baby daddy?”

Low-income and/or minority women interviewed for this study reported differential experiences when receiving care for their pregnancies, and identified both race and insurance status as the primary factors that influenced their interactions with health care providers. One example of which is Jessie, a 36-year-old woman, pregnant with her first child, and the only self-identified black woman I observed receiving care at Village Clinic. Having moved from Ohio to the Metro Detroit area two years prior, Jessie was adjusting to her new Michigan-based health insurance policy, as well as the increased frequency of doctor’s visits necessary for her prenatal care. When asked about her prenatal experience, she responded that she *“thought the level of care would be different.”*

Village Clinic was the third obstetricians’ office Jessie had been to after transferring care twice, following interactions with clinic staff she found to be offensive and disputes over insurance coverage. This was deflating for Jessie who, having waited for a while to start a family with her husband, felt that this very personal journey toward parenthood was becoming marred by bureaucratic tape and insensitive staff; *“I don’t need someone to hold my hand, but I would like to develop a little more [of a] personal relationship when we’re doing something so personal to me.”* She felt that her care, with both general practitioners and OBGYNs, alike, was very different from her experience in Ohio—*“I don’t know if they’re overwhelmed with patients, [but] they really don’t know their patients…To come into a room and someone is going to examine you and take blood and they don’t even really acknowledge your name…I don’t expect you to know my life history, but you should, at least, acknowledge my name.”*

Her prenatal visits began at a women’s clinic in Southfield, where Jessie said she received care from an unengaged staff of physicians. When her husband accompanied her to one of her visits, the obstetrician never even acknowledged his presence in the room. Following her appointment, Jessie expressed her dissatisfaction in a clinic survey. At her next visit, the obstetrician pulled out the survey and offered Jessie her reasoning for not interacting with her husband.

> *"Her explanation for not addressing my husband in the room was that she never knows who the babies' fathers are. So, her patients typically could be a boyfriend/girlfriend situation or could be the father or could not be the father. So, her way of handling it was just not to address the men at all."*

This admission on the part of the physician was unsettling for Jessie. When I asked why she thought that the obstetrician had made that assumption about her husband, she replied:

> *"Race could come with it, for sure. That's the first thing that comes to my mind. The fact that the practice was kind of on the border [of Detroit]—I guess they probably get some [people] from…the inner city. So, I guess, based on the patients…she had encountered, that was her assumption. Race plays a big enough role in a lot of things; I don't want it to be a part of my pregnancy situation and how we're being treated."*

Following this interaction, Jessie decided to switch to a different obstetrician for her prenatal care. At the second obstetrician's office, Jessie objected to being billed a $2,000 delivery charge upfront, an office policy for all patients. The office required this fee to be paid, even though Jessie had private, employer-based insurance coverage from a well-known local insurance company. When Jessie asked about the fee, the office manager was surprised that she would question the charges, saying *"she didn't know where"* Jessie *"came from,"* but this was how they do things at their office. *"The office manager went so far as to tell me because I was asking so many questions, that I was not a good fit for their practice."* Again, Jessie made the decision to find a different obstetrician, but when she requested her medical records be transferred to Village Clinic, the office manager sent her the forms to her in the mail…ripped into pieces.

As Jessie's story demonstrates, racial/ethnic identity may powerfully shape both the experience of women as they navigate through prenatal care, and also, how they interact with the health care system, in general. Unfortunately, Jessie's story was not uncommon among the women interviewed for this study. Several of the research participants stated that they explicitly experienced discrimination during the course of their prenatal care. In fact, when asked if they thought a woman received differential pregnancy-related care based on her social background, 17 of 29 women, from both urban and suburban recruitment sites, agreed. Of these 17 participants, 14 reported that they felt class or insurance status motivated inequitable treatment, and 9 reported that race/ethnicity or general appearance also played a part. Most disconcerting was the way by which the interviewees felt care was different for women as a result of a low-income, minority status: being treated poorly by health care workers, experiencing prejudice or discrimination, having fewer options, and receiving lower quality care or less skilled clinicians. While these findings may seem obvious given the current racial climate in the United States, I was taken aback by the firmness and specificity with which the interview participants offered their affirmative responses.

For instance, Carrie, the self-identified black woman, whose desire for a natural labor and delivery was described in Chapter 4, strongly believed that marginalized populations of women received differential treatment. Not only did she feel that social background impacted a community's overall health (*"the way you live, the things you eat, and the way people treat you"*), she felt that the hospital's reaction to patients is reciprocally influenced by the demographics of the patient population it serves. She specified that at hospitals serving many *"colored women,"* the care is totally different, particularly in the way the staff talks to them. Carrie felt that black patients who *"have more money"* and are able to go to a more racially diverse hospital do not receive the same level of disrespect. For Carrie, race was a predominant factor in black women's interaction with the health care system—*"When we go to the doctor's, no matter what—especially when you're pregnant—you're viewed differently. You know, 'She probably doesn't know who the father is' or 'She's too young.'"* Carrie had encountered this first-hand. When she arrived for her initial prenatal appointment at Central's onsite clinic, one of the staff members asked her who was her *"baby daddy."* Carrie was taken aback: *"Hold on for a second. What do you mean, 'Who's the baby daddy?' You mean, 'Who's my husband?' It's like they talk to you the way they think you talk."*

Brittany, a 30-year-old, self-identified black interviewee, had a similar experience with the same clinic:

> *"I felt like I had no privacy. People were being judged and [the staff] didn't really care. They feel like they want to get these people in and out…I'm like, 'I got to go to this clinic that I don't even feel comfortable at!' And I didn't go back. First and last time there! [laughs]"*

Lisa, the 23 year-old, black woman who's pursuit of a VBAC delivery was first introduced in Chapter 4, echoed these sentiments, stating that she felt she had been judged by the Central

Hospital staff during her previous pregnancies. She told me that following the delivery of her second child, the obstetricians had told her that the placenta looked like she had smoked throughout her pregnancy. Having never smoked in her life, Lisa felt insulted and believed that they had made this assumption about her based upon her race. She was equally insulted by her previous obstetrician's suggestion that she have her tubes tied following this delivery—advice that was both unsolicited and offensive, invoking what she thought to be a prejudiced undertone.

These types of presumptions about racially marginalized patients and the resultant differential treatment may have a significant impact on the process of decision-making, undermining our idealized concept of a shared decision-making model, as it necessarily negates an egalitarian relationship between the practicing obstetrician and the low-income, minority mother. This dynamic plays out in both the physical and the social barriers encountered by expectant mothers of color in achieving a comfortable and respectful relationship with their care providers. As we could see with Jessie's story, experiences of prejudice resulted in an emotional barricade between patient and physician, which is particularly detrimental when concerning such a personal health issue as pregnancy.

Furthermore, such experiences created a physical obstacle to continuity of care for Jessie, Carrie, and Brittany, who all chose to leave prenatal clinics as a result of clinical interactions involving discrimination or prejudice. Such negative encounters in receiving pregnancy-related care effectively sever any feeling of rapport with the obstetrician and medical staff, creating an environment that fostered resentment, rather than mutual respect. Thus, a patient's appearance and perceived racial identity has the potential to dramatically altered the course of labor and delivery and the laboring mother's agency during the process. The impact of prejudice can greatly influence minority women's perception of the health care system more generally, which may jeopardize their trust of physicians, tarnish their faith in the medical system, and motivate them to forgo medical counsel for future health issues.

Interestingly, a large majority of the urban interviewees cited insurance status, rather than racial identity as the primary impetus for discrimination. Indeed, many of these women thought that it was their income level, which clinic staff presumed based upon their use of Medicaid or a Medicaid-Managed Care Organization combination, that fueled the unequal treatment they or someone they knew had experienced within this urban hospital system. It is important to note that racial stereotypes and insurance status are intimately linked both in the narratives told by interviewees and in the way in which clinicians seemed to view their patients. Brittany's comments on experiencing the judgment of staff at Central Hospital's onsite clinic seemed to encompass both racial discrimination and an assumption about her deservingness, based on her insurance. She felt that clinic staff members treat patients with Medicaid in this way because the feel like *"they're giving you something. Like, they don't want anyone paying for your insurance."* Ashley, another self-identified black interviewee, who had received care at Central Hospital's onsite clinic, also felt that both insurance and appearance influenced the way in which health care providers perceived their patients:

> *"If you don't have the best insurance, [health care providers] might feel like, 'Oh, I'm not getting the full amount…so, I'm just going to do the bare minimum to take care of this person. Of course, [someone with better insurance is] going to get better care because they can go to better hospitals or places with better programs."*

She felt that health care workers most often make assumptions about patients based on their appearance: *"If their hair is combed. The way they dress or maybe the way they talk.*

People take that stuff and believe, 'Oh, this person isn't smart enough…So, I can talk to them any type of way.'" Such pervasive societal imagery of pregnant, minority women as irresponsible may also play into the perceptions local obstetricians have of their patients. When observing at the urban clinic, I followed one of the obstetricians to see a patient who had missed several prenatal appointments.

> *OB: "How come you missed so many appointments?"*
> *Patient: "Transportation. I live all the way on the west side."*
> *OB: "You have to come to every week now through your pregnancy. Can you do that?"*
> *Patient: "Yeah."*

Following this encounter, I asked the obstetrician what she thought to be the cause of missed prenatal appointments. She replied that this *"happens a lot with low socioeconomic status patients"*—that *"they're either poor or [they] don't care."* She articulated even further that many are *"lazy"* and *"don't want to come"*—*"they see people all around them getting pregnant without prenatal care and think it's okay. So, they don't go."* This perception of low-income patients was expressed frequently among the observed medical interactions. While frequent in my observations, whether or not this is common among providers or other institutions locally is uncertain, but what is evident is that the social conceptions of deservingness and discriminatory rhetoric surrounding marginalized citizens has permeated the experience of prenatal care for many women interviewed in this research study, and that these assumptions powerfully affected the way these expectant mothers view the health care system and how members of the health care system perceive their patients. Carrie's description of this experience was particularly telling:

> *"Once they see your insurance, they try to make you feel some type of way…It's more of a stereotype. Not really like, 'I don't like you because you're this.' It's more like, 'I expect this from you because you are.'"*

Assembly-line Obstetrics & the "Business" of Medicine

Implicit in these observations is the process of patient homogenization, first explored in the discussion of medical expertise in Chapter 4. In employing a universal conceptualization of low-income, minority patient populations, stereotypes of marginalized women in Detroit can easily become incorporated into their care experience, as evidenced in the above narratives of the study participants. The very structure of the American medical institution necessitates an algorithmic approach to patient care, reinforcing a depersonalized construction of the individual patient within a standardized template of a "normal pregnancy." It must to be noted that the time constratint experienced by practicing physicians significantly limits most clinical interactions, and as a result, there is often very little opportunity to tailor clinical approach to each patient. Two factors observed at Central Hospital appeared to especially contribute to the homogenization of patient care—size of the patient population and provider continuity. The volume of patients was particularly high at Central Hospital's onsite prenatal clinic, where a portion of the outpatient observation took place. This clinic was usually overflowing with patients, who often waited upward of two hours for their scheduled appointments, and met with an inconsistent schedule of OBGYNs and resident physicians on any given day. In a word, it was absolute chaos. Managing such a large patient population appeared to be particularly challenging at this clinic, where observed prenatal visits were markedly shorter than those observed at either Metropolitan or Village Clinic. This time constraint required a systematic, though depersonalized, approach to care in order to meet the demands of the appointment scheduling, which could certainly erode the integrity of the doctor-patient relationship and contribute to the lack of communication reported by interview participants.

To explore how a large patient volume and subsequent provider inconsistency may impact birth-related decision-making, let's return to the story of Lisa, first presented in Chapter 4, who is a 23-year-old, self-identified black woman, who received care at Metropolitan Clinic for her third pregnancy. Having already had two cesarean sections, one emergent and one "elective," Lisa was determined to have a vaginal delivery, after learning of the option of a Vaginal Birth After Cesarean (VBAC) from a local midwife and being encouraged by other women's stories she had encountered through social media community groups. As was detailed in Chapter 4, Lisa had switched prenatal clinics at 28 weeks, after her decision to have a VBAC delivery was met with resistance from her original obstetrician. She found support from her new obstetrician at Metropolitan Clinic. A few days before she was due, Lisa began feeling contractions, but held off from going to the hospital, not waiting to arrive too early in the labor process for fear that she would be pressured to have a cesarean section. The day before she was due, Lisa decided she was close enough to delivery to head to Central Hospital.

Upon arrival, she told me that the obstetrical staff ruptured her membranes during a cervical check, in an attempt to speed up her labor, without informing her of what they were doing. The on-call obstetrician, who was not the physician Lisa had seen for her prenatal care, came into the room and suggested that they start pitocin. Lisa refused, believing that pitocin would make it more likely that she would need a cesarean section. A few moments later, some medical students were sent into her room and told her that they wanted to give her oxytocin; *"That's the same thing as pitocin, and I don't want it,"* Lisa told them. From the moment she arrived at the hospital, Lisa felt that she was pressured by the on-call obstetrician to have a cesarean section. The medical staff continually told her that she was not progressing through labor appropriately. The obstetrician even went so far as to say, *"You won't be able to do it. You didn't do it before."* Unfortunately, this pressure did not end there; Lisa told me that throughout her entire labor, the obstetrician argued with her, insisting that she abandon the vaginal delivery and consent to a cesarean section. In the end, Lisa vaginally delivered her son later that afternoon. The obstetrician was *"so mad"* that she left immediately following the delivery and never returned to Lisa's room for the remainder of her stay at the hospital.

Lisa's story is an example of one of the major pitfalls of American obstetrical care, and that is the inability to know which obstetrician will be present on the day of delivery. This was a common theme among both suburban and urban interview participants, many of whom expressed frustration at developing a relationship with their prenatal obstetricians without knowing who would actually deliver their child. Furthermore, most women felt it was futile to attempt discussing labor and delivery planning with their obstetrician if they could not predict who would actually attend their delivery. Even Lisa, who had proactively searched for an obstetrician who would support her preferences, was met with resistance when it came time to deliver.

It is easy to forget that medicine is also a business, but in reflecting on this efficiency-driven rotation of in-hospital obstetricians and seemingly overwhelming amount of patients at Central Hospital, the influence of our capitalist economic interests on the American medical institution becomes more apparent. For instance, hospital labor and delivery units generally operate in a similar way; each day there are particular obstetricians who are on-call, meaning they are at the hospital for a designated amount of time and care for whichever patients come in for delivery that day. On occasion, the obstetrician who sees the patient for regular prenatal care is contacted and will come in for the delivery, if able, but often times they are in clinic, out of town, or otherwise unavailable. If the hospital is a teaching institution, there will also be medical residents involved in a large portion of childbirth management, which adds an additional layer of unfamiliarity for laboring women and discontinuity between prenatal and peripartum care relationships.

This model of care resembles an assembly line, in that obstetricians on scheduled shifts treat the flow of patients as needed without necessarily having an established doctor-patient relationship. Consequently, this structure of care contributes to the absence of a shared decision-making model (as discussed in Chapter 5), and provides an explanation for the paucity of preference-based discussions in prenatal care reported by the interview participants. Additionally, this seems to result in detachment between the in-hospital physician and the laboring patient, potentially generating a level of estrangement both between these two parties and between the physician and their job, itself, a concept I'm calling estranged "labor," that I will further elaborated on in the Chapter 7.

Teaching hospitals, like Central Hospital, are especially prone to this type of revolving door medicine, as patients are seen by many different physicians, resident physicians, and medical students. In contrast, Outer Hospital solely employed privately practicing physicians, and patients were rarely seen by resident physicians or medical students during my observations. Not only do these types of medical environments contribute to the feeling of depersonalized care experienced by women, like Lisa, but they may also compromise the effectiveness of communication concerning labor and delivery management. Though this dynamic is not unique to Central Hospital alone, the degree of patient volume and circulation of obstetrical care providers, in comparison to Outer Hospital, may have lead to a pronounced lack of egalitarian decision-making and patient autonomy among the urban research participants.

Medicaid Reimbursement and Patient Volume

The maintenance of a large patient volume appeared to not only be motivated by respective population size, but also by the economic makeup of each geographical region. As previously discussed, the majority of patients receiving care at the urban field sites utilized either Medicaid or a Medicaid-Managed Care Organization (MCO) combination for their prenatal care expenses; Village Clinic did not accept any patients with Medicaid insurance, reportedly due to the low proportion of reimbursement generally received. Indeed, both of the suburban obstetricians interviewed as part of this study mentioned the issue of insurance reimbursement as an important factor in their medical practice. As one suburban obstetrician articulated during the interview:

> *"You'd like to think that practicing medicine is just the medical part of it, but if you're in a private practice, the business part of it sort of gets in the way…Even though you'd say, 'Well, I just want to take care of patients and do the right thing'…you may make some decisions based on economics because, in order to survive out there, you have to do stuff like that."*

In urban hospitals, like Central, where the majority of the patient population has state- or federally-funded insurance as their primary source of coverage, there is potentially an economic incentive to maintain a larger patient volume, in order to generate a greater amount of capital in lieu of the lower percentage of reimbursement when treating patients with Medicaid or Medicaid-MCO coverage.

The “business of medicine” has become strikingly more obvious in the United States, particularly in the current climate of health care reform. This, combined with the growing cost of medical education and the continued decline of insurance reimbursement, seems to result in an economically-driven mindset within hospital institutions, which might, in part, explain both the large patient volume observed at Central Hospital. It may also explain the obstetrical propensity to induce prior to a patient’s due date, routinely schedule cesarean sections, and augment labor with pitocin, despite a lack of medical indication. In such examples, there is certainly a component of economic consideration that colors obstetrical management. Thus, patient insurance status and variation in reimbursement percentage appears to be a socioeconomic variable that warrants further exploration, as an influential factor in labor and delivery decision-making, as well as in the American health care system, more generally.

Conclusion

In this chapter I explored the unique sociocultural and economic environment of pregnancy-related care in Detroit, examining how the divergent contexts of the urban and suburban field sites influenced the experiences of expectant women who participated in this study. The socioeconomic stratification in the region was manifest in the minority interview participants reports of discrimination and prejudice during clinical interactions. Aside from the obvious humanistic concern generated by these narratives, it can certainly be argued that such encounters compromise the integrity of doctor-patient relationships and erode expectant mothers’ trust in their medical care providers. I also explored the potential impact of racial and income inequality on obstetricians’ perspective of, and potentially, approach to their patients.

Furthermore, I argued that the very structure of American obstetrics—and American medicine, more generally—cultivates a homogenized approach to patient care in which such stereotypical presumptions of marginalized patients are easily employed. I also contrasted the observed patient population size and consistency of providers between Central and Outer Hospital, demonstrating that the large volume of patients and rotation of obstetricians at Central Hospital created potential barriers in patient autonomy and shared decision-making, as demonstrated in Lisa's birth story. Lastly, I argued that the overcrowded environment of the urban field sites is not just a result of the size of the respective population, but that the smaller amount of reimbursement from federally-funded insurance companies potentially generates an economic incentive for maintaining such large patient volumes, which adds an additional degree of difficulty for urban research participants in the acquisition of cooperative and individualized obstetrical care.

Chapter 7: Discussion and Conclusion: why should we care how women deliver?

This dissertation has presented the findings of an anthropological study of the sociocultural context of childbirth management in Metro Detroit. In developing the primary focus of this research study, I wanted to identify factors, whether individual, collective, or institutional, that either limited or encouraged the various birthing choices available to laboring women. In doing so, I hoped to identify unique social aspects of prenatal and peripartum care in the Detroit area that played a role in doctor-patient relationships and the level of patient autonomy accessible to local expectant women. When presenting the initial research outline for this project, I was posed with the following question: "Why does it matter how a woman delivers?" While seemingly simplistic, this question forces us to examine what may be the most important finding of any anthropological study of medicine—that is how medical knowledge and practices impact the everyday lives of individuals. While medicine, in general, is a highly influential aspect of our societal framework, childbirth, in particular, marks a watershed moment in the lives of every mother. It is a time of transformation and emotional growth—it's the moment when you meet your child. This fact, in and of itself, should be enough to argue that the way in which women become mothers is important, but we can bolster this claim even further.

Several research studies from a variety of disciplines demonstrate the measurable repercussions of traumatic birthing experiences. Post-traumatic stress disorder, postpartum depression, and failure to achieve prolonged breastfeeding are all associated with a chaotic and emotionally tumultuous childbirth (Beck and Watson 2010; Elmir, et al 2010). What has also become clear, through the stories of the women I interviewed for this study, is that childbirth experiences can profoundly shape the way in which a woman views herself (see Grace's story in Chapter 5). Of additional importance is the way childbirth, and birth-related decision-making, in particular, serves as a lens through which we can better understand the influence of societal values and beliefs on the practice of medicine. In taking this perspective, we, as anthropologists, can effectively examine the role of cultural context, economic interests, and dominant ideologies in the creation of American medical infrastructure.

The Language of Decision-Making: subtleties in authoritative knowledge

In my discussion of medical knowledge and expertise in Chapter 4, the inherent power hierarchy of authoritative knowledge is evident, as well as its role in creating a stratified dynamic of decision-making. While the acceptance of medical expertise and technological interventions generates unequal power dynamics in birth, it is important to note that most women I interviewed did not perceive their experience as such. None explicitly stated that they felt their physician was coercing them into decisions. It is true that many of the women I interviewed had labor and delivery experiences wildly different than what they'd hoped, as many women have had in the wealth of ethnographic studies on childbirth, but there is an apparent difference between perceived experience on the part of the women I interviewed and what I observed during this study. Because there is such a pronounced gap in technological and medical fluency between obstetrician and expectant mother, the women I observed were unable to interpret the presence of "medical necessity" and necessarily relied on the clinician to make this key determination (See Chapter 4).

The disparity in comprehension of medical knowledge is essential in the maintenance of hierarchical decision-making, and is used, whether consciously or unknowingly, by obstetricians to preserve an authoritative position in their interactions with patients. It places the advice and opinions of the physician outside the reach of their patients, such that they are not challenged, either individually or collectively, in their knowledge or forms of practice. Furthermore, the patient's dependence on the clinician's knowledge seems to result in a significant level of influence in most communications between the two. As with the concept of stratified medical space, there is no neutral realm of communication between physician and patient, as whenever a patient encounters a physician, they also encounter the immense backdrop of medical authority, higher-level education, wealth, and societal reverence.

Because of the dominance of biomedical knowledge as the arbiter of healthy pregnancy (see Chapter 4 and 5), the expectant mother's interaction with the obstetrician is particularly influential in informing the decisions women make about their pregnancy. What are expectant mothers encouraged to think about when making decisions concerning their pregnancy? Considering their authority in the management of prenatal and peripartum care, the advice given by obstetricians holds particular import. Based on this observation, I argue that the division of authority in decision-making between the expectant mother and the obstetrician occurs mostly through subtle linguistic cues. Questions regarding various birthing interventions were often posed as closed-ended (*"Do you want an epidural?"*), rather than open-ended and amenable to the expectant woman's input (*"What techniques for managing labor pains are you familiar with?"*). The limited time physicians have to see and interact with their patients may account for the directive nature with which these techniques were introduced. Even so, this approach diminishes the expectant woman's input and, quite possibly, sways her decision. Moreover, this manner of questioning only serves to emphasize the differential level of power between physician and patient, as a result of medical expertise.

Induction is perhaps the most complicated of the interventions discussed in this dissertation, as there are a variety of methods by which it can be performed. Additionally, induction can be deemed as both "medically necessary" and "elective," two categorizations whose distinction can often become blurred in actual practice. Furthermore, the specific parameters for the use of inductive techniques are sometimes dependent upon the discretion of the individual physician. This is only further complicated by the favorability a woman feels toward inductive techniques when she is late in her pregnancy and, most likely, uncomfortable, anxious, and excited. As is evidenced by the lack of preference-based discussions during prenatal care among interviewees, these decisions are not being discussed at a time when expectant mothers can fairly consider their options. Rather, conversations about inductive techniques are often left until the last weeks of pregnancy or even after labor has already commenced, when women are clearly more agreeable toward their use.

Even more so than anticipation or discomfort, the decision to induce is influenced by the authority biomedicine claims over insuring a healthy pregnancy. Indeed, the ubiquity of "risk," so intricately embedded in the structure of prenatal care, plays an important role in this process; because the obstetrician suggests it, even a simple mention of induction insinuates its potential necessity in promoting a healthy pregnancy. During participant observation in both prenatal clinics, the notion of induction was routinely introduced around week 37 or 38 (the milestone at which the mother is considered, medically, to be at term), which may put into the mind of the expectant mother that she could and/or should go into labor soon. The purpose of this argument is not to evaluate the appropriateness of obstetrical management in a given situation, but rather to call into question the supposed autonomy of an expectant mother's decision-making when so completely immersed in these authoritative structures. In other words, my goal is to point out how incredibly influential the type of communication between obstetrician and expectant mother is in determining pregnancy management, even when such decisions may appear to be completely preferential and autonomous on the part of the laboring mother.

Discipline and Delivery: the panopticon in obstetrical structures of care

In Chapter 5, I introduced the concept of stratified medical space, arguing that all medical settings do not present a uniform distribution of power between patient and physician. Rather, I argued that authoritative hierarchies exist on as a gradient based upon the context in which clinical interactions take place. The most important conclusion to make from this arrangement is that no medical setting can be considered neutral ground for decision-making—that the obstetrician's familiarity with the facility, daily routine, equipment, and staff necessarily grants them added comfort with medico-social interactions, and that such comfort allocates an advantage to them within the differential power of labor and delivery decision-making. Thus, through the acquisition of medical knowledge (see Chapter 4) and their competency with hospital-based social interactions, the obstetrician achieves a level of sociocultural capital within the hospital that is unmatched by any other birthing attendant or participant.

As described in Chapter 5, the typical labor and delivery unit closely resembles the architectural template of Foucault's *panopticon*—the achievement of power and discipline through constant surveillance and observation (Rabinow 1984a; Rhodes 1991). Perhaps the most interesting dynamic within the panopticon is that human is both the surveyor, and also, the surveyed. Consequently, the interaction between two fellow human beings is disfigured, transcending the normal form of human relations to become a clearly delineated hierarchy, not only of power, but also authority, morality, and dignity (Rabinow 1984a). Indeed, the physical division of medical staff and patients manifests also as a social division, defining the appropriate forms of interaction between the two (Rhodes 1991). As we could see in the examples presented in Chapter 5, this division powerfully changed the context of observed decision-making at

Central Hospital, such that determinations about childbirth management were relegated to the distinctly medical space of the Fishbowl. Not only does this generate a spatial disconnect in decision-making discussions, but it also has larger implications about the collective agency of individuals when interacting with our health care system.

According to Foucault, the panopticon represents a form of discipline and power that is conspicuously integrated into the fabric of various social institutions, including medicine (Rabinow 1984a). In his argument, Foucault posits that disciplinary techniques, like the panopticon, "reduce" the body, such that populations may be coerced into subjection and be stripped of the ability to challenge existing hegemonic powers in society (Rabinow 1984a). It is through this standardization—this normalization of populations through "specialized institutions"—that juridical subjection, societal inequalities, and the dominant base of accepted knowledge is reproduced. Efficiency is often the justification for various practices adopted in the clinical and hospital setting, yet, as Foucault articulates, the proliferation of surreptitious disciplinary forms has been "through mechanisms of power which…are integrated into the productive efficiency of the apparatuses from within, into the growth of this efficiency and into the use of what it produces" (Rabinow 1984a: 208). Thus, notions of biomedical efficiency serve the purpose of obscuring constitutive acts of power, surveillance, and control. In doing so, institutions, like medicine, can effectively generate political power and economic growth, and in using techniques, such as the panopticon, can do so with near invisibility of the politico-economic interests they serve.

Race and “At-Risk” Status

As was also discussed in Chapter 5, authoritative hierarchies of decision-making appear to be especially pronounced among marginalized populations of expectant mothers, as they are generally disempowered socially and economically and, thus, less able to challenge the authority of biomedical practice. Indeed, ethnographic data demonstrates that expectant mothers from minority populations receive differential medical management during their pregnancy, which is justified biomedically through their distinction as “high risk” (Bridges 2011; Zhang, et al. 2012). Reaffirming the existing social order, bodies of poor women are produced “as problematic entities in a distinctly medical sense,” such that federal systems of health care, like Medicaid, “produc[e] poor, pregnant women as possessors of unruly bodies” (Bridges 2011: 74). With the introduction of “risk,” the “social imperative” of clinical encounters revolve around neutralizing one’s “at-risk-status,” justifying the over medicalization of minority patients and making them necessarily targets for manipulation and subjugation (Bridges 2011; Hunt and deVoogd 2004; Rabinow 1984b).

The control achieved by technological intervention during childbirth effectively produces what Foucault calls the “docile body,” meaning a body “that may be subjected, used, transformed and improved” (Rabinow 1984b:180). The body is an “object and target of power”—a point at which dominant structures of operation can manipulate individual behavior, and eventually, collective modalities, so as to generate obedience, politically, and productivity, economically (Rabinow 1984b:180). Risk as a medico-social label has a dual nature—individualistic, in that it imparts responsibility for individual actions, and societal, as the greatest risk is generally designated to groups outside of the dominant social strata (Douglas 1992). It is no surprise then, that the greatest degree of manipulation during the course of labor and delivery often occurs among low-income, minority women. As Khiara Bridges (2011) found in her ethnographic study of childbirth in New York City, black bodies are perceived as and produced by biomedicine as the least "obedient" bodies, such that increased medical intervention is utilized to control them, under the guise of medical necessity. As a result, the loss of decision-making autonomy among "at risk" populations is legitimated through seemingly objective reasoning. Furthermore, rather than confronting the devastating impact of social inequality on individual and community health, instead "high risk" designations obscure sociocultural aspects of health status, while also reinforcing not only the conceptualization of minority women's bodies as "abnormal," but also the purported necessity of medical expertise in the achievement of a healthy pregnancy.

Manifest in this arrangement is Foucault's concept of "biopower," which describes the control of populations through the imposition of political forces onto bodies (Rabinow 1984b). Serving as a point where "relationships between individual and social bodies" merge, the body politic provides a similar perspective in elucidating the "power and control" exerted by biomedical institutions over individuals and society (Scheper-Hughes and Lock 1987:23). Through "biopower," medicine assumes a normative posture, which authorizes it to not only distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives" (as cited by Loyd 2010:41).

Medicaid is the New Black: defining a unique racial identity in Detroit

In interpreting the use of "high risk" designations in minority populations and the subsequently pronounced division of power in health care interactions, intersectionality theory provides an understanding of the complex relationship between various types of marginalized status. Using intersectionality theory, we can determine that class, gender, and race/ethnicity work in concert to generate the challenges encountered by low-income, minority women when receiving their pregnancy-related care. In Chapter 2, I discussed the variety of interpretations and applications of racial/ethnic identity present in the medical community and explored the ways by which this often shapes clinical approach to minority patients. In Chapter 6, the narratives of women I interviewed echoed these sentiments and demonstrated how stereotypes of low-income, minority women in Detroit have altered their care experiences and even the perspectives of obstetricians I observed.

However, I argue that the experience of black women receiving care in Detroit is distinct from other black patient populations in the United States. Indeed, the degree of inequality in Detroit is unique and generates a particular type of racial and class discrimination that is specific to this region. The current socioeconomic stratification of the Metro Detroit area is a result of long-standing oppression and discrimination, as is manifest in the city's current urban landscape of intense racial and economic segregation (See Chapter 2 and 3). Historically, a variety of measures, including discriminatory housing laws and opposition to public school integration, have been used to prevent black citizens from gaining access to the same privileges enjoyed by white residents in Southeastern Michigan, which generated a geographic division that has continually reinforced systems of racial and economic inequality (Boustan 2010; Sugrue 2005a).

In using the structural-constructivist approach (see Chapter 2), it is clear that racial identity within the context of Detroit is something entirely different than it may be in Chicago. Indeed, "blackness" and "whiteness" in Southeast Michigan are "spatial definition[s]," as well as cultural constructions (Sugrue 2005b). In this way, race can be utilized as a description of physical traits, assumed behavioral choices, and also, geographic location. Simply the word

“Detroit” invokes an image of abject poverty and devastation. In many ways, “Detroit” has become synonymous with “black.” I even observed medical professionals describe difficult patients, following up their statements with, *“I work in Detroit,”* as if that admission conspicuously translates the stereotypical imagery of a non-compliant “welfare queen” (Roberts 1997).

Borrowing from Sugrue’s (2005) concept of racial identity in Detroit as spatial, I argue that Medicaid and other federally-funded forms of health insurance have also become entrenched in the description of racial identity within the region. Because of long-standing socio-economic stratification and the subsequent concentration of poverty and black residents within the city limits, the majority of Medicaid recipients in Metro Detroit are black. As a result, Medicaid insurance coverage can serve as a proxy for describing black racial identity, and potentially, used by medical personnel as a more socially acceptable way of invoking particular discriminatory assumptions about their patients. In this way, medical institutions can powerfully shape perceptions of low-income minority patients and reinforce existing dominant structures of oppression among socially marginalized populations, as medical categorizations are often interpreted as representative of objective science. As such, medicine has the potential to bolster this shared imagery of blackness and poverty and, in turn, justify prejudiced discourse of morality, responsibility, and deservingness among low-income, minority patients, a concept that certainly warrants further anthropological examination.

Estranged “Labor”: A Marxist perspective on the American medical institution

As described in Chapter 6, the structure of in-hospital obstetrical care and the resultant depersonalization of pregnancy-related care created doctor-patient interactions that were amenable to the type of discrimination experienced by the women I interviewed. I argued that the structure of obstetrical care—a flow of patients serviced by shift-scheduled obstetricians—resembled an assembly line. At Central Hospital, the large patient volume and amount of obstetrical staff not only homogenizes patient identity, but also creates a significant disconnect between laboring women and their obstetricians, which can significantly alter the dynamics of birth-related decision-making, as was seen in Lisa's pursuit of a VBAC delivery.

Assembly line medicine also generates an important division between the physician, their labor (i.e. delivering babies), and its products (laboring women). Capitalist systems operate on the essential tenet that man's labor and its products are not a part of him; they are inherently alienated—an object outside of himself (Tucker 1978). This "estrangement" results in the product of man's labor belonging to someone other than himself, namely the capitalist (Tucker 1978:78). Given that birth territory is generally in the hospital, the products of labor (healthy mom and healthy baby) must necessarily be the property of the medical institution (Lock and Nguyen 2010). Thus, a social and economic relationship between the birthing mother (product), the physician (laborer), and the hospital institution (capitalist/owner of wealth) can be developed. The result is the alienation of mother from both the obstetrician and the process of labor, itself, a concept which is mirrored in the language often used to describe a hospital birth ("the *doctor* delivered the baby").

As discussed in Chapter 1, the anatomical fragmentation of the medical gaze necessarily objectifies and reifies the body, such that human beings and their parts become commodities (Sharp 2000; Foucault 1994; Taussig 1980). In this analogy, the laboring woman and the delivery of a healthy baby become commodities for the medical institution, and through this relationship, are assigned value as potential sources of wealth. However, it is not the corporeal aspects of woman and child that have value; indeed, the “value of commodities is the very opposite of the coarse materiality of their substance” (Tucker 1978:313). Marx argues that if we consider “the value of commodities [to] ha[ve] a purely social reality…the value can only manifest itself in the social relation of commodity to commodity” (Tucker 1978:313). I argue that this exchange of commodities and resultant social and economic relationship between laboring woman, obstetrician, and hospital institution exists through the use of obstetrical interventions.

Through the utilization of technological intervention, there occurs an exchange of commodities between obstetrician/resident physician and the hospital institution—the former gaining social capital through acquisition of technical skills and the latter acquiring monetary wealth. Although I have established the general propensity within obstetrics to employ interventional medicine during labor and delivery, this type of technical fetishism, meaning the creation of a social relationship from the exchange of commodities, can be particularly pronounced within teaching institutions, like Central Hospital, where there is a number of physicians-in-training who require the mastery of such procedural skills for surgical subspecialties, such as OBGYN (Tucker 1978:321). Thus, it may be possible that this process of objectification and commodification is more prevalent among urban teaching hospitals, which could significantly compromise patient autonomy and, on a broader scale, impact the approach to care of marginalized patients.

Conclusion

In concluding this dissertation, I would like the return to the initial question presented in the beginning of this chapter: why should we care how women deliver? As a form of cultural practice, it is evident that childbirth and how it is interpreted, approached, and accomplished significantly shapes both individual women's lives and societal understandings of health. The birthing stories provided by the women I interviewed for this study demonstrated just how deeply influential their experiences during pregnancy and birth can be on their physical, emotional, and mental well-being. In focusing on childbirth decision-making, this research project was able to examine not only patient autonomy in birth-related choices, but also the impact of sociocultural variables on hierarchical structures within the medical institution. By epistemologically examining medical expertise and the communication of medical knowledge related to pregnancy and birth, this analysis also provided an understanding of the role of social context in the obstetrical approach toward childbirth. Lastly, this research project evaluated the influence of socioeconomic stratification on pregnancy-related care for low-income, minority women in Detroit and argued that authoritative power in biomedicalized birth can be especially pronounced among these marginalized patient populations. In completing this dissertation, I find that the relationship between expectant women, obstetricians, and sociocultural context is even more integrated and complex that I initially understood.

However, there are some alterations in obstetrical care that could strengthen the relationship between expectant mothers and their obstetricians, and potentially, soften the division of power in labor and delivery decision-making. The first would be an integration of preference-based discussions during prenatal care delivery. This is not an altogether foreign concept in obstetrical care, as it already sometimes implemented through tools such as birthing plans, but it may be more effective if the preferences women outline in a birthing plan are discussed with the obstetrician directly. Should this type of practice become standard in prenatal care, the availability of birthing options and exchange of information related to various interventions could be communicated more effectively. Not only would this provide women with the knowledge needed to arrive at such decisions, but it would also supply them with information necessary for decision-making at the time of delivery, should the course of labor change.

It would be unrealistic to suggest a reformation of the American medical institution to address the proposed disconnect between laboring woman and obstetrician that results from assembly line medicine. However, medical education may be an avenue by which clinical approach can be effectively restructured to cultivate a more individualized perception of patient care. Rather than incorporate isolated courses of “social medicine” or “cultural competency” into the medical curriculum, discussions of race/ethnicity, culture, and economic status should be integrated directly into the basic medical science coursework. As a result, medical education could employ a critical examination of social aspects of patients’ lives and promote a more nuanced understanding of individuality, encouraging a personalized clinical approach to patient care. Medical training is an important component in the societal construction of health, especially as it pertains to pregnancy and childbirth. Obstetricians still largely dominate the production of pregnancy knowledge. So perhaps, by attempting to reformulate the approach to and understanding of individual patients during medical education, we, as anthropologists, can restructure the future production of pregnancy knowledge and challenge the existing hierarchies of decision-making, such that conceptions of risk, racial identity and class status, are understood as they truly are—fluid and socially variable, rather than objectively immutable.

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