Managing Labor and Delivery among Impoverished Populations in Mexico: Cervical Examinations as Bureaucratic Practice

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ABSTRACT Birthing experiences for low-income and marginalized women have frequently been framed within explanatory models of authoritative knowledge and power dynamics. Many of these explanatory models have pointed out the structural violence inherent in the biomedical model of birth. The research on which this article is based suggests that clinicians' stressful work environment and class-based stereotypes of low-income women resulted in the routinizing of inhumane medical practices. Hospital overcrowding due to health reforms led to clinicians being primarily concerned with moving patients swiftly through the system. Clinicians increasingly relied on the cervical examination as a marker for labor's progress and a shorthand method to track cervical dilation. Using ethnographic data collected in the obstetrics ward of a public hospital in Mexico, in this article I explore the emergence of a bureaucratic routinizing of obstetricians' everyday practice. I provide a new understanding of the encoding and entrenching of everyday medical practices and their effect on the reproductive rights of women. [*bureaucracy, reproduction, women's health, patient-physician relationship, Mexico*]

RESUMEN El parto de mujeres marginadas y de bajo ingreso generalmente se explica por medio de modelos de conocimiento autorizado y por las dinámicas de poder. Muchos de estos modelos explicativos han hecho hincapié en la violencia estructural intrínseco dentro del modelo biomédico de parto. La investigación en la que está basada este artículo sugiere que el estrés del ambiente laboral de los portadores de salud al igual que los estereotipos sobre mujeres de bajo ingreso resultan en la rutina de prácticas médicas inhumanas. La saturación del hospital por cambios en la ley de salud significa que la preocupación de los médicos está enfocada en mover las pacientes rápidamente por el sistema. Los portadores de salud dependen cada vez más sobre el examen vaginal para medir el desarrollo del trabajo de parto. Basado en datos etnográficos recolectados en la sala de tococirugía en un hospital público de México, en este artículo se explora el surgimiento de una forma de burocracia alrededor de las prácticas diarias de los obstetras. Este análisis provee una nueva manera de entender la codificación e incorporación de las prácticas médicas diarias y el efecto que tienen sobre los derechos reproductivos de la mujer. [*burocracia, reproducción, salud femenina, relación médico-paciente, México*]

It was a stifling June morning in 2011 in the *tococirugía* (labor and delivery) ward of a public hospital in Mexico. As patients labored in small cubicles, clinicians made their rounds, checking the women's dilation to measure their labor's progress. As Doctor Reyes, an obstetrician, attended to one woman, he checked her cervical dilation with one hand, leaning over her and rubbing her abdomen with the other hand.[1] Beside him stood a nurse

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and an intern, observing. Tears streamed down the face of the laboring woman, Victoria, as she writhed in pain on the gurney. Seemingly ignoring her tears, Reyes urged her, "Push, push, as if you were pooping. Come on, *gorda*. Push down here, not up there!"[2] An intern, also apparently disregarding Victoria's suffering, focused on filling out Victoria's medical record and asking her questions about her age, date of birth, home address, and whether she had diabetes or hypertension. Momentarily taking his hand out of Victoria's cervix, Reyes pumped the pedal on the gurney to incline it so her feet were lower than her head. Turning to the rest of the room, he said with roguish arrogance, "This is the Reyes Technique. Gynecologists don't do this." With Victoria's next contraction, he asked her, "You have pain? Here it comes, push!" and immediately reinserted his whole hand into her vagina beyond his wrist, straining simultaneously as she did. Victoria whimpered and then screamed. Two contractions later, Reyes pulled out his hand, righted the gurney, patted her still-pregnant abdomen absently, and walked off to prepare for Victoria's delivery. Victoria lay back on the gurney, her face wet with tears, and gasped with large sobs.

What this physician called "the Reyes Technique" is a method for manually dilating the cervix to speed up delivery.[3] In Reyes's words, "I put [women] in a more vertical position, give them Pitocin [a hormone to speed up labor through stronger, but more painful, contractions], have them raise their leg and push against my chest, and then I manually open up the cervix . . . Sure, the neck [of the cervix] can tear. But I check it later and suture it." He claimed that with this technique, babies would come out in ten minutes after the onset of active labor, and the need for a cesarean was averted. He added, "Even if some people call me a butcher, this [technique] is better for several reasons. The hospital is so crowded that we need to move patients along faster; it is better to have ten minutes of pain than two to three hours of slow contractions. And if the baby takes too long and [women] are allowed to labor naturally, then the baby can asphyxiate." Despite this rationalization, for the women laboring in the ward, techniques such as Reyes's were simply one more way in which their bodies were, in the words of one midwife, treated like a "font of holy water"—a continually touched body available to any clinician passing by.

This vignette exemplifies the interactions between the clinicians and their low-income female patients that I observed during my fieldwork at this hospital. Although the cervical dilation engaged in by Reyes is an extreme example, the use of cervical examinations during labor to determine a patient's dilation and readiness to give birth is considered both standard and necessary in modern biomedical care. Health institutions such as the World Health Organization suggest that cervical examinations should be limited to those that are strictly necessary, with once every four hours being sufficient to obtain important information to aid clinicians' decision-making (Downe et al. 2012), and should ideally be done by the same provider (Hassan et al. 2012). Scholars have shown, however, that many hospitals carry out examinations more frequently than necessary (Shaban et al. 2011), causing increased pain to the laboring women (Bergstrom et al. 1992).

In this Mexican hospital, the practice is for cervical examinations to be done at least every half hour. The examinations experienced by these women were not only frequent but agonizing and dehumanizing. As such, their experience reflects the conclusions of previous scholars who have framed the birthing experiences of low-income and marginalized women within the explanatory models of authoritative knowledge and power dynamics. Authoritative knowledge, as defined by Brigitte Jordan (1997), is knowledge that "counts" and has weight in decision-making about health and the body, even in the presence of (and often in opposition to) other knowledge systems. Among the scholars who have examined this topic, several have pointed out the structural violence that inheres in the biomedical model of birth (Davis-Floyd 2004; d'Oliveira et al. 2002), while others have examined the physical violence exerted upon women's bodies—sometimes referred to as the "surgicalization" (institutionalization of surgery within reproductive care) of women's bodies (Diniz and d'Oliveira 1998:S37; see also Castro and Erviti 2003). According to Laurence Kirmayer (2004), such violence is inherent in the functioning of impersonal systems that are applied to a class of people without regard to their particulars.

What causes clinicians in this hospital to engage in unnecessary and painful practices for birthing women? In this article, I answer this question by showing how the intersection of clinicians' stressful work environment and class-based stereotypes of low-income women results in the routinizing of inhumane medical practices. Hospital overcrowding due to health reforms means that clinicians have to move women swiftly through the system. Furthering the arguments of anthropologists of reproduction such as Emily Martin (2001) and Robbie Davis-Floyd (2004), I suggest that the bureaucracy of birth runs deeper than just the emphasis on efficiency and technology; it also manifests in micropractices of clinicians that become so routinized that they ultimately have little medical use. Clinicians have increasingly relied on the cervical examination as a marker for labor's progress—as an expedient and efficient way to track a woman's cervical dilation. But in the drive for expediency and efficiency, in Mexico this clinical practice has become callous and detached. Several scholars (Castro 2004; Castro and Erviti 2003) have noted numerous problems in the delivery of reproductive health care in Mexican hospitals, ranging from humiliation to coercion to various forms of abuse. My work helps to explain some of these problematic medical practices and to contextualize, though not excuse, the behavior of clinicians. I specifically examine how clinicians' medical practices in this public hospital in Mexico have become dangerously and almost mindlessly routinized. As I demonstrate, the dispassionate and often painful care received by women such as Victoria is an expedient behavior

for clinicians in situations where overwork, lack of sleep, and a pronounced hierarchy mark their every interaction, resulting in what John Furler and Victoria Palmer call the "bureaucratic inhumane form of medical care" (2010:5). Here I extend Furler and Palmer's concept of bureaucratic care by applying it not to large-scale bureaucracies (such as the ministry of health) but instead to the microscale routinizing and standardization of daily medical practices by the clinicians themselves.

This study offers an excellent example of how the biomedical management of labor, which places an emphasis on numbers, technology, and the progress and speed of labor and delivery, has had a negative effect on the birth experiences of women, as noted by previous scholars such as Martin (2001) and Davis-Floyd (2004). Hospital Público, like all bureaucracies, is marked by a strict hierarchy and chain of command, paperwork, expert training, and stable rules that determine advancement through the system (Foster 1976:15; Weber 1968). Additionally, because the hospital's emphasis is on labor and birth, it is organized as an industrial production line of childbearing in which efficiency and productivity are paramount and achieved through the technologization of the female body. The actions of the clinicians in this hospital demonstrate what Josiah Heyman refers to as bureaucratic thought work, which organizes thoughts and actions in order to control the "slippery, sometimes-resistant, recipients of organizational orders" (1995:261). Though the practices of clinicians described in this article might seem horrifying to most observers, they can also be seen as an example of medical bureaucratic thought work, in which a division of labor routinizes people's actions (Heyman 1995:263). Not only are women's births subjected to this bureaucratic thinking, but the practices of physicians themselves are equally subjected to and constrained by bureaucratic models in which birthing must be expedited as quickly as possible. As Colin Hoag has observed (2011), bureaucracy is comparable to science in its ability to dominate and control bodies, and medical bureaucracy thus represents a marriage of two systems aimed at the control and management of people's bodies and decisions over their lives. This claim is supported by the work of several medical anthropologists who have explored the overruling of women's bodily knowledge by biomedical hierarchies and its effect on women's choices. Their work has analyzed how women's bodies have been the sites of extensive and extended biopolitical contestations (Ellison 2003:338), particularly the role of the state in categorizing mothers (Chen 2011; Howes-Mischel 2012; Smith-Oka 2012) based on their perceived degree of "goodness" or "chasteness" (Haney 2012) and the use of technology to determine the "responsibility" of pregnant women toward larger precepts of the state (Fordyce 2012).

Drawing on a trio of voices—those of clinicians, patients, and midwives—I explore in this article the ways that clinicians' work stress and assumptions about low-income women's compliance in labor made the cervical examination the ultimate bureaucratic index for managing birth. I reveal the different ways in which multiple cervical examinations are seen by each group: as a useful indicator and tool by clinicians; as fearful, painful, and humiliating by the laboring women; and as unnecessary and inhumane by midwives. Ultimately, I analyze the conversion of everyday medical practices into expedient but often demeaning and even inhumane medical practices within a Mexican obstetrics ward.

The ethnographic research on which this article is based was carried out for three months over the course of two field seasons in 2008 and in 2011, and it consists of qualitative and quantitative data on the prenatal to postpartum experiences of female patients at a Mexican hospital I here refer to as Hospital Público.[4] During my time there, I interacted through interviews or observations with 71 patients, 30 physicians (interns, residents, and full-time), and nine nurses. I also interviewed 12 local nurse-midwives and traditional birth attendants who observed the birthing process at the hospital. While none of the midwives worked at the hospital (per hospital rules), in 2011 they were enrolled in a professionalization course offered by the hospital and had been allowed to observe births in the ward. The majority of the female patients I interviewed ranged from 36 weeks pregnant to early postpartum; a large proportion (70%) of these patients were first-time mothers. All the interviews were done in Spanish, and I recorded data into field notes and audio. The semistructured interviews with these women revolved around their birth expectations and experiences, the quality of the care they received, their reasons for coming to the hospital, and their infant-care and family-planning practices. The semistructured interviews I conducted with clinicians addressed their medical practices and philosophies, definitions of *compliance and risk*, birth-management procedures, and use of medical space. Semistructured interviews with midwives took place during the professionalization course, in the hospital corridors, and in their homes. A significant part of the research was my participant-observation of physician–patient interaction in all three wards.

I observed and was involved in all stages of the women's postconception reproduction—from prenatal care through labor and birth to postpartum and recovery. Through deep immersion, I very carefully trod a line between the role expected of me by the hospital director and physicians (which one of the physicians tellingly, if inaccurately, described as that of an outside anthropologist doing research on "why these women have so many children"[5]) and the role for which I most strived (that of the insider ethnographer who could establish good rapport with the women during very vulnerable moments in their lives). The intimacy of the situation often allowed the women to overcome barriers or inhibitions and permit me to participate in their labor. I was able to support 18 women during their labor and birth, functioning as a doula by helping them with contractions, rubbing their backs, guiding their breathing, and holding their hands. At their insistence, I stayed with them throughout the labor and birth of their children and was able to witness firsthand the

troubling nature of the interactions between them and the clinicians.

TREATING THE UNINSURED: HOSPITAL PÚBLICO

Puebla is a large, bustling city in central Mexico known for its many churches (locals like to brag that there is a church for each day of the year), its educational institutions, and the conservatism and piety of its inhabitants. As in the rest of the country, however, an immense disparity exists between the wealthy–upwardly mobile and the urban–semiurban underclasses. Indeed, the state of Puebla in which the city is located has some of the poorest and most marginalized populations in the nation, many of whom are indigenous and live in remote hamlets high up in the sierras. Large numbers migrate to the city, searching for work and a new life, become part of the urban poor, and rarely have access to educational, financial, or health security.

The Mexican health-care system's coverage of its population has historically been fragmented (Knaul et al. 2005). The current three-tiered system consists of (1) people covered by private health insurance, (2) workers who are covered by government-provided social security health services,[6] and (3) the uninsured, who fall outside of the formal labor sectors and thus lack opportunities to acquire healthcare coverage. In response to this hierarchical access to health care, the country reformed its General Health Law in 2003 to create a new system named Seguro Popular (People's Health Insurance) to guarantee that these marginalized populations receive financial support for health care. Its objective has been to reduce the number of families who become impoverished by health-related expenses (Sosa-Rubí et al. 2011). Oportunidades is another nationwide program that gives conditional cash transfers to impoverished women in exchange for their and their children's participation in health, nutritional, and educational advancement opportunities (Smith-Oka 2013). All government-run clinics and hospitals across the country accept Seguro Popular and manage Oportunidades, including Hospital Público. Because of these policies, many more people now have access to biomedical health care.

Hospital Público is a large hospital serving very low-income populations. As one director said, "Everything here regarding the care of the mother and child is free—the birth, the cesarean, all is free" (field notes, June 10, 2011). The maternity ward—which is divided into three sections: prenatal, labor and delivery, and recovery—has 215 beds and attends more than 8,500 births a year. Approximately 25 percent of these births are by adolescents. One director described, in well-rehearsed and precise words, the hospital's important mission:

> This hospital is born from a deep need. The state of Puebla has six million inhabitants and has three million within the social security system. The rest have no social security. And this hospital was built for this type of patient. Here we receive [patients] from all over the state. Obstetric, gynecological, oncological pathology, and all pathology related to the woman-mother, associated with pregnancy . . . [This] is the *only* hospital designed to attend to highly complex problems. [field notes, June 23, 2011]

The tococirugía ward is an example of a technocratic model of birth that is highly medicalized and technology driven. As Davis-Floyd (1993) points out, the emphasis is on producing the perfect baby, and this is achieved by separating mother from baby through the use of technology and medical authority. During early labor, female patients robed in scruffy hospital gowns wait in a room lined with hard plastic chairs. Most of them sit or pace nervously, enduring contractions and rarely making any small talk with other laboring women around them. The attending physician calls each of them into the examining room, where they receive a cervical examination and ultrasound, and determines whether the patient should move to the next stage or be sent home to wait until labor is more advanced. A woman who is dilated more than five centimeters is placed on a gurney, wheeled a few meters to the plexiglass divider marking the tococirugía ward, and then asked to painstakingly slide over the divider onto a waiting gurney in that ward. The women's gurneys are never rolled through the adjacent door—gurneys and wheelchairs are kept in their respective wards, rarely crossing over, making the laboring women's experience even more uncomfortable for the benefit of the healthcare workers and the hospital's inventory system.

Once in tococirugía, the laboring woman is placed in one of seven labor cubicles. These plexiglass-walled cubicles run side by side along one wall of the ward, their open side facing the nurses and physicians' station. Lying on gurneys, the female patients are attached to an intravenous drip of fluids and Pitocin, a drug used to speed their labor, and are checked periodically by any of the physicians or nurses working that day until they dilate to ten centimeters.[7] At that point, they are wheeled to one of the four surgery and delivery rooms, where the delivery takes place. In clipped tones, Nurse Escobar stated that the typical birth consists of the following:

> Genital antisepsis, catheters, and gynecological position [horizontal and legs in stirrups]. Once they've done the antisepsis, they place the surgical drapes, wait for the baby to come out, clamp the umbilical cord, and they pass it to the pediatricians. They check the baby. [Then] they wait for the afterbirth; they carry out a check of the uterine cavity and to see if it contracts well. If there was an episiotomy, then they fix it and they give her Pitocin.[8] [field notes, July 11, 2011]

Another nurse, Nurse Franco, observed that the patients all experience "a painful birth, without analgesic; it is a natural birth. All the births are that way, without analgesia. [An episiotomy] is frequently [done] to avoid tearing."[9] The nurse's use of the term *natural* simply refers to the lack of pain relief, as there is nothing natural about the use of Pitocin or the constant cervical examinations.

Because the entire maternity unit is generally filled to capacity, there are many more patients than recovery beds. More than one physician complained that they "are unable to keep up" with the number of patients, many of them blaming

the situation on the healthcare reform that allowed previously marginalized populations access to health facilities. The space constraints become clearly evident with the constant flow of patients in labor, birthing, and recovery. Because of this lack of space, many mothers who have recently given birth are moved from the recovery area to gurneys along the passageways in the emergency ward. Given the high number of patients, the clinicians make every effort to move the women through their birth process as rapidly as possible, a situation that leads to exceedingly high stress levels for both clinicians and patients.

UNABLE TO KEEP UP: THE CLINICIANS' PERSPECTIVE

In our interviews, many of the nurses and physicians working at Hospital Público reported having begun medical school with dreams of helping people and of working at a noble profession serving others. Some had wanted to work for the poorest populations, intending to help them overcome health-related difficulties in their lives. Working at Hospital Público was for many exhilarating at first—encountering unusual medical cases, delivering babies for the first time as interns, making decisions over women's reproduction. But most reported finding it hard to maintain that excitement. The number of patients seems never ending, the paperwork mind numbing, the resident rotations of 32-hour shifts debilitating. Occasionally, scattered among the many patients lining the passages, one could find residents sleeping on empty gurneys, trying to catch a few minutes of sleep between procedures.

But whatever their original intentions and however hard they worked, clinicians could not overcome the daunting structural reality that the hospital is at 140 percent capacity every day.[10] As one director stated, this "exceeds all the norms that state that hospitals must be at 80% capacity. Since its inauguration . . . the hospital has had an exponential increase that has almost overcome us" (field notes, June 23, 2011). As a result, harried physicians and nurses go to each patient, asking quick questions before moving onto the next one, and thus can never keep up with the patients. Many of them felt they accommodated the demands of the public system with little reward. Doctor Reyes complained, as he stretched his hands overhead and shook out his tired fingers, "One should attend to each [prenatal] patient for 15 minutes. There should be about 14 patients per shift, but we attend to over 40 per shift. The quality of care is much lower" than it should be.[11] Reyes's observation regarding the lack of optimal care was common among the physicians at the hospital; the majority of those with whom I spoke admitted that their overwork and stress was affecting their ability to care for their patients as they should. Although the nurses at Hospital Público tended to be more sympathetic to the patients than were the physicians, they also felt hampered by the Mexican healthcare system in which their role was simply to support the medical staff. One senior nurse complained wistfully, "Our role is to help the physicians. . . . But medical things are very backward [in Mexico]; we don't yet have regulations like in the USA. There [nurses] do participate. . . . We could practically have an office, be able to attend births" (field notes, July 20, 2011).

Perhaps as a defense mechanism against their own powerlessness to provide the quality of care they knew was possible, the clinicians tended to be dismissive of their patients; in my conversations with them, none expressed empathy for their fears or pain, nor did any express a sense of personal responsibility or failure for the quality and impersonality of the care they provided.[12] Instead, many seemed to blame the patients themselves for the overcrowding that drove their practice. This was epitomized by one female senior resident who, while attending to a young, very pregnant woman in the prenatal ward, commented sneeringly to the attending female physician, "Look at her, doctor! Three gestations: two cesareans and one miscarriage, and she comes *here* with labor pains!" The evident disdain for the decision-making abilities of the patients is reminiscent of that uncovered by Khiara Bridges (2007) in a public hospital in New York.

The clinicians considered the patients homogenously problematic because of their poverty and lack of education. Doctora Acosta, one of the physicians, described the typical patient as

> multiparous, with poor hygiene, [and] probably only having received one prenatal visit. Sometimes there are many older ones, with low socioeconomic status, from rural communities. Those are the typical ones. They have infections, use no family planning, have little hygiene. There is a lot of promiscuity in the little villages. They have vaginal and urinary tract infections. [field notes, June 28, 2011]

One of the nurses added bluntly that most patients

> won't have had any prenatal care, no [medical] consultation; some might not even have known they were pregnant. They come from distant communities, they have no prenatal care, and they have never taken care of themselves. They come with hypertension, [with] diabetes, with *producto obitado* (deceased fetus). [field notes, July 11, 2011][13]

The generalized perception of the physicians was that the patients' lack of hygiene, poor prenatal care, and backgrounds often made it even more difficult for them to manage the risks and maintain the health of mother and child, further adding to their stress.

Much of this workload fell on the shoulders of the first- and second-year residents. The hospital hierarchy was such that interns and early residents were assigned the "grunt work" of tococirugía, third- and fourth-year residents managed more complex cases and surgeries, and *médicos adscritos* (full-time physicians) managed the ward and any difficult cases. It was clear from my observations that the work ethic of the particular *adscrito* (full physician) on duty determined the atmosphere in which the rest of the team worked. Doctors Acosta and Reyes, for instance, worked hard at managing patients during labor as well as delivery; everyone on their teams worked just as hard, and there was a general air of cooperation among the clinicians. Doctor Junco,

however, spent most of his time joking and sitting at the nurse's station with senior residents while junior residents hurriedly cared for patients. One morning, as Junco "held court" cracking bawdy jokes, Doctora Arce, a first-year resident, rushed from one laboring woman to another, dragging along a heavy typewriter to take down each patient's medical history. Glasses slipping down her nose and sweat glistening on her forehead, she would briefly sit down and check on each woman's labor before rushing to the next one. Doctora Aguirre, also a resident in her first year, hovered at the sink behind the nurse's station to take a five-minute break to quickly gulp down a soggy sandwich and a bottle of Coke, and then immediately returned to her rounds, stripping off her gloves impatiently between patients and doing her best not to fall asleep. For the harried residents, paring down everyday medical practices into a quick routine allowed them to attend to patients in a much more efficient manner.

"I AM VERY AFRAID": THE PATIENTS' EXPERIENCES

Few of the women I interviewed who gave birth at Hospital Público spoke about their experience positively. While they were joyful at having a healthy child, most of them described having felt fear, pain, discomfort, and humiliation while at the hospital. The women gave voice to their unsatisfying birth experiences with expressions such as "[they] treated us like chickens. . . . All of us the same"; "the only thing I liked about the hospital is that they treat the babies well. [They] don't [treat] women well"; and "the doctors . . . are despots; they do what they want" (conversations with author, July 7, 2011).

Most women also described the constant scolding they received. Gaby, who spoke with ill-disguised contempt for the poor treatment she received, described how, while she was waiting in early labor and several of the other women were groaning or screaming in pain, "A female doctor came out and told us, 'Now you scream in pain, but nine months ago you were screaming in pleasure.' Well, what does she care? A baby should be made with love, not pain or violation."[14]

Much of the scolding delivered by the clinicians seemed based on a combination of perceptions of noncompliance, notions of increased risk, or the effects of their workload on clinicians' patience. An example is the experience of Rosita, for whom the birthing process was terrifying. As I walked into tococirugía on the day she was giving birth, I was struck by the pure anguish of her face, reminiscent of Edvard Munch's "The Scream." Tears were streaming down her face as she sat rocking back and forth on her gurney, clutching the railings with each contraction. A bloodstained diaper lay crumpled beneath her. Her dark hair was loose and hanging across her face, and an eyelash clung to her right cheek. As I rubbed her back and helped her to breathe, Catia, an intern, came up to do a cervical examination. Rosita begged to be allowed to finish the contraction, saying, "Please, wait, wait for me a bit." Ignoring her request, the intern instructed her to lie down, checked her, pronounced her at nine centimeters dilated and walked away. With her eyes tightly closed, Rosita experienced a few more contractions, occasionally crying out, which led to a nurse walking up to her gurney and warning that if she kept crying, "You will get a cervical examination." Soon, Doctor Herrera (a third-year resident), Catia, and a nurse came up to the gurney. Herrera was dressed in camouflage-print scrubs, an Om tattoo visible on his inner right wrist. Rosita was in the middle of a contraction and asked them to wait. They did so begrudgingly but requested she lie down. As soon as the contraction was over, Herrera put on gloves and inserted his hand abruptly into Rosita's vagina, causing her to scream out, "Ow, doctor! Stop hurting me!" He curtly told her to stop crying, and when she continued to whimper, "You are hurting me!" his reply was a harsh "And . . . ?" He then slipped off his glove, said she was still at nine centimeters, and walked off. Rosita's birth was ultimately attended by Doctora Arce, who, only minutes after Rosita's painful encounter with Herrera, performed a variant of the Reyes Technique to dilate Rosita's cervix the final one centimeter.

What we see in Rosita's birth experience is what Marcia Ellison describes as "deeply ingrained cultural assumptions about the categories of women who can legitimately lay claim to their sexuality, fertility, and maternity" (Ellison 2003:336). The axes of class and gender had already placed Rosita in a position of little choice in which she had to be obedient and compliant to survive in this medical setting (Smith-Oka 2012). Although she had no control over her laboring body, she was expected to find a way to control it or the physicians would do it for her, expediting Rosita's labor with multiple cervical examinations and manual dilation. Her labor was therefore an example of how reliance on these bureaucratic and impersonal thought works (Heyman 1995) allowed clinicians to gain some control over the slippery nature of labor because, from the physicians' perspective, one resistant patient can back up the assembly line and raise everyone's stress levels.

During the labor of another woman, Magdalena, the cervical examination seemed almost a byproduct of clinician distraction. The day Magdalena was in labor coincided with a training visit by physicians from various small clinics around Puebla. As Magdalena's strong contractions contorted her petite body, she was surrounded by one of the visiting physicians and Doctor Figueroa (that day's chief of medicine), Doctora Aguirre, and two nurses. Most of them stood around her gurney discussing the day's events; only the visiting physician would occasionally lean over Magdalena and gently encourage her to breathe. Magdalena would take a few gasping breaths, closing her eyes between the contractions. After some time had passed, Doctor Herrera joined the group, and the conversation between him and Aguirre turned to their rotation schedules and how tired they were, about which they laughed. Herrera absentmindedly pulled on a glove and examined Magdalena's dilation, dispassionately instructing her, "Push! Push!" then turned to Aguirre

and continued his interrupted conversation without turning to the patient's chart to note his observation.

What I found particularly striking about most cervical examinations at this hospital was not only that were they done by a different clinician each time but that the information obtained was only intermittently written on the patient's chart or shared with other clinicians. This meant that patients received more examinations than necessary, as there was little record of what they had already received. Indeed, most examinations were aimed at detecting when patients reached full dilation rather than the progression through dilation. Thus, until full dilation, patients might be examined multiple times. So although cervical examinations should provide important information about the labor's progress, in this case they seemed to have become a mere exercise, often seeming designed only to show the woman that she was being cared for or controlled during her labor (Bergstrom et al. 1992), as when the nurse warned Rosita each time she cried out that she would be examined. Such a lack of recordkeeping might on the surface seem to be a very unbureaucratic practice, as most bureaucracies stress the importance of documents and records. I argue, however, that it is the (almost mindless) routinizing of the cervical examination, even when the information gathered is not recorded, that becomes a bureaucratic practice. In most cases, the multiplicity of examinations seemed to be aimed at showing the patients who was in control of the birth rather than at determining their movement through labor.

Clinicians often rely on technology to bolster their authoritative knowledge and exert control over the management of pregnant women; as Eugenia Georges notes, technology "provides a context for performing and reinforcing medical authority and, in doing so helps consolidate a growing . . . medical hegemony over women's reproductive experiences" (1996:170). Although cervical examinations are very low technology, at Hospital Público they remain something that only physicians can do. Indeed, in my first field season, one of the residents confused me for an intern and invited me to examine a laboring woman he had just examined so that I could gain experience. In a cervical examination, the physician's hand becomes the technology and instrument. In this hospital, where the labor is organized as an assembly line, the technopractice of the cervical examination is used not to assess the progress of labor but the woman's failure and shortcomings regarding the rate dictated by the hierarchical medical setting.[15] Thus, whether strategically or inadvertently, the multiplicity of cervical examinations is an effective means of managing women's bodies.

This practice persisted despite the clinicians' apparent awareness that, as mentioned earlier, studies show that minimal intervention is the favored paradigm for a normal birth and that interventions should be employed only for valid medical reasons (Downe et al. 2012). At the hospital professionalization session attended by midwives and traditional birth attendants, for instance, the physician running the session informed them that among the primary risk factors for various obstetric morbidities, including fever and infection, were a high number of cervical examinations and episiotomies. She subsequently acknowledged, with no irony or apology, that the patients at Hospital Público received many more cervical examinations than the books recommended. Although all of the hospital physicians engaged in the practice of administering a high number of cervical examinations, they did not seem to regard the number of cervical examinations as a problem or worry about the potential to increase infection because, as one physician stated, the women frequently had vaginal or urinary infections on arrival anyway. Thus, concerns about infections and doing no harm were overcome by the need to move patients through the birthing process as quickly as possible.

The female patients I observed and spoke with lived through their birth experiences with much pain and fear. Victoria, who experienced the Reyes Technique, whispered to me in anguish, "That doctor hurts me a lot. I am very afraid." The women viscerally felt that they had been stripped of dignity, although they acknowledged that their treatment at the hospital was just illustrative of the ways in which poor people are generally treated in their country. As Roberto Castro and Joaquina Erviti (2003) have shown, a pattern of disdain and humiliation exists in many public hospitals across Mexico, where female patients' opinions and suffering are frequently discredited and ignored. The patients in my study knew that this hospital was a "place for the poor" and that they would not get the sort of treatment they would at a private institution.

"PHYSICIANS PRACTICE ON WOMEN'S VAGINAS": THE MIDWIVES' PERSPECTIVE

Midwives in Mexico primarily practice as traditional birth attendants or urban midwives; their clients tend to be from low-income or indigenous backgrounds. In the 1970s, Mexico restructured the requirements for traditional birth attendants to bring them more in line with the biomedical model of care through certification programs, but their practice was limited to the household level, not at that of clinics and hospitals. Much of the medical attitude in the hospital toward midwives was negative, as evidenced by one physician's words: "We have bad experiences with midwives. Their [patients] are the ones who arrive only to die" (field notes, June 10, 2011). Several midwives resented this attitude. One midwife complained, "In Brazil, Salvador, Guatemala, the midwives are in the hospital from the beginning. But not here. The midwife is kept down. They don't allow us to work [in the hospitals]. They said that with [this governor's] government they would allow us into a ward to work [but] . . . " (field notes, July 12, 2011).

Although hospital policy did not allow them entry into the facility as practitioners, midwives and birth attendants were often invited to participate in professionalization courses at Hospital Público to provide them with up-to-date biomedical knowledge and practices. In 2011, those who attended the course were allowed, for the first time, to enter

into tococirugía but only as observers. The nurse in charge of the course told them they were being allowed to enter into that medical space so as to "see how they do cesarean[s] and how they take out the baby"—on the condition that they "keep [their mouths] shut, don't lend a hand, do nothing" (field notes, July 12, 2011). Their role was to be seen and not heard: "We will look much nicer if we are quiet. . . . Nice [and] quiet" (field notes, July 12, 2011).

In my interviews with them, the midwives told me they found the treatment of the patients that they had observed very problematic. Basing their judgments on their own authoritative knowledge about birth, all of them described the hospital birth as *inhumano*—inhumane. They were particularly struck by the number of times patients received cervical examinations; the midwife Almudena, who, when she heard from one of the physicians that patients routinely received more than five examinations in one hour, was the one who had mordantly commented that the female patients were "like a font of holy water" (field notes, July 12, 2011). Emilia agreed, stating, "They do [cervical] examinations without lubricating the glove. And they don't tell them, 'Listen, I'm going to do a cervical examination, I'm going to see how your baby is doing, I'm going to see how you are doing.' No! As if they were animals. Pow! They check them" (audio recording, July 28, 2011).

All the midwives described their horror and revulsion at the treatment of the patients and shared various troubling situations they had witnessed. As Almudena told me, "So you come out with your heart in a knot. . . . Poor women! How they are treated! And all because it is free" (audio recording, July 27, 2011). Emilia was particularly vocal about what she had seen. She had been working as a nurse-midwife at a private clinic for more than 23 years and had attended thousands of births. As she rushed around her small apartment, making food and coffee for us, she told me, "Yesterday I saw a horrible experience, but I remained quiet, quiet. I wanted to run out of there. A 17-year-old girl could not stand the labor pains; she had a lot of pain, a lot of pain, really a lot of pain. So, the [clinicians] go over and check her [cervix]." Taking a deep breath, she continued,

> The girl would . . . cross her legs; she did not let them examine her. There was no kind word. . . . No, what they did to her was shout, and shout, and shout, and shout. Ay, the girl lost her bowels. Her hands and back were smeared, because she could not handle the pain. And I asked myself why they did not give her some anesthesia so the girl could feel less [pain]; they could talk to her and calm her, because the baby could die inside. And I said [to myself], "No, better stay silent because if not. . . . " So I was very hurt for that girl.

Pausing a moment, Emilia then said heatedly,

> Afterwards the baby was born . . . but they scolded her, they told her . . . that they would tie her, that it was a public [hospital], and that if it had been a private place they would charge her twenty thousand pesos.[16] They humiliated her, telling her that she was poor and that was why she was there. That it was a place of charity and that she had to . . . endure everything they did to her. [audio recording, July 27, 2011]

I was curious about Emilia's use of the phrase "tie her" (in Spanish, *amarrar*)—considering the context in which it was used, I assumed it meant a tubal ligation rather than the more vernacular use to refer to a physical binding.[17]

> **Vania:** = "And they told her they would tie her?"
> **Emilia:** = "Uh huh. 'We will tie you because you are getting very impertinent. We will tell your husband to authorize us to tie you.'"
> **V:** = "So tie [her] so she has no more children?"
> **E:** = "No, to tie up so that she would not move! Very ugly." [audio recording, July 27, 2011]

Celina, who worked as a doula and childbirth coach among the wealthy populations of Puebla, prided herself on her expertise in natural childbirth and enrolled in the professionalization course to potentially become a midwife. Her understanding of natural childbirth differed significantly from that of the nurse I quoted earlier. Speaking assertively, out of her own authoritative knowledge, she said,

> I'd heard of tococirugía before. I find tococirugía to be terrible, very inhumane. . . . Yes, ultimately the women get through it, but I find that a terrible way of having children, no? They give then Pitocin and they have them with contractions every minute, every minute. . . . It is too strong a labor. And it's not necessary to have children so fast, right? . . . And the [clinicians] put their fingers [into the women] and it could be that in ten minutes three different doctors put in their fingers. It's terrible. Everyone wants to know how she is doing, and so they practice on the women's vaginas. . . . It's hard, but that is the Mexican health system . . . What we need is for [clinicians] to stop *toqueteando* (constantly touching) the women. [audio recording, July 27, 2011]

Clinicians constantly examining patients without recording the important information served to pointlessly perpetuate the bureaucracy. Celina's comment captures not only how cervical examinations were being used as an expedient measure of labor but also how this medical bureaucratic practice had taken on a life of its own, because speed, not the women's well-being, was the operative goal.

IMPRESSING BUREAUCRACY UPON WOMEN'S BODIES

Although the clinicians' use of multiple cervical examinations has become normative in Hospital Público, it was not motivated by conscious cruelty. The clinicians I interviewed and observed did express concern for their patients in the abstract, encouraging them to engage in family planning or to live more healthily. But once the particulars of each patient began to manifest themselves—i.e., the patient was adolescent, had not brought the appropriate paperwork, or did not follow the rules—then the clinicians responded with exasperation and callousness. Their ultimate goal was not to exert emotional, physical, or verbal violence upon the patients but, rather, they claimed, to have a healthy baby and what I refer to as an "unmorbid" mother. I use the term *unmorbid* rather than *healthy* because, in this setting, at the end of the process the patients were relatively free of illness or disease, though, as a result of being rushed through labor

and recovery, not fully healthy. After all, as Doctor Reyes stated, after employing his technique, women's cervixes were often torn and needed suturing.

Patient morbidity has been affected by the increase in the number of patients at Hospital Público.[18] This increase has not been accompanied by a proportional increase in hospital and clinical infrastructure, and it has therefore further stretched an already overtaxed system. Such a situation places the clinicians in a quandary: most try to do the best they can under the circumstances, but the increasing flow of patients is not reflected in their wages, work schedules, and timetables, a situation also observed by Deborah Boehm (2005) among physicians in the United States who struggled to keep up with their increased patient and bureaucratic overload. Indeed, in mid-2012, personnel at Hospital Público staged several protests regarding their low wages and the lack of compensation for the long hours they worked.

The physicians' response to the chaos has been to turn to the structures provided by bureaucracy. To maintain order and manage the large number of patients, the clinicians in this hospital have standardized patient care routines as much as possible, using cervical examinations as the main source of information on cervical dilation and women's labor. Although cervical examinations are a necessary part of managing women's labor, as Sahar Hassan and colleagues (2012) point out, their repetition at short intervals is useless. Nonetheless, evidence cited by Hassan and colleagues (2012) and Insaf Shaban and colleagues (2011) indicates that an overuse of the cervical examination is common across the world and that there is a significant association between the high frequency of examinations and the multiplicity of providers and between first-time mothers and the number of examinations. Research has also found the failure to record the gathered data on patient charts to be common (Davis-Floyd et al. 2010). Evidence also suggests that use of Pitocin can actually reduce the rate of dilation until almost full dilation (Downe et al. 2012), making the clinicians' overreliance on these examinations problematic, as the data they seek are not an accurate indication of the actual progress of labor. Even more importantly, the pain caused by a cervical examination often has a negative impact on the progress of labor due to the increased anxiety and stress it creates for the mothers (Downe et al. 2012).

At Hospital Público, however, cervical examinations have become the central marker of a patient's labor rather than just one of many indicators. As a result, clinicians follow through with this practice without regard for the larger context of each woman's birth—e.g., ignoring Rosita's previous miscarriage as a risk factor, Victoria's three prior uncomplicated vaginal births, or Gaby's elevated risk for a cesarean. I contend that this embedded bureaucratic and impersonal structure driving medical practice is perhaps the most problematic issue with the assembly-line model of birth.

In the routinizing of practice at Hospital Público, emerging from clinicians' need for a simple and rigid structure in their practice in response to overcrowding and overwork, they have also pared away any practice that seems extraneous, such as asking the patients questions about how they feel during their labor or talking them through their pain. Because of the overcrowding and the structure it has reinforced, all of the clinicians' energy has become focused on the state of the patient's dilation. Cervical examinations thus become an index for determining a patient's progress during labor, a shorthand measure of labor that embeds other factors (a woman's age, parity, stage of labor, etc.) within it but allows clinicians to focus on the most apparent measure (dilation).[19] In this way, clinicians' reliance on this index allows them to be efficient rather than compassionate in their practice.

As seen from the women's voices and experiences above, the patients were fearful of the physicians and of being yelled at because they were poor and did not fit the mold of a "good patient." As the midwife Emilia stated, such women are caught in a situation in which they must accept the largesse of the state, of the hospital, and of the clinicians because they are poor. The constructed narrative regarding female patients at Hospital Público revolved around the physician's need to cycle the women out as fast as possible. In this narrative, clinicians talked about how much work they did and how much the women created problems for them, frequently complaining that "the [women] don't cooperate." The patients thus were frequently made to believe that they were at fault for any problems in their delivery, as evidenced by the harsh order that "[your birth] will be fine depending on your cooperation. You have to help the doctors" (field notes, June 18, 2008) that was given to Estefanía, an adolescent mother. Jessica, another teenage mother experiencing her first birth, said, "When you are in the delivery room, they shout, 'Be calm, don't do anything.' And [I] was calmer than others who were screaming. I just did what the doctor ordered me to" (field notes, July 6, 2011).

Furthermore, the patients were expected to be grateful for the treatment and the amount of effort the clinicians had expended on their care. Indeed, even Victoria, who had experienced the Reyes Technique and the subsequent rapid, aggressive birth of her daughter, could not contain her gratitude toward Reyes and his staff immediately after the birth. As she lay on the delivery bed, she grasped Reyes's hand and thanked him for saving her with his amazing care, saying, "May God bless you, doctor!" He good-humoredly joked, "Thank you. The blessing is good. But you can thank me with a cake from La Zarza [a well-known bakery in Puebla] for forty people" (field notes, June 27, 2011), an attempt at humor that showed his ease with this routine of birth. A few days postpartum, however, Victoria admitted, "I was very frightened . . . the doctor hurt me. . . . Are all of them like that [at the hospital]?" (field notes, July 21, 2011).

Somewhere between their experiences of pain and gratitude, the patients' fear (of the clinicians, of either complying or not complying) created a deep distrust of the doctors and

the medical system. In a strangely Hegelian master–slave dialectic, the more they distrusted the clinicians, the more eager they appeared to be to comply and follow orders. In the words of the Scottish politician Sir Mountstuart Grant Duff, quoting a 19th-century patient in the European colonies, "The more absolute one's mistrust, the more servile one's obedience" (1905:124).[20] What is most noteworthy about this observation is that it reverses the prevalent belief about health care: that compliance emerges when patients trust their provider. Instead, the more the patients at Hospital Público distrusted the clinicians, the more compliant and servile they became. The evident class and educational differences between the clinicians and patients also contributed to this dynamic. As they reported in their conversations with me, the patients were well-aware of the hierarchy between the physicians and themselves, and they complied with the physicians because they were their superiors, not because they trusted their judgment. In such a case, the authority of the clinicians is persuasive less because of their expertise and more because it "includes the veiled threat of powerful sanctions" (Irwin and Jordan 1987).

As Hoag (2011) observes, bureaucracies are often seen as dangerous by those who are subject to them. The interactions I observed at Hospital Público demonstrate his contention that bureaucracy and science are closely related in that they are both modernist and technocratic, ultimately concerned with the domination of bodies, and "profoundly masculinist" in terms of seeking efficiency and speed and deriding nature as they champion culture (2011:84), not unlike Doctor Reyes's earlier quote about natural labor versus one with physician-induced dilation. While some researchers (Maheux et al. 1990) have shown that female physicians tend to be more concerned about physician–patient relationships as well as the social and humanistic elements of care, my research at Hospital Público suggests that female physicians and nurses were equal participants within the system as their male counterparts and shared similar views about patients. This demonstrates that something more than gender is at work here and shows how the bureaucracy embedded in the medical practice is such a powerful force that it erases factors such as gender that are often seen as shaping people's behavior.

This would seem to support George Foster's (1976) observation that part of the purpose of the bureaucratic process is to protect the system, making the needs of the clients (or patients) of secondary importance. Although Michael Herzfeld's (1992) analysis of the process of legitimating bureaucracies and their selective indifference, which he terms a "secular theodicy," is based on the distance that most bureaucrats maintain from their clients, the case of the physicians and nurses in Hospital Público demonstrates that even when providers and clients are in constant and literally physical contact with their patients, the needs of the system tend to take precedence over the needs and well-being of the patients.

CONCLUSION

Based on ethnographic data collected among clinicians and patients at an obstetrics ward in Mexico, I have demonstrated in this article that the everyday practices of obstetrical care coalesced around the cervical examination as an indicator of labor's progress. This result and the indifferent and callous treatment of female patients result from the bureaucratic process of streamlining practices to the detriment of patient care. Extending the work of Davis-Floyd (2004) and Martin (2001) about obstetric emphasis on speed and efficiency during birth, I show how bureaucracy and routine are almost unconscious practices in which clinicians engage to expedite labor and move patients rapidly through the system. That this need for efficiency conflicts with an idealized norm of patient care has also been noted by medical anthropologists working in nonobstetric contexts, such as psychiatric wards (Sayre 2001). My interviews and observations of the clinicians at Hospital Público also support Susan Irwin and Brigitte Jordan's (1987) finding that practitioners do not perceive such medical practices as coercive but, rather, as natural, legitimate, and in the best interest of all parties.

Indeed, from the clinicians' perspectives, it was not their own practices but the patients themselves who were most to blame for the conditions under which they were cared for. This perspective was compounded by the high levels of work stress the clinicians experienced and by healthcare reforms that added patients but little infrastructure to an overcrowded system. Clinicians themselves were brutalized by the system. As a result, according to my observations and interviews with patients, they experienced painful and fearful births during which they received a steady stream of scolding accompanied by dehumanizing cervical examinations. Midwives' critical views of the disdainful and unnecessarily painful care the women received at the hospital were informed by their own practices and authoritative knowledge of birth, which frequently contradicted the biomedical model in both approach and practice.

With this study, I provide new insight into how everyday medical practices can become encoded into bureaucratic mindlessness. Ultimately, I present the cervix as a figurative window into the culture of medical practice in Mexico and elsewhere. While I acknowledge the violence, intended or not, implicit in these practices, I also see it as part of a larger pattern of behavior influenced by both structural forces (welfare and health reform, lack of health infrastructure) and social forces (patient stereotypes, clinicians' stress levels, and hierarchy). Paying attention to the bureaucratic thought work of a clinical setting clarifies the role of the institution and shows, under certain social and work-related conditions, individuals increasingly rely on shorthand daily practices until most of these small-scale practices become as mindless and routine as any large-scale bureaucracy.

It is not easy to suggest policy changes, as many of the problems described here unintentionally emerged from necessary healthcare reforms. On a large-scale level, one

immediate need is to build more hospitals to attend to the underserved populations. Additionally, while in some countries midwives are included in reproductive care with great success for birth outcomes, such is not the case for Mexico. Significant reform would have to take place before midwives are allowed to practice in any of the large public hospitals. Nevertheless, their addition to reproductive care would reduce many of the problems I have described, such as obstetrician overwork and understaffing. Finally, on a small-scale level, the addition of the partogram (a chart to track cervical dilation) would be an easy way to record dilation without resorting to multiple and unnecessary examinations. Such a layer of paperwork, while part of a classic bureaucracy, would actually diminish the routinizing of the cervical examination, thereby improving patients' experiences with the medical care at this hospital.

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NOTES

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1. All names given for the hospital and the people are pseudonyms. In the case of easily identifiable people, I have used composites.
2. *Gorda* literally translates as "chubby," but it is used throughout Mexico as a form of endearment.
3. This technique dates back to early Rome, where midwives would apply fundal pressure (to the top of the uterus) and manually dilate the birth canal (O'Dowd and Philipp 1994).
4. This research was approved by the Institutional Review Boards of the University of Notre Dame and of the hospital field site.
5. This was not an isolated question, as I was asked similar questions a number of times. As one reviewer of this article suggested, it is likely that the physicians' understanding of my research might be a reflection of their biases and concerns—the poverty of the patients, their seemingly endless number of pregnancies, and their inability to have the "right" number of children at the "correct" age.
6. The IMSS (Instituto Mexicano del Seguro Social [Mexican Social Insurance Institute]), ISSSTE (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado [Institute for Social Security and Services for State Workers]), and PEMEX (Petróleos Mexicanos [Mexican Petroleum]) all run health programs for their workers.
7. Pitocin (an artificial form of the hormone oxytocin) is routinely used across many parts of the world to increase the strength and speed of contractions. It is primarily used, however, in conjunction with analgesia (epidural or other methods) to make sure that contractions continue but do not unnecessarily hurt.
8. Pitocin is designed to help the uterus contract back to normal size. Although Pitocin is convenient for the clinicians, it can increase the pain for the women.
9. There is a general lack of analgesics in public hospitals in Mexico, which are typically reserved for cesareans and other surgeries. As one reviewer of this article pointed out, epidurals are costly and take time and additional staff (anesthesiologists) to administer. The physicians do use local anesthesia for episiotomies, however, and tend to use it quite generously. The nurse's comment was not intended to add particular ideas or values to the women's experiences. Rather, for her it was simply a matter of routine that births at the hospital have no analgesia and are routinely done with episiotomies (cutting of the lower vaginal opening [perineum] to widen it).
10. Other hospitals across the world with such high levels of overcrowding experienced very high rates of maternal mortality, a lack of medications, and many problems with healthcare delivery (Sundari 1992).
11. Diniz and Chacham (2004:102) point out that in Brazil the overcapacity situation is caused by an "epidemic of cesareans," whereby women have to stay longer in hospital, thus using beds for longer periods. Hospital Público's cesarean rate is 45 percent.
12. Demonstrating this displacement of blame, one of the directors noted that patient mistreatment was one of the main problems with the medical staff but attributed it not to conditions in the hospital but to issues outside of work: "If one has personal problems, one should not bring them to work" (field notes, June 23, 2011).
13. Medically, the fetus is always called a *producto* (product) in Mexico.
14. Gaby was so dissatisfied with how her labor was being managed that she petitioned for release from the hospital after she had waited in a hospital bed for 12 hours with no help. Her husband, a policeman, pressured the hospital administration, who reluctantly allowed her to leave. Her baby was born by cesarean at a private clinic, where the physician said that she had lost so much amniotic fluid that her baby was stuck to the uterus. Similar situations in which clinicians berate patients for screaming have been noted by researchers in other parts of the world (Castro and Erviti 2003; d'Oliveira et al. 2002).
15. Thank you to one of the anonymous reviewers for making this point.
16. Approximately US$ 1,700.
17. While the correct Spanish term for a tubal ligation is *ligar* rather than *amarrar*, because this conversation took place at a hospital and with a patient who was considered "problematic," my

impression was that the clinicians had to be referring to a (more mundane) tubal ligation rather than a (more aggressive) tying down of a patient.

18. As noted, the hospital's cesarean rate is 45 percent, which is well above WHO guidelines.
19. The cervical examination at the hospital is used in a similar way as the Human Development Index, which ranks countries based on their degree of development and is a statistical shorthand that embeds many factors (standard of living, life expectancy, literacy, education, etc.) within a single index.
20. "Méfiance la plus absolue, obéissance la plus servile." My translation.

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