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Microaggressions and the reproduction of social inequalities in medical encounters in Mexico

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ABSTRACT

This article examines the role of microaggressions in the interactions between biomedical personnel and marginalized patients to addresses the constitutive property of medical interactions and their contribution to a class-differentiated and discriminatory local social world. Based on ethnographic fieldwork over the course of three months (2008–2011) the study examined the clinical relationships between obstetric patients and clinicians in a public hospital in the city of Puebla, Mexico. It reveals four factors present in the social hierarchies in Mexico that predispose clinicians to callous interactions toward "problematic others" in society, resulting in microaggressions within clinical encounters: (a) perceptions of suitability for good motherhood; (b) moralized versions of modern motherhood inscribed on patient bodies; (c) a priori assumptions about the hypersexuality of low-income women; and (d) clinician frustration exacerbated by overwork resulting in corporeal violence. This work concludes by questioning the efforts for universal health rights that do not address underlying social and economic inequities.

1. Introduction

As in many countries in the global South, one of the central concerns of Mexico's development agenda is providing wider access to health care in an attempt to close the economic and social gap between its most affluent and its poorest citizens. Yet access to care does not guarantee compassionate care. This ethnographic study of the medical interactions between middle-class clinicians (physicians and nurses) and their impoverished patients at a maternity hospital in Puebla, Mexico reveals acts of microaggression by clinicians toward the patients under their care. As defined by previous scholars (Hill, 1998; Solórzano, 1998), microaggressions are subtle insults and demeaning behavior typically aimed at people of color (or as I posit in this article, to "problematic others" in general) that reflect and enforce the perpetrators' perceptions of their superiority (Solórzano et al., 2000).

Microaggressions can be damaging to the recipients, exacerbating existing structures and hierarchies. Sue et al. (2007) have categorized microaggressions into three types: microassaults (overt verbal or nonverbal derogatory actions, such as racial epithets), microinsults (rude or insensitive interactions, such as assuming that a member of an underrepresented group was hired because of preferential treatment), and microinvalidations (interactions that negate, dismiss, or nullify recipients' responses to microaggressions, such as calling them oversensitive). Although these actions may seem relatively minor as a form of abuse, Sue et al. argue that microaggressions express a covert form of racism that is often ambiguous, nebulous, and, consequently, more difficult to identify or protest. As my analysis will demonstrate, the clinicians at the hospital where this research took place not only engaged in all three forms of microaggression, but also in a fourth, which I term corporeal microaggression. Corporeal microaggressions emerge from mainstream perceptions of moral superiority and are expressed as violent bodily treatment, such as sterilization efforts that target single mothers. An analysis of corporeal microaggressions contributes to a deeper understanding of the growing concern with obstetric violence (Dixon, 2014). I argue that microaggressions function within this medical setting to reflect and reinforce class and race-based explanations of otherness.

Based on my examination of clinical encounters between patients and clinicians in this maternity hospital, I argue that microaggressions can be attributed to two structural causes: (1) the poorly funded hospital system developed for impoverished populations, and (2) a historically driven national discourse about class, gender, and ethnicity. Together, my findings suggest that providing adequate, humane, and ethical medical care for Mexico's poor is not

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merely a matter of founding or funding additional clinics, or even of providing better training for clinicians, but of addressing larger social and cultural dynamics. In so doing, this analysis will contribute to the current literature on microaggressions, social hierarchies, and obstetric violence within medical settings and explore their implications for medical reform in Mexico and elsewhere. It also furthers work I have published previously (2012, 2013b) by providing an explanation of the reasons *why* violence and discrimination emerge in obstetric encounters. I provide a bridge between microaggressions and intersectionality by showing how moralizing attitudes about certain people (marginalized women) becomes expressed in words and actions by the very people (middle class clinicians) charged with caring for them.

Mexico is a useful site to study the ways that specific historical processes have marginalized, otherized, and stigmatized impoverished women's reproduction, because ideologies of modernity have been central to its national identity. Mexico is a middle-income country marked by tremendous historical and current disparities across various axes—class, ethnicity and skin color (indigenous, mestizo, white), gender, and location (urban, rural). The intersection of these social categories has created systems of marked discrimination and disadvantage for certain populations (i.e. female, impoverished, dark skinned, rural), while simultaneously privileging other social categories (i.e. male, wealthy, light skinned, urban). These racial, gendered, and class dynamics are historically traced and perpetuated. Stern (1999) and Molyneux (2006) argue that during the 20th Century nation-building efforts and into the 21st Century, women have been encouraged to reproduce and cultivate appropriate offspring for the nation. To this end the state focused on the science of puericulture (child development), where women's domesticity was rationalized, moralized, and hygienicized. According to both scholars, new scientific discourses of human development, hygiene, nutrition, and health were disseminated to mothers from backgrounds deemed backward or problematic.

Maternity hospitals such as the one I examined in this study represent just a recent manifestation of a decades-long attempt by the state to shape motherhood. As a result of these efforts, puericulture has become seamlessly integrated into health campaigns and policies, especially those aimed at low-income populations (Early Stimulation, Oportunidades/Prospera, etc.), and into the practices of government-run hospitals and clinics (see Smith-Oka, 2013a; Secretaría de Salud, 2002).

I argue that the historical circumstances of stratification in Mexico have predisposed middle-class physicians to a certain indifference towards the poor and that the microaggressions I observed emerged from what Kirmayer (2008: 458) defines as "radical otherness"—a marked social distinction between patients and clinicians—that exacerbates the social difference between these groups. In its examination of some of the mechanisms that control and monitor reproductive practices, my analysis has also been informed by studies on empathy (Hollan and Throop, 2008; Neumann et al., 2011), by linguistic analyses of microaggressions and discriminatory content in face-to-face interactions (Hill, 1998), and by Morgan and Roberts's (2012) concept of reproductive governance. I further the concept of reproductive governance by revealing some of the mechanisms that control and monitor reproductive practices. Such an approach allows a broader investigation into the culturally patterned predispositions to microaggressions within clinical settings that are fostered by, and reinforced through, the discursive themes of national belonging as well as the morality about good and bad motherhood, class-based modernity, and the supposed hypersexuality and hyperfertility of low-income women. Such tropes persist in popular discourse and are woven into government policies, resulting in microaggressions in clinical encounters.

1.1. Study site and methods

This article is based on ethnographic data I collected over one month in 2008 and two months in 2011 at Hospital Público (a pseudonym), a large public maternity hospital in the city of Puebla, in central Mexico. The research was examined and approved by the Institutional Review Board of The University of Notre Dame (Protocol #11-321).

Puebla is a densely populated city within the Mexican state of Puebla, which in 2010 was home to just over 1.5 million people within the city limits and to almost 2.7 million in the larger metropolitan area, making it the fourth largest city in the country (INEGI, 2010; CEIGEP, 2014). Although Puebla is one of the wealthiest municipalities in Mexico, the social and economic disparities between its affluent and impoverished populations are significant. In 2014 the city's poverty rate was 33.9%, including 6% living in extreme poverty. Despite the Mexican government's efforts to expand access to social and health services, only 38.8% of Puebla's population had regular access to health services (CEIGEP, 2014). The state of Puebla has 66 hospitals total, most of which are in the city of Puebla itself, but this number is not adequate to meet the needs of the large population. The ratio of physicians, registered hospital beds, and operating rooms per 100,000 people was 125.7, 61.1, and 2.1 respectively (INEGI, 2010).

Most of the city's impoverished population is dependent on ill-funded government hospitals and clinics for their medical care. Many of them are enrolled in welfare programs, such as Seguro Popular, providing health insurance for the very impoverished, or Prospera (previously known as Oportunidades), providing conditional cash transfers to mothers for their children's health, nutrition, and education. These programs aim to improve health and social conditions among the population. The majority of people enrolled in these programs receive medical care from public clinics and hospitals such as Hospital Público. Hospital Público's patient-base consisted of some of the poorest inhabitants of the city and state, most of whom were uninsured and had almost no safety net.

The hospital attended to between 8500 and 9000 births a year, and typically functioned at 140 percent capacity, creating uncomfortable conditions for the patients and high stress for the physicians and nurses working there. Due to the lack of space and beds in the maternity ward, patients were moved through the system as rapidly as possible. Approximately 25% of the births were by adolescent mothers, and the hospital's cesarean rate was 45%, more than three times the rate recommended by the World Health Organization (Gibbons et al., 2010) and higher than the state's rate of 37.4% (INEGI, 2012).

Data collection methods consisted of participant-observation and semi-structured and unstructured interviews with 71 female obstetrical patients, 9 nurses, and 30 physicians. The interviews with patients took place at the hospital, with the exception of 5 more in-depth interviews conducted at the patients' homes postpartum, which addressed their experiences with birth and motherhood. Interviews with clinicians also took place at the hospital—in the waiting areas, examining rooms, and physicians' offices. These interviews addressed clinicians' relationships with patients, their definitions of good and bad patients and mothers, their attitudes to national childbirth and family planning programs, and their definitions of medical risk (Smith-Oka, 2012; 2013b). I participated in the labors and births of the patients by serving as a doula, holding their hands during contractions, rubbing their backs, and helping them as best I could through their fear, pain, and discomfort. Overall I conducted over 120 h of observations of clinician–patient interactions. I obtained informed consent from all

adult participants.

I recorded interviews in either audio or written forms, asking similar questions of clinicians and patients, speaking with a variety of interlocutors, and collecting data until I reached saturation (Gravlee, 2011). At the request of obstetrical patients, my interviews with them were solely hand-recorded. I took detailed notes as we spoke, often pausing the conversation to go over key ideas to maintain accuracy. I analyzed the data by manually coding each interaction and framing it within the larger social context within which it took place. I coded all the data, first using open coding, then shifting to focused coding as patterns emerged.

I carried out all the interviews in Spanish. As a woman born and raised in Mexico, my understanding of the language and culture allowed me an emic view of the interactions, although many participants viewed me as both an insider and an outsider. In the hospital I was required to wear scrubs or a white coat, which visually set me apart from the patients and made me appear to be a clinician. This meant that I had to work harder to gain rapport with patients and gain their trust, which I often achieved by displaying empathy for their vulnerability during labor and birth. This uniform had quite the opposite effect upon the clinicians, who would often forget my role as an ethnographer and express their opinions openly about patients, speaking to me as if they assumed I agreed with their perspectives. On many occasions clinicians would even mistake me for a medical student and suggest that I participate in examining a patient.

1.2. Clinicians at Hospital Público

Most of the physicians I interviewed expressed what seemed to be genuine concern for the health and well-being of their patients, focusing on self-care and responsibility, in which they generally considered their patients deficient. Every clinician I spoke with shared their candid opinions about their patients and what they saw as their inability to fully care for them because of their intractable social problems. They considered their patients problematic, non-compliant, immature (in age or reason), and unable to control themselves (whether sexually or during labor and delivery). They were frustrated by the seemingly interminable stream of patients they attended and having to repeat to each of them the need to use contraception, to follow good diets, and to care for their health. Many physicians also complained that the bi-weekly rotations through the hospital negatively affected their ability to form a relationship with patients.

The clinicians, especially lower level residents, were clearly overworked, exhausted, frustrated, and stressed by their job in the ward. The strict hospital hierarchy and the high-pressure culture of the medical space were evident in the interactions between different clinicians—from interns to physicians. Interns did most of the odd jobs, fetching stirrups or files for physicians or running samples to labs. Junior residents (first and second years) did most of the grunt work, caring for patients in labor and birth with little rest, but always under surveillance from senior residents or physicians. Senior residents (third and fourth year) carried out a significant amount of the work, but were able to relax more often and joke with their staff more regularly. The physicians were the most relaxed, with more regular and humane working hours. Such power dynamics inevitably eroded the energy and enthusiasm of the junior staff, most of whom rarely seemed to relax or smile during their shifts (Smith-Oka, 2013b).

While clinicians openly criticized their working conditions (for instance, staging protests in 2012 demanding an improvement in wages from hospital administrators and state officials), these protests did not center upon a larger political action for improved patient care, as seen by Wendland (2010) in Malawi. Instead, such criticism centered solely on clinician frustration and lack of benefits.

2. Results

Analysis of my observations and interview data revealed four major assumptions on the part of the clinicians regarding their patients, which were frequently expressed in forms of microaggression. Three of these forms resulted in aggressive behaviors that roughly corresponded with those described by Sue et al. (2007): notions of what constituted suitable motherhood were frequently expressed in what could be considered microinsults; moral beliefs regarding what modern mothers should do took the form of microassaults; and a priori assumptions that low-income women were hypersexual and hyperfertile could be inferred from microinvalidations. Yet my analysis also revealed a fourth and even more dehumanizing form of microaggression. It illustrated clinician's frustrations over what they saw as patients' lack of compliance with middle-class norms and their authority that sometimes resulted in violent bodily treatment. I term this form corporeal microaggression. As my discussion of these types of microaggression will show, each emerged from complex social contexts and pressures, incorporating both verbal and physical interactions. Most significantly, multiple forms of aggression often took place simultaneously in any one patient's experience.

2.1. Assumptions regarding suitability for motherhood: microinsults

Clinicians' frustrations with their patients and their working conditions were expressed in multiple forms, including outward anger at patients, impatient treatment, irritated comments, teasing, or dismissive laughter. A large portion of the negative comments I observed revolved around the suitability of the patients to be mothers.

The interactions of one male physician particularly well illustrate how those frustrations and underlying assumptions were often expressed in microinsults. Although he seemed to enjoy his work—joking and smiling with staff and patients alike—he was often aggressive in his management of birth and generally unconcerned about the pain experienced by his patients. On one occasion, he examined an 18-year-old woman experiencing her first pregnancy who had come to the emergency room with cramps and fatigue, which she thought was early labor. The patient was very fearful of labor and birth. As she sat on a hard plastic chair alongside several other women in early labor, she would periodically cringe and grasp my arm. By the time she was seen by the physician, she was extremely anxious about birth.

The physician addressed her concerns about her fatigue by joking that she would need to get used to a lack of sleep, telling her, “Because you'll never sleep when the baby [comes]. You will get up [all the time to check on it …]. If you are *fodonga* (slovenly and lazy) you'll just ignore it.” He then proceeded to calculate her weeks of pregnancy. The patient had thought she was 43 weeks pregnant, but the physician's calculation turned out to be 38.5 (40 weeks is the usual length of pregnancy). He turned to her and said, “You see how you lie then!” Then with a grin he asked her, “Are you easy?” She blushed and, with a slight stutter that revealed her confusion about the question, answered that she had been with her boyfriend for two and a half years. Continuing to tease her he replied, “You see, you are not that easy. You did not get pregnant. Maybe you didn't know how.” She replied hotly, “Yes, I did!” At the end of this exchange he winked at me and the female nurse and intern in the room, the audience of his little joke, saying cheekily, “I'm the worst!”.

In the above conversation, the physician teased the patient by

making several comments that had the effect of framing her in a negative moral light: laziness in caregiving, deceitfulness, sexual proclivities, and lack of knowledge about reproduction. In addition, his performance of "being the worst" established an alliance with me and his medical staff, while simultaneously othering the patient as the object of ridicule. Despite the seeming good-naturedness of his interaction with the young woman, his attitude suggests an intentional aggression anchored by gender and class privilege. He teased and performed because he could, making the interchange about him rather than the patient seeking his help.

Teasing is a form of intentional provocation that makes a negative statement about the recipient framed as humor (Keltner et al., 2001). The young woman's response demonstrated Eisenberg's (1987) claim that teasing effectively creates uncertainty in the recipient because, though its intent is to be playful, the recipient may believe the utterance to be true. But when the patient above responded to the physician's questions and assertions with anger and confusion, the physician considered the interaction even funnier, her response an affirmation that his teasing had been successful. Although the physician signaled that he was teasing through a disclaimer ("I'm the worst"), a lighthearted tone, and winking, his supposedly innocent behavior reflected darker class- and gender-based stereotypes as he treated a vulnerable, unmarried, low-income young woman who, in his eyes and those of the hospital, was in need of learning appropriate behavior. As in Hill's (1998) analysis of mock Spanish, the physician's use of teasing revealed racialized and class-based stereotypes of his patient as lazy, deceitful, sexually loose, and disorderly (see also Solórzano, 1998). As others have observed, teasing often occurs when social norms have been violated and is intended to shame the recipient (Eisenberg, 1987; Schieffelin, 1987; Keltner et al., 2001). In this case, the physician shamed the unmarried pregnant teenager by pointing out her faults with respect to what society expected from motherhood and thereby also highlighting the social chasm between him and his patient.

The physician's assumptions that the young patient would be *fodonga* with her child care, easy with her sexuality, deceitful about her life, or ignorant about reproduction were more than just offhand comments, instead fitting squarely within class-based ideas of the poor motherhood of impoverished (and, in this case, also adolescent) women. Such indictments of women by society demonstrate what Haney terms imperiled femininity, which results from assessments of a woman's "moral condition" (Haney, 2012: 242).

As in other medical settings, the historical contexts of status and power profoundly shape the way that these medical interactions take place. The particular class and ethnic history of Mexico has created a distinct social distance between different groups that is mirrored by the microaggressions in these encounters. The physician's assumptions reflect the almost insurmountable social divide between both parties—he could make these comments with impunity because he was a physician, he was educated, and he was male. He was also in charge of the patient's prenatal care and, likely, her eventual birth. Such comments traveling down the social structure (wherein inequalities of status already created tensions) tended to reinforce and broaden the fissures between both groups. Through these microinsults, as with other types of microaggression, the division between physician and patient, powerful and powerless, us and them, became all the more emphasized. As I will demonstrate, this license to adopt such microaggressions often expanded into other forms of violence—scolding, harsher physical examinations, or cruel uses of language to elicit fear in the patients. A patient's inability to counter with any effective retort further fed their sense of disempowerment in these contexts.

2.2. Assumptions and moralizing for good motherhood: microassaults

Mothers across the world, whether wealthy or impoverished, often are targets of shaming and moralizing regarding anything from birth practices, infant feeding, or sleeping arrangements. In Hospital Público, formal and informal talks underscored the persistent assumption about low-income women's inadequacy to be mothers. These talks, based on Ministry of Health models, focused on early child stimulation and cognitive development and took place in the waiting rooms of the hospital, where the audience consisted of family members of patients or patients waiting to be attended. Most hospital visitors spent many hours waiting in these rooms (sometimes overnight) and listened to these talks to break up the boredom. The speakers were young and usually female psychology or social work students, who worked at the hospital to gain practice hours for their university majors.

The Mexican Ministry of Health (Secretaría de Salud, 2002) has produced guidelines for early stimulation to train health and social workers to identify risk factors (genetic, physical, and/or social) in children from birth to age two. The language used in the documents is for the most part culturally neutral and specifically emphasizes the effect that structural factors such as poverty or education can have on a child's development of gross and fine motor skills, social skills, and language development. The guidelines, based on international standards of child development, also address the potential effects of maternal health issues during pregnancy and maternal involvement on a child's future.

Although the guidelines are designed to be culturally neutral, the talks at the hospital included much more of what Masters et al. (2014: 118) call discretionary moralizing (emphasizing risk and moral deficiencies in a population) and reflected a modernizing rhetoric that emphasized western and middle- and upper-class perspectives on proper child rearing. The talks included such topics as how to speak to one's child to ensure proper cognition, the importance of playing classical music instead of *banda* or reggaeton music (which the speakers claimed have too many instruments and do not properly stimulate children), and the developmental necessity of referring to a child by name rather than calling it by the generic "baby" as was assumed to be common among lower-income populations. The explicit aim of these behaviors was to develop a child's potential and avoid emotional, cognitive, and physical problems. As one speaker stated, "The stimulation has to be from birth until two years of age, so that the brain develops and learns".

The speakers emphasized that children who had received cognitive stimulation would excel in life. After listing several problems that children might have (crying, being beaten in school, swearing, and being unable to speak up for themselves), one speaker told her audience "If we stimulate our babies none of these things will happen. If they are not stimulated all this will happen. If they are stimulated then they'll be able to say what they want".

To even more emphatically connect "good" mothering and children's health, one speaker actually suggested to her audience that crib death, or SIDS, was caused by direct maternal emotional neglect. Asking her audience outside the emergency ward if they were familiar with crib death, she implicitly blamed such deaths on the babies' mothers,

> The reason is that, though I understand that as women we have a thousand-and-one activities (as woman, mother, wife), my baby might be lying on the bed. If we leave them too long they will realize we do not love them and they will allow themselves to die. That is the reason they stop breathing. […] It is better to

> prevent [this] if you don't want it to happen. One has to give them the necessary love.

Underlying these culturally situated socialization preferences was an assumed lack of "modernity" and "civilization" among the target population. These talks also directly linked motherhood, socialization, and children's success (or, conversely, death) in order to shame the assembled mothers into behaving in what was presented as the most correct and sanctioned way to interact with their children. This overly simplistic, linear logic additionally suggested that good parenting was easy and that children's success was wholly dependent on what mothers did during a child's early years. Although these talks included no explicit belittling of impoverished people, together they constituted an assault upon a set of assumptions about the audience's lifestyles—about their likely choices of music, child's sleeping place, and women's roles—that were class-based. Such microassaults also reified the hospital administration's perceptions of their own superiority while simultaneously proving the inferiority of their patients.

As previous scholars have shown, targeting motherhood as part of a civilizing and racialized modernizing mission has a long global history, as evidenced by Hunt (1990) in colonial Burundi, Boddy (2007) in Sudan, or Van Hollen (2003) in India. By making the domestic sphere and mothers their main target, such "civilizing" policies draw from the mutual processes of "cultural incorporation and transformation" (Hunt, 1990:449) in an effort to inject these values and practices into the core of the family structure. In Mexico, these efforts have specifically focused on maternity, sexuality, and children (Smith-Oka, 2012). This conjoining of maternity with modernity, it should be noted, is not simply a reiteration of the traditional role of women as the primary caregivers, but as Stern has noted, a "rearticulation of all points of power within the domestic domain" (1999: 371–372).

2.3. Assumptions regarding patients' unbridled sexuality: microinvalidations

Another prevailing assumption about the patients was their unbridled sexuality, and hyperfertility (see Braff, 2013). Almost universally, the clinicians considered their patients very promiscuous. One female attending physician's words particularly demonstrated the class-based assumptions and general impressions of the patients 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 *ranchitos* [little villages].

Ranchitos, the diminutive version of *rancho* (rural village), does not simply indicate a location, but is often impregnated with meaning related to skin color and degree of indigenous heritage. Using classist and racist perspectives to classify the patients, the physician alluded to the prevailing dichotomy between rural and urban, poor and rich, unhygienic and hygienic, uneducated and educated, them and us. In this racialized space, as Braff (2013) observed during her work in a fertility clinic in Mexico City, reproductively problematic populations are perceived as being rural, not urban, erasing the reality and conditions of their actual lives. Such a paradigm, as Briggs (2000) suggests, confounds differences in class or location to emphasize difference, specifically with the purpose of underscoring the hypersexuality of racialized others (see also Masters et al., 2014). These class-inflected and gendered ideologies also are evident in the implied dichotomy between pure women and fallen women, wherein women are expected to conform to expectations of female virtue so as not to fall into the category of what Haney (2012: 246) terms the "body *cualquiera*"—the body nobody, the fallen body. As in other settings, the supposedly hypersexual behavior and lack of contraception and adequate mothering skills among Hospital Público's low-income and brown-skinned patients were viewed by clinicians as a reproductive threat to Mexican society (Braff, 2013; Soto Laveaga, 2007; Stern, 1999).

A few days after giving birth one patient recounted her own experience of a clinician's perception of her hypersexuality. While she had been waiting in the emergency room, a female physician began to harangue the laboring patients and jeer at their pain, saying, "Now you may scream in pain, but nine months ago you were screaming in pleasure". This had upset the patient, who told me, "Well, what does she care? A baby should be made with love, not with pain or violation." Such mocking of patients' sexual lives has also been observed by other scholars (e.g. Jewkes et al., 1998; Castro and Erviti, 2003; d'Oliveira et al., 2002) who have noted similar verbal aggressions and sexual humiliations issues within reproductive health services in hospitals in Latin America and South Africa. As Jewkes et al. observed in their study of abuse by nurses, clinicians use these through their verbal and physical aggressions to create social distance to emphasize their power over patients they considered to be inferior.

Clinicians also expressed significant frustration with their patients, whom they considered irresponsible reproducers who constituted a burden to the state. Similar to the staff in Bridges's (2007) study of a New York hospital who viewed patients as wily abusers of the system, the clinicians in the Puebla hospital frequently described their patients as problematic mothers who contributed nothing to society. As one female physician complained when she heard that I was an anthropologist researching low-income women's reproductive choices,

> Oh, won't you find out why they don't use contraceptives here? It is just that these [women] don't know. One explains and teaches them and nothing. I think that their IQ is very low because they always have children. And [they are] such poor, marginalized populations, and they have tons of children. They don't understand.

This comment perfectly mirrors the parenting talks I described above, explicitly connecting patients' reproduction with civilizing and modernizing language. I heard this frustrated comment repeated in different ways by several clinicians during my research.

The comments by physicians and nurses at the hospital in Puebla revealed an underlying aggression against women, low-income populations, and seemingly over-sexualized populations. This rhetoric also expressed moral judgments about sexuality, pregnancy, and normative obstetric patienthood that reflected clinicians' entitlement to judge and regulate women's reproductive and sexual choices. Comments such as the above-mentioned female physician's assessment of her patients might also have emerged from frustration with the number of laboring patients. Her description marked a clear class and educational status difference between the physician and her patients—the former as having higher educational, economic, and social capital than the latter.

Clinicians also frequently classified the women they attended as bad patients. According to one senior nurse a "good" patient was someone who "should be very clear about what she is here for, [knowing] that childbirth is very painful. […] She should not shout. […] She should keep calm and only make the necessary

effort, and follow the instructions." Her words emphasize cooperation and compliance, reflecting middle-class standards of what constitutes good order and respectable behavior. By this standard, the behavior of these patients in early labor fell outside of the clinicians' norm of "good" conduct even though they were behaving in ways that would normally be seen as natural for women in labor almost anywhere. It was evident that "good" patients were those who behaved correctly both inside the ward (by being compliant) and outside (controlling their sexuality). The overcrowding and unremitting heavy caseload of the physicians and nurses also clearly played a role in their oft-expressed lack of patience with what they saw as low-income female patients' willful non-compliance and ignorance. This frustration undoubtedly played a major role in clinicians' use of microaggressions aimed directly at their patients when they spoke of cutting and deforming their patients' bodies.

2.4. Assumptions regarding non-compliance: corporeal microaggressions

A common trope in clinicians' criticisms of their patients was "cooperation", by which they did not mean acting together for mutual benefit, which would imply some equality or common purpose, but about following orders, complying with medical directives in order to make the process easier (for clinicians). One female physician said that patients, "do not cooperate. And we explain to them. But they are subject to more complications because they don't cooperate. They don't follow indications for the examinations." While one nurse admitted that, "some are very cooperative", she followed this by stating that, "some do end up despairing and then make us despair". When clinicians felt despair in a situation, the patient was often blamed for non-cooperation. Though clinicians referred to "cooperation", this term was code for "compliance". When a patient seemed to be ignoring clinicians' orders or she acted in unexpected ways, she was typically perceived as non-cooperative and non-compliant. This perception often seemed to justify not only verbal reprimands but rough physical treatment and interventions that may have had some medical justification but that to an outsider or patient appeared very much like punishment.

The social underpinning of hierarchy implicit in these microaggressions can be demonstrated by the birth experience of one 16-year-old giving birth for the first time. I met her as she lay on the delivery table groaning and pushing, surrounded by more than half a dozen residents, interns, and nurses. As was the practice at this hospital that day's chief of medicine would occasionally come in, check the patient's cervical dilation with a vaginal exam, and give instructions to the residents. Residents then conducted additional vaginal examinations for a total of six such examinations during a one-hour period, each by a different physician. With each examination, the young patient squealed in pain, clutching my hand as I tried to help her through the pain. It was evident that she had little idea of what a birth entailed as after each contraction and vaginal examination she would look tearfully up and ask the physicians, "Is it over? Is it out?" These questions often elicited laughter from the surrounding clinicians, a form of microinvalidation occurring simultaneously with other, corporeal, forms of aggression. Despite her pushing efforts and eagerness to please, all the clinicians attending to her became extremely exasperated with what they saw as her non-compliance. Their underlying assumptions about this patient and others like her were expressed (in a recurring trope) by one senior female physician said to me in front of the patient, invalidating her, "You see? A single mother and she won't cooperate. She's been like this since her intake. She doesn't want to help. That's what they're like".

After a seemingly interminable number of contractions, and the clinicians' apparent impatience, one of the senior male residents then told the patient that if she did not cooperate, he would do a cesarean on her. To her horrified whimper, "No, no!" he responded, "Then cooperate". His words proved prophetic as, despite the patient's best efforts at pushing, she did receive a cesarean. While the resident later told me that the cesarean was done because the baby was in a transverse position, the way he had framed it to the patient was almost as a punishment for the exasperation she had caused.

Frustrated comments about bad mothers continued even after the patient gave birth. A group of three female physicians stood at the nurse's station discussing the patient, among them the day's chief of medicine, a collegial woman with an iron will whose scrubs had a design of the Tasmanian Devil cartoon character on them. As I approached the group, she smugly repeated a frequent question in the discourse among clinicians, "You see what they are like?" and without waiting for an answer, continued her criticism of the patient. The gathered physicians agreed that the patient had been very difficult and that her behavior was typical of patients at the hospital, reaffirming their expectations about their patients. One of the residents concluded that the patient was a perfect candidate for a tubal ligation, or what would constitute an additional cut to the patient's just-cut body.

I frequently observed this corporeal form of microaggression inscribed on the body of "problematic" patients by clinicians at Hospital Público. These acts of corporeal microaggression differ from the gendered violence have been observed in obstetric practice (Braine, 2008; Valdez-Santiago et al., 2013; Smith-Oka, 2013b; Dixon, 2014). Castro and Erviti (2014) argue that obstetric violence is rooted within a medical habitus where deep-seated notions of medical hierarchy, status, and gender collude to exert violence upon obstetric patients. As Dixon (2014) states, obstetric practice is violent and not merely medicalized, and is a form of gendered violence. I argue that corporeal microaggressions are violent but, differing from obstetric violence, they emerge from a substrate that moralizes motherhood, usually accompanied by other microaggressions.

The corporeal microaggressions at the hospital constructed a medical space in which the normative behavior for patients was modeled after "modern" and middle-class notions of motherhood. Because most patients I describe did not meet this expectation, their behavior became highly visible and under constant surveillance—even to the point of threats of violence. What was clearly evident in these clinical settings was the asymmetrical relationship between middle-class physicians and low-income female patients. In most of these encounters, the patients had no choice but to accept the microaggressions leveled at them and endure the subsequent procedures that reflected and replicated the dominant structures within Mexican society.

3. Conclusions

In this article I have provided evidence and a context within which to better understand how the complex daily structuring of class, ethnicity, and gender can result in microaggressions in a medical setting. I have argued that there are two chief impetuses for these problematic obstetric encounters: one, a specific historical process that has developed a social and ethnic hierarchy of radical otherness that marginalizes certain women, and the other, a product of hospital structure that presents clinicians with too little time and too many patients.

While a societal lack of care toward impoverished populations can help explain the barely disguised hostility that clinicians may feel toward the very people they have committed themselves to serve, it does not take into account deeper structural causes of

impoverished women's limited health care options or their seemingly aberrant behavior. Such attitudes towards the "unworthy poor" are not restricted to Mexico or even the global South, and can be seen, for instance, in middle-class attitudes toward female recipients of welfare in the United States and the United Kingdom (Bridges, 2007; Park et al., 2012; Masters et al., 2014). Within the specific context of obstetrical care, the discretionary moralizing and microaggressions evident in the medical encounters I have described place blame upon the Mexican female patients and their behaviors, but do not engage in a deeper (and very necessary) criticism of the underlying structures of a country that routinely disenfranchised these precise populations through efforts such as puericulture and maternal development. Such moral injunctions are part of the mechanisms of reproductive governance (Morgan and Roberts, 2012) deployed by the clinicians to control not only their patients' behavior but also their reproduction, thereby demonstrating the workings of power, gender dynamics, and hierarchies in the provision of health care.

The fact that a large portion of patients in the hospital were considered "problematic" in several ways (age, health, number of children) tended to compound the microaggressions they experienced from their physicians and nurses, who saw these women as transgressing social and moral norms (see also Nelson, 1999). Similar to the upper middle-class Haitian physicians in Maternowska (2006: 78) work, this perception conforms to the dominant class's expectations about "appropriate behavior toward the poor" rather than as a sign of broader societal inequities from which they themselves have benefitted. While from the outside—and from the patients' perspective—such comments and treatments bordered on the cruel, the clinicians engaged in microaggressive interactions to deal with problems they saw as unresolvable. Low-income patients who the clinicians often considered willfully ignorant and non-compliant with what "was best for them" became targets of aggressive treatment for being both vulnerable and at fault. As a result, physicians' comments not only revealed their class-based biases about their patients but also continued to exacerbate them in their interactions.

There are many important recent efforts to increase universal health access for populations across Latin America (such as Seguro Popular in Mexico, Plan Nacer in Argentina, Fonasa in Chile, or Aseguramiento Universal en Salud in Peru). These programs assert the human right to health care, especially maternal and child health, reflecting what Morgan and Roberts (2012) call the shifting political rationalities of reproduction. As I argue in this article, however, these well-meaning and very necessary programs could fail to fully reach their goals if they are also not accompanied by a concerted effort to understand and overcome persistent social and economic hierarchies in a society. The disjoint between an increased number of marginalized patients and a medical system unable to understand their lives will likely be exacerbated. As my analysis of the conditions and attitudes of clinicians in a hospital in Mexico demonstrates, medical care delivered without understanding for patients' lives ultimately reproduces the inequalities at the root of social problems.

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