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Bodies of risk: Constructing motherhood in a Mexican public hospital

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ABSTRACT

This article addresses the connection between risk and motherhood at an urban obstetrics hospital in Mexico. It primarily aims to explore the ways that clinicians define risk as well as how they conflate risk with bad motherhood. It discusses how clinicians' perceptions of their patients' social lives shape their interactions and decisions about the women's health. The study was based on interviews and participant observation in June 2008 and June–July 2011 with 71 obstetrical patients, 30 physicians, 9 nurses, and 12 midwives in the city of Puebla. Results show that birth itself was defined as a risky event, clinicians conflated social factors with biological factors in their management of risk, and the patients were a priori classified as bad mothers. This article proposes a reproductive habitus to explain the connection between health institutions, class, responsibility, blame, and clinical decision-making to analyze how risk is managed and blame enacted upon women's bodies.

Introduction

Anthropologists have examined risk as a cultural construct that powerfully shapes patients' experiences with illness. Risk rests on the assumption that modern life is filled with unpredictable dangers, which can—or at least should—be minimized through human intervention (Browner & Press, 1995). Kaufert and O'Neill (1993), in their classic work on risk and reproduction, state that the vocabulary of risk is used by both sides of the medical spectrum—by obstetricians opposed to home birth, and by midwives citing the multiple risks of excessive interventions. Medical anthropologists focus on various aspects of risk, such as surveillance/governmentality (Browner & Press, 1995; Lupton, 1999); self/other and blame (Denham, 2012); responsibility (Hamilton, 2012; Howes-Mischel, 2012); risky cultural practices (Chapman, 2006; Gálvez, 2012; Smith-Oka, 2012); and medical technologies (Fordyce, 2012).

Lupton links the idea of risk to apparatuses of biopolitics where the state strives to discipline and normalize its citizens (1999:61). Similarly, Hamilton's (2012) research among methamphetamine-using mothers illustrates the conflict between the absolutist biomedical/social/legal conceptions of drug-induced risk/blame and the social context within which many of these women live their lives and choices. When pregnant women fall outside of the norm they can be encouraged (or coerced) to engage in practices to return to that norm. High-risk, a classification that emphasizes extreme deviation from the norm, resonates with the larger structures that women exist within—where low-income women, already deviating from the mainstream, can be perceived as even higher risk. Consequently, greater efforts are made to bring their bodily practices back to that norm. Curiously, sometimes embracing normative standards and practices can have drawbacks, as Gálvez (2012) demonstrates among Latinas in the U.S. As she shows, Latina women frequently experience the birth weight paradox—they experience fewer pregnancy complications than expected when considering their minority status. But when they accept the risk inherent in their reproduction they often lose those precise cultural practices that contributed to their better birth outcomes.

A designation of high-risk in pregnancy is an indication of requiring "expert advice, surveillance and self regulation" (Lupton, 1999: 61). Kaufman (1994: 434) illustrates how health assessments solidify certain stages in life as medical problems "in need of a specialized, scientific, and totalizing approach." Throughout pregnancy and birth there are a multitude of tests, best practices, and concerns that should be followed for a positive outcome (Browner & Press, 1995). Problems arise when a woman is perceived to flout these best practices; oftentimes this situation increases the medical gaze—and technical implements—to reinforce medical authority. Yet, this approach "ignores many of the practical realties of women's lived experiences and certainly leaves no room for force majeure when discussing reproductive malfeasance" (Fordyce & Maraesa, 2012: 8), resulting in miscommunication, lack of informed consent, or perceptions of non-compliance.

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Despite ceding control, however, women continue to be held responsible for any problems. Blame is often central to notions of risk—someone has to be held accountable if something goes wrong. Risk is used to construct a moral community (Douglas, 1990). Thus, in the vocabulary of risk, if a woman dies in childbirth, she could be blamed for engaging in risky behavior that transgressed expected norms. Because self-regulation is central to risk, individuals are expected to police their behaviors to better serve their (and the state's) interests—a person is thus self-responsible for their own health (Lupton, 1999). Browner and Press (1995: 309) show how society imposes "nearly total responsibility on [women] as prospective mothers for assuring a favorable birth." In his analysis of the trajectories of blame for infant illness/death in Ghana, Denham (2012) illustrates the shift in blame from a traditional framework (where society or spirits were blamed) to a biomedical framework (where blame increasingly lay with the mother). Howes-Mischel (2012) demonstrates how the body of women in Oaxaca, Mexico becomes the site for risk and control through neoliberal notions of self-care—any problems arising are attributed to their unloving and irresponsible motherhood. And as Stern (1999) shows in her work on Mexico's early nation-building efforts, by essentializing mothers as the primary caregivers they are made wholly responsible for the welfare of the nation.

My work explores the idea of obstetrical risk and the culturally constructed practice of motherhood, particularly as used by Mexican physicians and health institutions to create certain categories of people and manage these people's reproductive lives according to these categories (Smith-Oka, 2012). Building upon Chapman's (2006) analysis of the interplay between cultural and structural factors shaping reproductive vulnerability and choice, upon Miller and Shriver's (2012) work on women's habitus and preferences and eventual birth choices, and upon Cartwright's (2008) habitus of motherhood, I propose the reproductive habitus as a frame of analysis. This framework explains the relationship between patients, physicians, and larger institutions. Different from body habitus (physique) used by physicians, I define reproductive habitus as modes of living the reproductive body, bodily practices, and the creation of new subjects through interactions between people and structures. As Bourgois and Schonberg (2007) state, by understanding the interactions of people, we can link them to structural power relations to understand how everyday practices and unconscious patterns of thought reproduce social inequality. Because habitus is processual, it exists in the hazy gray realm between consciousness and unconsciousness—it is what Lock (1993: 137) refers to as a "repetition of unconscious, mundane bodily practices." An important aspect of habitus is that it is an embodiment of institutions. Additionally, a person's habitus is dependent on history and memory; members of a social group frequently share habitus as they share a collective history and exist within a particular sociopolitical, economic, and natural environment that continually shapes their habitus. People respond to this environment and unconsciously develop their habitus, yet they also in turn—through their responses to stimuli—will shape their environment and the institutions. In this way, reproductive risk can be explained not solely as a politicized version of biological reality, but also as a concept that is shaped by people's actions and the larger institutions that structure their decisions.

In this article I use reproductive habitus to explain how low-income Mexican women's reproductive risk is shaped by broader forces and structures. I show how these women are seen to embody risk biologically and socially, and how clinicians employ guilt to achieve compliance. Building upon recent discussions on risk and reproduction my aim is twofold: (a) to explore the ways that risk is defined by clinicians within this medical setting, and (b) to analyze how risk is coupled with bad motherhood. The "bad mothers" are low-income women, usually young and poorly educated. Across the world, "good" mothers (e.g. married, knowledgeable, following the norm) contrast with the "bad" (e.g. unmarried, uneducated, "deviant") (Ladd-Taylor & Umansky, 1998). As I demonstrate in this article, women are a priori assumed to be bad mothers; this categorization shapes their risk factors, affecting their birth experiences at the hospital.

Setting and research methods

The results presented here emerge from a larger ethnographic study whose objective was to explore the role that traditional birth attendants (TBAs) played in first time mothers' ultimate birth outcome and satisfaction. It was carried out during three months, in June 2008 and in June and July 2011 at Hospital Público (a pseudonym)—a hospital for low-income urban populations in the city of Puebla, Mexico. This site was chosen because it was the state's largest and newest government hospital and consequently its health care delivery would not be hampered by old infrastructure or entrenched bureaucracy. The research hypothesis stated that women who had received combined prenatal care by a TBA and a physician would have a more positive birth experience than those who lacked that additional care, *even* if the TBA was not at the birth with them. While the data collection was systematic, the results, though promising, were not conclusive. What instead emerged was a picture of women's significant dissatisfaction with their labor and birth experiences primarily due to their problematic relationship with clinicians. The hospital had experienced significant burnout of their physicians, resulting in a noticeable decline in their relationships with patients. Thus, the hospital encouraged the research as it showed an in-depth picture of the high-stress delivery ward. As a Mexican, my understanding of the language and culture allowed me to delve deeper into the issues experienced by the participants.

Puebla has almost 2 million inhabitants in its metropolitan area and is growing at a rate of 2.62% per year (CONAPO, 2008). About 27% of the city's population consists of women ages 15–29, who have on average 2.06 live births. The state's fecundity rate is 2.52 children per woman (INEGI, 2010), while the <1-year-old infant mortality rate is 21.75 per 1000 births; this rate has halved in the past 15 years (INEGI, 2008). The state's maternal mortality rate is 58.8 per 100,000 live births, which is higher than the national rate of 51.3, placing it as the fourth highest rate nationwide. Many of these deaths are caused by a lack of access to public health services as well as the low quality of care in medical settings (Patiño, 2008). The state government has increasingly relied on various social welfare programs to decrease maternal and infant mortality, ensuring that most births occur in hospitals, training midwives and other medical personnel, and improving medical infrastructures and/or facilities. These programs are Seguro Popular (health access/insurance for the most destitute), Oportunidades (conditional cash transfer program for children's health/nutrition/education), and Arranque Parejo en la Vida ("An equal start to life," providing information and health services for women's reproduction) (Smith-Oka, 2009).

Hospital Público (HP) attends to over 50,000 people/year—most of whom are uninsured and low income. Considered one of the best government-run hospitals in the state, it is certainly one of the most modern. The maternity wing—inaugurated in 2005—offers patients free obstetric, gynecological, and other reproductive health services. This hospital maintains 65 registered beds and 150 unregistered ones (i.e. gurneys, labor beds, and those in the obstetrics/emergency wards). Records show that the hospital attends between 8500 and 9000 births annually. Daily it is at 140% capacity, a rate that has rapidly increased since its inauguration.

Using a combination of opportunistic and targeted sampling I enrolled the following participants in the study: 30 physicians, 9 nurses, 71 patients, and 12 midwives. None of the midwives worked at the hospital. Instead they all attended hospital-organized certification courses during 2011, which included weekly, supervised rounds in Labor and Delivery. Most patients ranged from 36 weeks pregnant to early postpartum and varied between 18 and 38 years of age. Most of them (70%) were first-time mothers. The interviews with women revolved around their birth expectations and outcomes, quality of care, infant care practices, and family planning. Interviews with clinicians addressed their definitions of compliance and risk, birth management, and use of medical space. All interviews were conducted in Spanish. I handwrote interviews and field notes, as most women considered notes less obtrusive than audio recordings for capturing sensitive information. The data collection method was a limitation to the study. I was, however, systematic in noting down exact quotes, and often paused the narrative to make sure all the person's words were written down. I used thematic analysis for the qualitative data. I sorted it into piles and groups, and subsequently analyzed it by using open and focused coding (Emerson, Fretz, & Shaw, 1995). I identified data into classified patterns; I then combined and cataloged the related patterns into sub-themes. This allows for comprehensive use of the data and to understand the larger picture.

While I observed 31 physician-patient prenatal consultations in the prenatal unit, the bulk of my research time focused on the labor ward where I conducted 235 h of observation of women from early labor through recovery. I observed the births of 10 women and interviewed 24 women during early postpartum. Five of the interviews took place in their homes where we spoke in depth about their feelings about lack of empowerment and satisfaction with their birth. My status as a medical anthropologist granted me a certain amount of flexibility, and I was permitted to participate actively in several of the women's labor and birth experiences. I carried out participant observation in the prenatal and delivery wards, specifically prenatal checkups in the former, and labor and/or childbirth and immediate post-childbirth recovery in the latter. The participant observation consisted of physical and emotional support of the women during their check-ups and labor and/or delivery—filling out paperwork, backrubs, support during contractions, breastfeeding support, dressing their baby, etc.

The research was examined and approved by the Institutional Review Boards of the University of Notre Dame and of Hospital Público. The research followed internationally recognized ethical guidelines adopted by the American Anthropological Association. Prior informed written consent was obtained from all participants before becoming part of the study. All participants were literate, understood the explanation of the research, and were provided with a copy of the information sheet. All interviews were confidential and pseudonyms have been used for all participants.

Findings

Several key themes repeatedly emerged in my interviews and observations: (a) clinicians defined birth as a risky event, (b) clinicians conflated social factors with biological factors in their management of risk, and (c) the women were a priori classified as irresponsible and bad mothers. These recurring themes emphasized how integrally linked the concepts of risk are medically, socially, and economically.

Defining birth as risk

The birth unit within HP is a classic example of a technocratic model of birth, as defined by Davis-Floyd (1987). In early labor the women pace in a waiting room lined with hard plastic chairs, at which time they receive an ultrasound. During active labor the women are moved into Tococirugía—the labor and delivery ward—to one of seven labor cubicles. These plexiglass-walled cubicles are side by side along one wall of this ward, with one side open and facing the nurses/physicians' station. Women lie on gurneys and are attached to an intravenous drip with fluids and Pitocin. Laboring alone, they are allowed no support from family during the entire process—the hospital's rationale is due to space constraints and the maintenance of sterility. The women receive periodical vaginal exams from any of the present clinicians. Delivery takes place in one of four surgery/delivery rooms. Immediate recovery is in a small, crowded, and sweltering room adjacent to surgery. Here the women lie side by side on narrow gurneys where they, and their newborns, are carefully monitored for any post-birth problems. Approximately 6 h postpartum the women are moved into shared rooms in the recovery ward where they stay between 12 and 36 h until released from the hospital.

Most days there are many more women than recovery beds. One of the physicians said in an aggrieved tone that they "are unable to keep up" with the number of women. The space constraints are clearly evident: many recently-birthed mothers sit on gurneys lining the passages. The clinicians make every effort to move the women through their birth process as rapidly as possible so they can attend to the high number of patients. This literal and figurative push to speed the birth process leads to exceedingly high self-reported stress levels for the clinicians and patients. And while these practices can also increase infection rates, some of the physicians stated they were less concerned about this because the women frequently had vaginal or urinary infections on arrival. The midwife Emilia expressed her criticism about vaginal exams, "Look at that. [The physician] does not tell her 'look ma'am, I'm going to examine you' nor does he put on lubricant. Very bad!"

Perceptions of risk in HP are closely tied to issues such as malformations, injury, or death. Doctora Godoy stated,

> "The main pathologies [exhibited] are the low and high-risk births, preterm birth, preeclampsia, eclampsia, with lupus, renal failures, etc. We receive [patients] from across the state. We are the only one with Intensive Care. There is a high incidence of premature [birth], at around 19%; also teenage pregnancy, which is at 23–25%. These are younger than 19. [They appear] with all sorts of pathologies, risk of low weight, etc. Maternal deaths are because of hemorrhage, eclampsia, and sepsis. Last year there were eleven [deaths]. […] That seems high to us. […] About 45% [of births are] cesareans; that is because we are a third level hospital. These are patients with no prenatal care and they simply arrive in the emergency room. They come from low socioeconomic levels, with only a primary or secondary education, and they don't have access to another health system."

Though the hospital received many high-risk patients, not all were high-risk, yet many of them were treated as such—all received Pitocin, periodical vaginal exams, routine episiotomies, and, if within 6 h had not delivered, their birth became a cesarean. Doctora Arce, a first year resident, who was so overworked she was rarely able to eat during her long shifts, hurriedly said,

> "One must know what labor entails, how she dilates, how many hours [have passed], and based on that then one decides [what the risks are]. It is not just one parameter. [One takes into consideration] the mother, the baby, if the mother progresses, if the baby has the cord [wrapped around], if the [heart] rate goes up or down. If one decides to do a cesarean. If the baby suffers

then the birth is accelerated and [it] is born. If something lacks then a cesarean is done. There are many things."

As mentioned above, midwives were not part of the hospital staff. However, they were permitted to observe labors and deliveries as part of their certification course. One of these women worked as a doula among Puebla's wealthier populations. A strong advocate for natural childbirth, she criticized a cesarean she saw in Tococirugía,

"The doctors let [the woman] dilate completely and finally told her she could not give birth. If that woman had been allowed to sit up, she would have given birth. […] It was a big baby, but not impossible. The baby […] had already passed the pelvis; it's impossible for it not to come out."

Emilia, though in many ways equally critical of how birth was managed at the hospital, would point to the laboring women in the ward and state how she would intervene and manage them differently—with stripping membranes, medicinal plants, different positions, external versions, or kind words. She stated, "I have worked for 23 years in a clinic. I have attended thousands of births. Thousands. And there were many in here, [some] with hypertension, which were necessary cases for a cesarean." She added, "The scientific must go hand in hand with the natural."

Self-reported stress was a major factor that shaped the lives of the physicians, and their subsequent management of their patients' labor and births. Several elements were involved in this stress—the extremely long and arduous work hours and rotations, the overcapacity of Tococirugía, and the highly structured hierarchy that placed much of the responsibility on the shoulders of first-year residents. Physicians were expected to move patients through the birth process as rapidly as possible.

Doctor Reyes prided himself on developing his own technique of "digital dilation" as he referred to it, which he used on as many births as possible. He said, winking roguishly,

"I call it the Reyes Technique. I put [women] in a more vertical position, give them Pitocin, 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."

Victoria, who experienced this technique, fearfully whispered after Dr. Reyes finished, "That doctor hurts me a lot. I am very afraid." She said at a later interview that she did not consider birth as risky, citing her previous three home births as examples. She repeated her fears of her hospital birth, stating,

"I felt awful the way he hurt me. Now I feel some sort of cramps to the side of my [vagina] […]. I felt a horrible pain. I could feel how he pulled me and felt as though he removed something. […] Are all [doctors] like that? […] And though the doctor was kind, he hurt me a lot. And there were so many people there. I am not used to that, as with my other children I gave birth [at home]."

Martha, whose birth was a cesarean, stated bluntly, "The only thing I liked about the hospital is that they treat the babies well. They don't treat the women well."

Nurse Franco commented that the typical patient at the hospital was allowed to be "two to 3 h in labor. When she is practically complete then she is moved to a [delivery] room." Doctor Reyes maintained that his technique was effective because the hospital was so congested that they needed to move patients along faster. He added, "It is better to have 10 min of pain than 2–3 h of slow contractions; if the baby takes too long and they are allowed to labor naturally, the baby can asphyxiate, which then means special schools, therapies, and such, which is a big expense." His words present an interesting conflation of the concern with the movement of women through the birth stages and the risk involved in birth itself—for him, birth was an inherent risk that could only be diminished through an increase of medical techniques. Primarily concerned about the welfare of the infant, the agony his patients felt with his technique and the subsequent consequences to their long-term reproductive health seemed secondary.

Social risk and biological risk

In the prenatal unit clinicians considered several factors when evaluating a pregnant woman's risk level, interviewing patients to gain information about their social habits, sexual lives, and general prenatal care. During these consultations the clinicians searched for information on two forms of risk—social and biological. Social risks were connected to the woman's socioeconomic status, marital status, and family planning. Biological risks included a woman's age, diet, parity (number of pregnancies/births), birth spacing, and presence/number of cesareans. Additional important information to determine the woman's risk was obtained through the physical examination that yielded information on fetal heart beat, amniotic fluid levels, cervical dilation, etc. These biological factors were central to the physicians' determination of potential risks for each patient's labor—related to the visible symptoms exhibited by the patient.

There was much concern about the women's background, as illustrated by Doctora Acosta's comments,

"The typical patient here is multiparous, with poor hygiene, [and] probably only having received one prenatal visit. Sometimes there are many with greater age, 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."

Her words evoke the underlying paternalistic class structure of Mexico, which shapes the relationships between physicians (middle-class) and their patients (mostly low-income). Class in Mexico is often inversely proportional to indigenous ancestry—the greater indigenous ancestry one has the lower one tends to be on the social ladder. Emilia, the nurse-midwife, summed it up after a particularly harrowing time in Tococirugía, "The women are treated that way because this is a low income hospital. That would never happen at a private [hospital]."

Class differences shape physicians' perceptions of their patients as lacking knowledge about the correct way to manage their pregnant bodies. Such a perception increases concern about the potential for additional risks. Doctora Sosa, herself also pregnant in 2008, during one consultation urged her young patient to take care to protect her fetus from potential harm. She queried,

"Have you been to the nutrition [office]? If you are not constant your child can have problems. If not your baby will be born without you having had any nutritional care. You have to go to the nutrition [office]. You have a baby inside you and you have to look after yourself. […] We will keep an open admission to the emergency room [for you]. You have a urinary infection; I'll give you a treatment. If it does not go away you risk having a preterm birth."

Rapidly listing the risk factors to look for—the baby's lack of movement, bleeding, vaginal discharge—she concluded by asking about her patient's use of ferrous fumarate (a standard form of iron supplement at the hospital) adding, "I'm going to give you calcium; otherwise you will decalcify."

Special attention was paid to the number of children a woman had as well as her age. Any woman younger than 25 was told that her age was a severe risk factor and she needed to be careful about

future pregnancies. Most women who had previous cesareans had a planned cesarean for subsequent births, unless the physician determined that her risk was not high. Such women were questioned intensely about their contraception plans, such as the following exchange between Doctor Reyes and his 22-year-old patient with a prior cesarean:

Physician: "Are you planning to get pregnant [after this birth]?"

Patient: "No, I would like the *dispositivo* [IUD]"

Physician: "Are you going to get your tubes tied?"

Patient: "No"

Physician: "You know the risks? […] If you want a future pregnancy you will have to plan [the cesarean] […] If not your womb will tear, you will bleed out and die […]. Think about it."

Doctor Reyes then examined her and concluded she was 3 cm dilated; he immediately ordered her moved to Tococirugía for her cesarean. As he prepared her order papers he said, turning to the woman's sister, "If the contractions continue she can rupture, bleed, and die. It is already an emergency."

While Doctor Reyes's words show a combination of various risks of concern, the central emerging risk factor is the woman's refusal to have a tubal ligation. Tubal ligations are considered more viable contraception options than IUDs because they are permanent—IUDs, as semi-permanent options, do not fully dampen down the cycle of risk, only halting it temporarily. Women's refusal is extremely troubling to the hospital's physicians as it demonstrates their (apparent) lack of concern with their life or that of their future children's.

In the labor and delivery ward, while biological risk was always at the forefront of clinicians' decisions, the underlying factor defining a woman's risk was her behavior. Nurse Ruiz, who confided that she admired the American system of health where nurses had significant decision-making power, stated quietly about what would define a good patient, "She should cooperate, be emotionally mature. When they are on the threshold they should handle it. There are some mature ones who do show their pain, but not like others who scream and scream." All laboring women were told that their birth would proceed well if they cooperated. Estefanía, experiencing her first birth, was told by one of the nurses after she plaintively asked how her birth was going, "Your birth will only be fine if you cooperate. You have to help the physicians." Isabel, whose birth resulted in a cesarean, was told by the female anesthesiologist that, "Things will go well if you cooperate." And yet, most women verbalized that they tried to comply and listen to the clinicians, as Jessica, a young first-time mother said postpartum, "The nurse, the doctors all treat us like chickens, no one was treated differently. […] I did what the *doctora* told me to."

The automatic perception of noncompliance was evident in the interactions between the clinicians and the patients, illustrated by the words of Doctora Acosta,

> "Some [women] do [cooperate]. Others don't and so we explain [things] to them. But they are subject to more complications because they don't cooperate. They don't follow the indications during the vaginal exams, like how to place their legs, how to arrange themselves so we can listen to the baby, not to push. They can go into fetal distress, hemorrhage."

Within her words are embedded ideas about the certainty of risk—she sees a direct correlation between a woman's non-cooperation and the risks of her birth. Risk in this context becomes a certainty. One older female patient, who writhed in pain and occasionally shouted during her delivery was told, "Don't shout! And don't breathe that way because you deprive your baby of oxygen." The women seemed to be controlled through their silence.

From risk to bad mothers

Estefanía lay on a narrow delivery bed while a male physician carried out a vaginal exam. Two nurses stood at her head. Everyone shouted "push" at her. Over a dozen clinicians surrounded this single mother-to-be as she grunted and pushed through her labor, lying on dingy sheets soaked with amniotic fluid, sweat, and urine. Her knuckles were white from gripping the metal railing of the birthing table on which she lay; she was kept immobile by an intravenous drip of Pitocin. She squirmed on the table and stared around with frightened, tear-filled eyes. One of the physicians muttered, "You see? A single mother and she doesn't want to cooperate. She's been that way since she came in. She doesn't want to help [us]. That is what they're like." Estefanía was periodically scolded by nurses and physicians alike to behave, to be a good girl, to push out that baby as she was told, and to not risk her child's life by non-cooperation. In the clinicians' eyes she would certainly become a bad mother: she was single, a teenager, and part of the urban poor. Estefanía's experience exemplifies how obstetricians wield the notion of risk to mediate their preconceptions about these low-income mothers' lives.

And while Estefanía had desired a vaginal birth, her son was eventually born by cesarean. After carrying out a vaginal exam, the attending physician abruptly pulled his hand out and made a slashing motion over Estefanía's belly, simultaneously indicating that she was not progressing fast enough and should receive a cesarean. Later, some of the female staff stood at the nurse's station discussing Estefanía, saying how difficult she was and how that behavior was typical. It was concluded that she was perfect for a tubal ligation. In this way she would no longer pose a risk to future children—either through her womb rupturing with future pregnancies or by her bad mothering. The moral undertones to the perceptions of bad mothering were clearly evident, as such morality implied that only "good" women could be "good" mothers. By this definition, unmarried and underage women (de facto "non-compliant" and "disobedient") are not good mothers.

It is the perceived lack of concern for their children that prompted physicians to conflate the possible medical risks with the women's motherhood. On one occasion Doctora Rodríguez, angered by the number of children her patients seemed to have and their (perceived) cavalier attitude to life, said, regarding a woman with four previous cesareans who was undergoing a dilation and curettage for an incomplete miscarriage,

> "…I told [that woman] that she should have a [tubal ligation], that she could die, but she just laughed. You see how irresponsible these women are? She dies and what happens to the kids? […] Every morning after I get up I ask God to look after me so my children are ok, but these irresponsible women don't care. They are not responsible."

In Doctora Rodríguez's view, because the woman did not listen to her about the risks of large families and consecutive cesareans, she was irresponsible and thus a bad mother. And while four cesareans could be problematic for any woman's health, Doctora Rodríguez's anger seemed less about the woman than about the effect this could have on her children. Consequently, physicians here consider tubal ligation as the only solution to prevent such bad motherhood, such as one of the physicians who, on finding out that I was an anthropologist investigating reproductive health, said,

> "Oh, won't you find out why they don't use contraceptives here? It's just that these [women] don't know; one teaches and explains it to them but nothing. I think their *coeficiente* [IQ] must be very low, because they always have children. They are such poor and marginalized populations, and then they have such a mess of kids. They don't understand."

Diana, another young patient, also struggled under the accusation of risky, irresponsible behavior. She was pregnant with her second child and the labor progressed very fast, the baby crowning as Diana was still on a gurney in the labor cubicle. All four delivery rooms were occupied and so the staff rolled Diana's gurney into the far corner of one of these rooms as she strained and pushed. Everyone shouted at her to be compliant because she was pushing against orders. Her baby girl was born a couple of pushes afterward. Seconds later one of the attending physicians scolded her for pushing when she was explicitly told not to because her baby could have lacked oxygen. She told Diana that she could have killed her child. Diana burst into tears. In that same breath she was asked if she would get an IUD. One of the residents scolded her that she now had two children and if she did not use a contraceptive she was very irresponsible. When Diana softly said she would get the IUD, the resident said, winking at me, "Well, then I'll not scold you any longer." For this physician, compliance reduced risk, ultimately leading to better mothers.

Discussion

For the women of this study, risk was intertwined into all aspects of their reproductive experiences. The dangers existent within labor and birth are only too real, however, with infants born by emergency cesareans at 26 weeks with no hope of survival or even a 10-year-old girl giving birth (Lohr, 2011). The issue becomes about "how [these risks] are politicized" (Douglas, 1990: 8) and how they take on a life of their own, moving beyond the scientific or objective facts. A warning about a woman's womb tearing and "bleed[ing] out and [dying]" is less about a scientific/objective view of the risks of birth, but rather catches at the medical imagination. Though physicians are required to be objective and scientific, the horror of a patient bleeding to death is an "emotionally charged experience" central to medical practice (Kaufert & O'Neill, 1993: 47). Robertson (2001) demonstrates that discourses of health are never just about health—they come attached to other interests and agendas. Such discourses are fundamentally normative—they code for how society should look and behave. In HP, while norms are shaped by and through medical practitioners and their collective body of knowledge, they are implemented individually upon each woman—she becomes a canvas upon which to inscribe society's expectations for new lives.

Other scholars have explored the interplay between social and biological factors affecting birth. Berry (2006) investigates Guatemalan Maya midwives' decision-making in obstetric emergencies, showing how women tended to focus on social factors while biomedical personnel placed emphasis on the biological/physiological to explain problems in birth. Chapman (2006) describes how Mozambican women view the most serious obstetric complications as caused by witchcraft. Women frequently keep silent about pregnancy, despite biomedical precepts to the contrary, until they feel that they are less vulnerable to witchcraft. My work in HP adds nuance to these conversations about social-biological risks. In this case, it was not solely women who saw social factors as causing risk. Clinicians based many of their opinions and practices on the social background of their patients. As Doctora Acosta stated above, a woman's lack of cooperation was believed to beget even greater complications. Risk for the women in Tococirugía was frequently connected to their behavior and its potential harm to their fetus.

Fordyce (2008) proposes in her research on Haitian immigrants in Florida that the use of narratives about epidemiological/clinical risk create certain assumptions about maternal and fetal subjectivities. She states that health institutions use statistics to *create* categories of people in order to medically manage and control them. It also allows society to help them, yet keep society safe—especially if they are problem populations (Hacking, 2006). This creation of categories conforms to ideas of normalcy and spans the is/ought divide (Hacking, 1991). Low-income women in this hospital *ought* to comply and behave responsibly—they should not "have such a mess of kids,"—yet they could not because they had been a priori classified as abnormal. Ignoring the social contexts that shape women's reproductive choices, such a categorization of risk allowed clinicians to regard them as potentially dangerous and irresponsible reproducers.

The underscoring of women's responsibility for achieving a favorable birth employed the emotion of guilt to achieve compliance, but with no real medical reason behind the concern. Few of the laboring women were truly non-compliant that they would literally harm the health of their birthing baby. Yet they were automatically treated as bad mothers. Kukla (2005: 83) states that "unruly" mothers are "carefully regulated, policed, and controlled" so they cannot affect their offspring or the larger body politic. The women in my study walked into the hospital as bad mothers. If they followed their own practices on pregnancy or childcare they were bad mothers. But even if they followed the best (medical) practices they remained bad mothers—as evidenced by Estefanía or Diana's experiences. Such a situation is very disempowering to the women—making them feel "like chickens," as described by Jessica above.

This medical system is deeply institutional—medical practices and training of this sort are seen elsewhere (Chapman, 2006; Maternowska, 2006). It is a fairly homogenized system of training, wherein birth is a risky endeavor in need of medicalization. Normal birth for the physicians at HP was medicalized, supine, and routinized. It was also planned. As Brunson (2010) reminds us, within the biomedical model of risk, when birth is considered a natural event, it does not need to be planned. But when births are considered neither normal nor natural, as in HP, there is an increase in their management and control.

Within the expectations of behaviors the habitus of "rational, self-regulating 'hygienic citizenship'" is imposed upon the women (Mitchell, 2006:352). The women *should* embody these expectations until they become second nature. As in other parts of the world, mothers who happen to be poor are perceived as inherently problematic (Maternowska, 2006). As Lazarus (1997) illustrates, class often determines birth choice and outcome—middle-income women center upon retaining control, while low-income women do not expect to have control but hope for continuity of care. The lack of continuity of care—illustrated by the multiple vaginal exams the women received, each by a different clinician—fed into women's sense of disempowerment.

Though there is no denying that Mexico has extremely marginalized and disadvantaged populations whose children are particularly susceptible to illness and malnutrition, the described discourses place the onus of responsibility on the mothers and their mothering abilities. Thus the clinical setting can become the locus to re-socialize mothers and reshape them into compliant women and mothers. Contraception becomes a central tool in this process. In Estefanía's case, the "single mother [who didn't] want to cooperate," the clinicians had already classified her as unfit because of her age and marital status; these perceptions were compounded by her "non-compliance." Indigenous, marginalized, and low-income women in Mexico exist within a system of stratified reproduction—where certain populations are encouraged to reproduce while others are discouraged (Colen, 1995); their reproductive futures are only valued if they not only produce the acceptable low number of children but also if they are "good mothers" to those children.

Within the specific culture of the maternity services at HP the habitus of the physicians and patients was shaped by structures of poverty, funding issues, infrastructure deficiency, and marked

physician hierarchy. The physicians responded to this situation by intensifying their delivery of health into an assembly-line system of reproduction. Thus risk, and its control, became tangible and manageable. The reproductive habitus shaped how the physicians adapted to the structuring structures as well as how they used biomedicalization to mitigate risk. Reinforcing hierarchy through their actions, physicians encoded a set of control practices that were deeply embedded within the system. The result of this behavior became a patronizing commodification and objectification of the patients with whom they interacted with exasperated detachment. And, as Bourgois and Schonberg (2007) remind us, these everyday obstetric practices reproduce social inequity, simply reinforcing the larger social structures within which each of these groups of people (clinicians and women) exist outside of the hospital's walls. The clinicians were by and large middle class, with relative financial security, and access to material wealth. The women were overall low-income, often with little financial security, and having a marked dependence on the state for their welfare.

The physicians' interaction with the women was an emergent property of the larger habitus—they saw the mother's risk as a certainty. Doctor Reyes's digital dilation perfectly illustrates this structure. His concern for the woman and her needs appeared incidental to the birth outcome. In these births, risk was of immediate concern—the baby needed to be born as rapidly as possible. Yet the long-term health effects (and future reproductive risks) of techniques such as digital dilation or unnecessary cesareans on the mother were not factored into the physicians' decision-making.

Conclusion

The cases described in this article reflect many of the issues present in hospital birth about the relationship between women's bodies and the body politic. From the medical perspective, the women carry risk at all stages: through the prenatal period they might eat unhealthily or lack biomedical care; during labor and/or childbirth they might be non-compliant to the trained personnel, not use available technology, or be obstinate and difficult (endangering the baby's life); and postpartum if they continue to practice risky behavior (subsequent pregnancies, children by different men) then they simply reinforce the expectations held of them—that they are out of control and non-compliant reproducers.

Significantly for a country such as Mexico, a central element embedded in the creation of risk is class. The majority of the patients at HP are low income, while the clinicians for the most part are middle class. Ideas about knowledge, legitimacy, and responsibility are at play here. The women are classified as high-risk and problematic not solely because of real (and perceived) biologies, but because of who they are to begin with—impoverished, poorly educated, and likely to have many children. And yet policies aimed at addressing their risk are based on what Douglas (1990: 9) calls the innocent model of risk—which ignores both cultural biases and power contests that can shape decisions. Risk, as Fordyce and Maraesa (2012) remind us, is a messy concept irremovable from its cultural context. An approach such as the reproductive habitus, therefore, is a useful step to understand the larger structures that shape the behaviors of the various components of this system.

Denied agency at every turn, many of the women searched for ways to gain self-affirmation and achievement after their birth. They focused on the health of their newborn rather than the disempowerment and humiliations they experienced. Most of them, unable to ignore the structural violence done to them, simply hoped to forget their bad experiences and "vote with their feet" by choosing other options for future births.

As mentioned above, several programs (Oportunidades, Seguro Popular, and Arranque Parejo) have been developed in Mexico to address problems with women's health. While their aim is to provide monetary support and facilities for improving access to basic health (by subsidizing pre-conception/prenatal/postpartum health) and improving health outcomes, they have failed to alter the reproductive habitus. An increase in access for patients has not come with a parallel increase in infrastructure—leading to over-capacity situations experienced by HP. Bursting at the seams, the medical infrastructure is unable to keep up with the increased demand. In a way, such a situation reinforces the dominant perception of the poor: that there are too many of them and they have too many children. Ultimately, this compromises quality of care (Maternowska, 2006).

My work adds to the research on decision-making about birth across the globe (Berry, 2006; Brunson, 2010; Miller & Shriver, 2012), particularly how definitions of risk are politicized and deeply intertwined with their cultural context. While the underlying racial/class structure of Mexico would unlikely change, changes to Mexican health policy are necessary. Midwives should be professionalized and allowed to practice in medical settings. This would need to be accompanied by evidence-based clinical practice/education of physicians. As with any study, there are unavoidable limitations. It is not possible to state categorically that risk is associated solely with low-income women as the study was limited to one site. Further research is needed to explore comparative data from additional hospitals (public/private) to determine the presence or lack of medicalization and connection to risk across social classes. Additional research into the education of obstetricians is underway, and is expected to answer questions about the origins of perceptions of risk, medicalization, and decision-making.

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