

**“Patients
Without
Much
Culture”:
Physicians’
Characterizat
ions of
Indigenous
Women at a
Public
Mexican
Hospital**

by

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Abstract

While social scientists have observed decades of abuse towards marginalized women giving birth in public hospitals in Latin America, less examined is how physicians form negative beliefs about this patient population and how these perceptions shape clinical interactions. Based on three seasons of fieldwork, this paper utilizes the framework of intersectionality to explore the way in which social, cultural, institutional, and historical variables coalesce to shape derogatory clinical encounters at two public maternity hospitals in Southern Mexico. This paper argues that changes to Mexico’s public health care system, a profound history of race- and class-based discrimination, and local notions of morality regarding reproduction all uniquely interact to shape physicians’ relationships with patients. Ultimately, the interplay of these factors results in deeper disparities as the needs of patients are cast aside for those of health care institutions.

Biography

Kelly Colas, received a PhD in Anthropology from Michigan State University in December 2017 and graduated from the Michigan State College of Osteopathic Medicine in May 2019. She is now working to complete her residency in Internal Medicine at Georgetown University. She is the recipient of the 2018 Rita Gallin Award for Best Graduate Paper on Women and Gender in Global Perspective. Her research interests include medical decision making and women’s health disparities in Latin America. Her current research focuses on clinical decision making for labor and delivery in public hospitals with high rates of Cesarean Section in Southern Mexico.

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Introduction

It was a particularly busy day at Hospital General¹—a public maternity hospital in Merida, Mexico—as laboring women filled seven of the eight available beds in the birth ward, referred to as the “Toco.” As I observed the bustle of the birth ward, an intern tapped my arm. “Let’s go watch this birth!” she told me excitedly. As we neared the delivery room, I heard a series of loud screams that grew in intensity as we approached. Dr. Sofia, a third-year obstetrics and gynecology (Ob/Gyn) resident, was delivering the baby of a 16 year old patient. The room was incredibly crowded as two first-year residents, a few second-year residents, several nurses, and a handful of interns surrounded Dr. Sofia all facing the woman’s vagina. With beads of sweat trickling down her forehead, the patient moaned, “I can’t take this anymore. I really can’t do this.” Ignoring this comment, a first-year resident coached the patient to breathe through her mouth and to push with her next contraction. Without a word to the patient, Dr. Sofia began to perform an episiotomy, making a vaginal incision. “Doctor, why are you cutting me?!” the patient shrieked in pain. “Please stop!” “Ay, calm down,” Dr. Sofia responded without looking up. An intern commented to me that Dr. Sofia had injected the woman with lidocaine prior to the incision, as was standard for vaginal births at Hospital General. Several minutes later, Dr. Sofia delivered the baby. Exhausted, the patient laid silently on the bed as a first-year resident began to stitch up her episiotomy.

As the resident began to stitch, the interns and other residents that had come to watch the birth left the room. On our way back to the main area of the Toco, the intern commented to me, “They’re like that when they’re young... yelling, yelling, yelling. When they’re older, they’re more...” The intern made a serious face and breathed deeply.

“That patient is so young, just sixteen. But then she shouldn’t have gotten pregnant, you know?”

This vignette illustrates the tense interactions between physicians and patients that I observed over my three summers of fieldwork at Hospital General. I remember leaving Hospital General that day feeling deeply disturbed, questioning how these doctors could appear so indifferent to this patient’s suffering. Furthermore, I was struck by the intern’s comment implying this patient shouldn’t have become pregnant if she couldn’t endure this pain and treatment. My initial thought was that perhaps this situation was anomalous; maybe the physicians involved in this birth lacked empathy or were particularly harsh. Yet, I observed similar situations repeatedly throughout my three summers of fieldwork. As I came to know the physicians better, including Dr. Sofia and this intern, I found that they were far from heartless; they were genuinely kind people who truly wanted the best for their patients. Thus, I came to wonder how physicians become desensitized to patients’ pain. What systemic structures position these women from patients in need of care to a disruption to physicians? What social, political, and economic factors shape this behavior? Finally, why are patients in this system blamed for their circumstances?

This paper aims to explore these questions, examining a multiplicity of social, political, and cultural variables that influence physicians’ perspectives and subsequent treatment of patients. Through the lens of intersectionality theory, I argue that changes to Mexico’s public health care system, a deep history of race- and class-based discrimination, and local notions of morality regarding reproduction all uniquely interact to shape physicians’ relationships with patients.

Background

Intersectionality Theory as a Theoretical Framework

In analyzing the variety of factors that influence physicians' perspectives and actions towards patients, intersectionality theory provides a useful framework. Intersectionality theory contends that an individual's social location —variables such as gender, race, geographic location, economic status, and culture—distinctly influence an individual's perspective and subsequent behaviors. Intersectionality theory maintains that it is particularly important for researchers to understand the interplay of these dynamics in producing a unique experience or identity, or “the relationships among multiple dimensions and modalities of social relations and subject formations” (McCall 2005, 1771). Through exploring how subjects are formed through the lens of intersectionality, we can gain a greater understanding of how particular groups or individuals become “othered” or viewed as different.

Moral Regimes and Reproduction in Latin America

An important element to consider when applying intersectionality theory is the standard of morality within a given setting. Reproduction is a particularly salient area through which these ideas can be explored, as social scientists observe centuries of attempts by governments, religious organizations, and other groups to control and regulate reproduction (Ginsburg and Rapp 1991; Leavitt 1983). Morgan and Roberts (2012) contend that not all individuals in a given setting are equally encouraged to reproduce, positing that those in power hold individuals with different social and economic backgrounds to varying reproductive standards. They assert that such standards are enforced through utilizing “moral regimes,” defining moral regimes as “the privileged

standards of morality that are used to govern intimate behaviors, ethical judgments, and their public manifestations” (2012, 242). The authors contend that moral regimes must be examined within the specific historical context of a region, asserting that new rationalities are created for groups and individuals that are perceived to hamper the goals of the state (2012, 240-244). Giving the example of reproduction among Nicaraguan immigrants in Costa Rica, Morgan and Roberts note that studies have found health care professionals to view these immigrants as “irrational reproducers,” leading to a higher rate of tubal ligation among Nicaraguan immigrants (2012, 242).

Smith-Oka (2015) explores specific mechanisms through which such standards of morality are applied, finding that negative interactions between physicians and patients serve to condemn particular behaviors. She defines these interactions as “microaggressions,” describing these as “subtle insults and demeaning behavior typically aimed at people of color (or... “problematic others” in general) that reflect and enforce the perpetrators' perceptions of their superiority” (2015, 10). She contends that microaggressions between physicians and patients at a public maternity hospital in Puebla, Mexico took four different forms: microinsults (callous comments based on racist or prejudiced ideas), microassaults (negative verbal or non-verbal actions), microinvalidations (dismissing patients’ feelings or knowledge), and corporal microaggressions (derogatory physical interactions). Smith-Oka posits that microaggressions are a form of reproductive governance, as certain behaviors and decisions viewed as immoral or risky are punished through microaggressions. This framework is useful to understand how physicians at Hospital General and Hospital Pequeño interact with patients when they deem patients to be behaving irresponsibly or

against medical advice. Before I discuss how physicians at Hospital General and Hospital Pequeño create particular standards for patients, it is crucial to situate these physicians' within Latin America's history of race and class-based discrimination.

Mexico is an especially appropriate location to examine the concept of moral regimes, as scholars have observed centuries of discrimination against indigenous groups, particularly women (Castro and Erviti 2003; Mills 2010; Vega 2016). Gabriela Laveaga (2007) notes that in Mexico, poor, indigenous women were often the targets of governmental efforts to decrease reproduction. She writes that public campaigns in the second half of the twentieth century focused on changing particular behaviors seen as a hindrance to Mexico's attempts to modernize through decreasing population growth. She observes that these campaigns often applied stereotypes to indigenous people, casting the men as overbearing and macho, and the women as passive and docile. For example, Laveaga notes that one advertisement read, "She who is a true woman assumes responsibilities and takes decisions over her own life, her family and her reproductive activities. She who is passive fears responsibilities" (2007, 25). The women in such campaigns were often dressed in traditional indigenous clothing, thereby representing this passivity.

Birth control was a central topic in these portrayals, with the man represented as a dominating figure, forcibly pressuring the passive woman into having more children. Rural, impoverished individuals were particularly targeted in these campaigns. Laveaga notes one poster in which a woman was bent over with a child strapped to her back with a small bag of apples, reading "With such modest means, is it right to have so many children?" (2007, 25). As this campaign implies, controlling reproduction was an integral

component of becoming a responsible, modern citizen. Individuals already living in poverty who continued to reproduce were portrayed as a drain to national resources. Such messages illustrate the concept of moral regimes, as certain groups—in this case rural, poor individuals—are discouraged from reproducing.

As Laveaga underscores in her discussion, particular behaviors and characteristics are associated with individuals presumed to be of indigenous origin. It is critical to note that indigeniety in the context of Central and South America is not simply a racial categorization, but rather often re-inscribes social hierarchies through differences in culture between indigenous and *mestizo* individuals. Marisol de la Cadena (2000) observes how culture perpetuated racism in twentieth century Peru, as the “indigenous culture” was utilized as a proxy for rural, poor, and uneducated, whereas *mestizo* implied a person with education and economic agency. Cadena emphasizes that particular characteristics associated with culture, such as skin color or language, come to be seen as markers for larger behavioral and cognitive patterns.

Controlling reproduction continues to be at the forefront of Mexico’s national health agenda. From 2006-2012, the national Mexican Ministry of Health established three main goals regarding contraceptive use. These goals included increasing the use of contraceptives to 75% among women of reproductive age, to reduce the gap in contraceptive use between rural and urban populations by four percentage points, and for 70% of women to consent to a form of contraception at hospitals during the post-partum period (Secretaría de Salud 2008). As indigenous groups primarily live in rural regions, these guidelines are particularly directed towards decreasing the reproduction of these individuals (CONEVAL and SEDESOL 2015, 1). It is critical to consider how such

requirements might influence physicians' perceptions and behaviors towards women in public obstetric hospitals, given the history of reproductive discrimination against indigenous women in Mexico.

Health Care in Mexico

As low-income, indigenous women are largely the targets of governmental efforts to increase contraceptive use, public maternity hospitals serving these populations provide a particularly intriguing backdrop through which to examine how varying social, political, and cultural factors influence physicians' interactions with these patients. Mexico maintains a stratified system of health care, with private insurance for individuals willing to pay out of pocket, health insurance for the formally employed sector, and a form of public health insurance termed *Seguro Popular* for those that are unemployed or unable to afford private insurance. Created in 2004, the aim of *Seguro Popular* was to increase the number of insured individuals in Mexico, around 50% of the population in 2003 (Knaul et al. 2012). However, scholars have highlighted a number of issues with *Seguro Popular*, most notably that the misallocations of funds and weak infrastructure have led to overcrowded and underfunded public hospitals (Gakidou et al. 2006; Mills 2006; Puig et al. 2009). Physicians in the public hospital system experience a large patient volume; some sources estimate that public hospitals are regularly filled to two or three times their intended capacity (García 2015; Notimerica 2016). Additionally, researchers observe that the public Mexican hospital system has resulted in a notoriously poor quality of care for patients in public hospitals (Castro and Erviti 2003; Homedes and Ugalde 2009).

Maternity hospitals are particularly illustrative of the ramifications of the underfunded Mexican public hospital system. The number of women utilizing formal

health care institutions has surged within the last several years due to concerted efforts of Mexican government to expand the number of women giving birth with a physician (Gutiérrez et al. 2012, 107; Langer et al. 2012). This increase is particularly visible in the Yucatán. While 63.6% of births occurred with a skilled health attendant in formal health care institutions in the Yucatán in 1990, by 2014, that number rose to 94.9% (Luna, Muños, and Freyermuth 2015).

While the Mexican Ministry of Health had hoped that increasing hospitalized births would improve maternal health, scholars have detailed unintended consequences of the surge in hospitalized births in Latin America. First, similar to general public hospitals, the quality of services in public maternity hospitals has been observed to be notoriously poor, as public hospitals lack basic supplies and the capacity to manage a large number of patients (Ballinas 2009; Tamez González, and Eibenschutz 2008). In addition to a shortage of resources, social scientists have observed that blatant human rights abuses, typically against low-income women from rural areas, have occurred for decades in public Mexican hospitals, naming forced sterilizations, verbal abuse, and suboptimal care as a handful of examples of such abuse (Castro and Erviti 2003; D'Gregorio 2010; Sadler et al. 2016). Abuse between health care providers most frequently occurs in public hospitals, the location in which many indigenous individuals seek care. The Yucatán maintains the second highest population of indigenous individuals in Mexico, with over 29% of individuals over three years old speaking an indigenous language, primarily Mayan (INEGI 2015, 61-62). However, formal translators are incredibly rare in public hospitals, and janitors and family members are most frequently used as translators.

Given Mexico's profound history of discrimination—particularly against

indigenous women, —it remains essential to examine how physicians characterize this patient population, and how these opinions influence the subsequent treatment of patients. Through the framework of intersectionality, this paper will examine the multiplicity of factors, such as varying standards of morality and the constraints of the public hospital system that shape physicians' interactions with women, arguing that these dynamics ultimately result in microaggressions towards patients.

Methodology

The data for this paper was collected at two public hospitals, Hospital General and Hospital Pequeño, over three field seasons from 2014 to 2016 in Merida, Mexico, —the capital of the state of the Yucatán. The methodology for this project was primarily qualitative, consisting of participant observation and semi-structured interviews. I spent 108 hours observing in Hospital General and 58 hours observing in Hospital Pequeño, mostly shadowing physicians in the labor and delivery ward, but also spending substantial time in pre and post-natal consultations. I conducted twenty-four semi-structured interviews with physicians of varying training levels from these hospitals. The interviews lasted for an average of forty-five minutes, and consisted of questions regarding physicians' work experience at these hospitals, their medical training and background, and their perspectives regarding the patient population that they work with. Throughout my observations and interviews, physicians voiced their thoughts about the patient population with whom they work, often expressing frustration at patients they perceived to reproduce excessively.

**“We have patients here without much culture:” Women as Uncontrollable
Reproducers**

Physicians at Hospital General and Hospital Pequeño often described indigenous women as passive, particularly in the realm of family planning. This belief is poignantly illustrated in an interaction I had with Dr. Sofia, the third-year resident referenced in the vignette that opened this paper. In the labor and delivery ward during July 2015, I had asked Dr. Sofia a few questions about the patient population she works with. A couple of hours after our conversation, she approached me and asked if I was using photos in my study. I told her that that I might be using some pictures, without names or identifying information. “Well, I’ve got something for you then,” she responded. Dr. Sofia pulled up a picture on her phone of a consent form for a tubal ligation procedure. There was a line on the form that asked for the reason that the patient declined. A patient had written in this spot “Because I believe in Jesus Christ.” Dr. Sofia laughed, “This is what I was explaining to you earlier,” she said. She told me that she had another picture she wanted to show me but couldn’t find on her phone, in which a woman also declined a tubal ligation with the explanation, “Because my husband takes care of me.” “There’s so much *machismo* here,” Dr. Sofia sighed. Dr. Sofia saw these responses as being ridiculous to the point of comical; she felt these women justified their decisions with utterly irrational reasons. As Laveaga (2007) observed, Dr. Sofia views women as submissive to their husbands’ desires, finding these patients’ reasons for reproducing as illogical.

Dr. Sofia’s characterization of patients as uneducated and unwilling to stop reproducing was echoed in other physicians’ statements. When I asked Dr. Patricia, a first

year resident, if she felt that there were any special characteristics about the patient population at Hospital General that influenced the care she gives, she responded:

When they speak Mayan it's really difficult because we can't communicate with them. But also, we can't convince them to plan for their families... they have a false idea about what a tubal ligation is—they never want one. They'd prefer to have eight kids because they feel [getting a tubal ligation] is something bad.

Similar to Cadena's discussion of culture, Dr. Patricia constructs her idea of what indigenous culture means through several different markers. Dr. Patricia does not feel that all patients are unable to control their reproduction; she specifically connects this characteristic to patients who are Mayan-speaking. In her view, speaking Mayan stands for other aspects of culture, conceptualizing indigenous women as rampant reproducers. Dr. Patricia feels that Mayan-speaking women are inexplicably adverse to certain forms of contraception, instead preferring to continue to reproduce. As Morgan and Roberts (2012) noted, a moral regime is often apparent in understanding how reproductive behavior is regarded, as these moral standards frame certain behaviors as wrong or irresponsible. A moral regime is present in Dr. Patricia's remark, as she sees certain patients as ignorant and irrational. Thus, she creates a different standard for these patients: viewing a tubal ligation is an appropriate option for this population, preferable to continuing to have a large number of children.

Similar to Dr. Patricia's comment, several of the physicians responded to my question about special characteristics of the patient population by describing patients as having a "low level of culture." When I asked these physicians to clarify what a low level of culture meant, the response often involved the lack of family planning due to erroneous beliefs or lack of ambition. This idea is particularly salient in my interview with Dr. Isabella, a high-level administrator at Hospital Pequeño. When I asked Dr. Isabella if there

are any characteristics about the patient population at the hospital that affect the type of care that she's able to give, she responded, "The first thing is, we have patients here without very much culture... I think that's... one of the big limitations here." I then asked Dr. Isabella if she could explain to me what "patients without very much culture" meant.

She elaborated:

It means that 90% of women here who are pregnant didn't plan it.... It's not like other countries where first I assess my situation and say, "I'm ready now," or "I'm in the best situation to procreate." The woman from here—no. There's no empowerment with these women; that's also why there's a short period in between pregnancies here. Because they don't evaluate. There are no individual goals for a woman. Here, we're continuing to live within a culture where the more children a woman has, the more of a woman she is. She forgets about herself... and also the name of her oldest child who's taking care of her youngest, child number 13.

Dr. Isabella's statement reiterates Cadena's contention that culture includes a set of behaviors and beliefs that reinforce racism about a particular group, tying lack of control regarding reproduction to indigenous culture. Dr. Isabella sees patients' indigenous culture as a marker for irresponsibility and inability to family plan; she sees these patients as passively continuing to reproduce without goals. Her remark is imbued with moral rationales. She sees patients' lack of planning and assessment of their situations as reckless. Although she uses the tense of *nosotros* (we) in her statement, she sees herself as battling this ideology, thereby drawing a clear distinction between herself and these women. Implicit in her statement is her view that continuing to reproduce is detrimental for women that won't be able to care for the large number of children she presumes that they will have. Within the moral regime that Dr. Isabella practices, the responsible action would be for low-income women to limit their reproduction, yet she sees these women as defying this behavior by having more children.

Discipline for Excessive Reproduction

In addition to physicians expressing criticism towards women who they judged to be acting passively by not controlling their reproduction, during physicians' interactions with patients, I observed that physicians continually emphasized the importance of contraceptives to patients. When patients did not readily agree to contraceptive use, physicians utilized a number of microaggressions in their attempts to persuade women to use birth control.

Typically, a conversation regarding contraceptive use occurred after women gave birth. At Hospital General, patients were usually asked at least twice what contraceptive they plan on using (*Con que te vas a cuidar?*). Immediately after birth at Hospital General, women were wheeled into a room in the back of the labor and delivery ward, where they rested for several hours until space freed up on the second floor recovery room. Physicians rounded on these patients in the morning and evening, always asking during these times what contraceptive that patient planned to use after she left the hospital. Physicians yet again asked this question in the recovery ward on the second floor during rounds. At Hospital Pequeño, a general practitioner named Dr. Fabiola worked solely in family planning. Dr. Fabiola carried around a large cardboard poster, with various contraceptive items taped to it, asking patients at each bed what contraceptive they planned to use and then jotted down that patient's answer.

I learned quickly during observations in both settings that “none” was not an acceptable answer to the question *Con que te vas a cuidar?* (What kind of birth control will you use?). Patients classified as “high risk” —most commonly due to young age, pre-existing medical condition, adverse medical event during pregnancy or delivery, or a high

number of pregnancies, —were typically subject to additional scrutiny by physicians. Women who refused birth control were especially pressured by physicians to accept contraception. While physicians typically pointed to some form of medical risk as their initial reason for emphasizing contraception, ideas of patients as socially and economically risky often arose throughout the conversation. In the next section of this paper, I will present an example of an encounter that I observed on the recovery floor of Hospital General to illustrate this idea.

Microaggressions and Birth Control Use: “If I were you I’d never get pregnant again”

The following vignette is taken from my field notes from August 2016, describing my observations during patient rounds:

Dr. Juliana was leading rounds as the physicians examined an 18-year-old patient who had given birth to her first child the night before. I was told by an intern that this patient currently has high blood pressure and had a small seizure during labor. Draped in an oversized orange hospital gown, and looking far younger than 18, the patient appears to be bored in the recovery room; after all, there are no TVs, magazines, or books for patients to read during their stay. She looks down as the group of physicians arrives at her bedside, chipping away at her partially painted nails. “You had a really serious situation last night,” Dr. Juliana tells her, “What are you going to use for contraception?” The patient continues to look down and does not respond. “Listen, if I were you, I would never get pregnant again,” Dr. Juliana remarks, rubbing her own pregnant belly. “You’re high risk and you had a really serious situation. Women with your condition die. I would wait at least 5 years to get pregnant again,” she continues. The patient still does not look up or respond.

Dr. Juliana tells her that they will decrease her dosage of hypertension medications over the next day, and reassess if she is able to leave the hospital tomorrow.

The following day, I join Dr. Juliana and the residents on rounds. When we near her bed, the 18-year-old patient eagerly looks up at the group of physicians and asks in a hopeful tone “Can I leave yet?” Dr. Juliana asks her who is caring for her baby while she is in the hospital. “My husband,” the patient replies. “And what about when your husband goes back to work?” Dr. Juliana asks. “My mother-in-law will watch her then,” the patient answers. “What will your mother-in-law and husband do if you have another seizure?” asked Dr. Juliana. Dr. Valentina interjects, “Your baby is going to want a healthy mother.” “It was because of the pregnancy,” the patient murmured. Dr. Juliana and Dr. Valentina fervently exclaim in unison. “NOOOO!” Dr. Valentina asserts, “It was because you had hypertension and THEN got pregnant. If you sign a paper to leave the hospital against our advice and get sick again, *Seguro Popular* [the public health insurance] won’t cover it. Do you know how much that costs? It’s 20,000 pesos a night.” The patient remains silent and looks down at her hands. “If you won’t think of yourself then at least think of your baby,” Dr. Valentina scolds. We move on to the next bed.

The next day, I am present again as the physicians examine this patient. The physicians have determined that this patient will be able to leave today. Dr. Juliana holds up two bottles of medication to the patient. “Okay we’re going to send you home with these two medications. You have to return in a week. It’s your responsibility. You are responsible for your own health.” Dr. Juliana continues, switching to the subject of contraception. “What are you going to use for birth control?” she asks. “You can’t get pregnant for at least 3 years.” The patient looks away from Dr. Juliana, remaining silent.

Dr. Juliana carries on, “We can give you injections but the intrauterine device (IUD) would be ideal. The IUD lasts for 5 years and you get it checked every year at your local clinic to make sure it’s in place. Or we can do injections every two months.” She bends down to the patient and says, “It’s really important that you do so because you’re high risk and this could happen in your future pregnancies. You’re so young; you have to plan well.” Dr. Jimena, a first-year resident, sits on the edge of the patient’s bed and begins to talk to the patient about birth control. Several minutes later, Dr. Jimena says to the patient, “Ok, repeat back to me what I said and why it’s important.” The patient repeats Dr. Jimena’s statement about contraceptives, “I will receive injects for two months and then receive an IUD.” Dr. Jimena nods approvingly. “Injections it is,” Dr. Jimena announces triumphantly.

In this example, we can see several instances of “microaggression” as described by Smith-Oka (2015). There are verbal microaggressions through Dr. Juliana and Dr. Valentina’s interaction with this patient, as they dismiss this patient’s desires for her care. Additionally, Dr. Juliana makes the assumption that this patient will want to become pregnant again quickly, and scolds her for being so irresponsible. Later, Dr. Valentina describes a scary scenario to this patient in which she could be hospitalized for days, assuming that 20,000 pesos would be unimaginably expensive for this patient. Furthermore, Dr. Valentina’s reprimand that this patient should at least think of her baby implicates a standard of “good motherhood” for this patient, putting her baby above herself. During one of the few occasions that this patient spoke back to the physicians regarding her medical condition (her hypertension), Dr. Valentina and Dr. Juliana immediately invalidated her comment that the pregnancy was responsible for her seizure.

Such interactions fit Smith-Oka's (2015) description of microaggressions, as Dr. Valentina and Dr. Juliana continually invalidate this patient's thoughts and actions, implicating that her initial refusal of birth control is a reckless decision.

Viewing these physicians' behavior through the lens of intersectionality, we can see a multiplicity of factors that interact to shape physicians' actions, resulting in microaggression towards this patient. First, physicians' conceptualizations of patients must be understood amidst a history of prejudice towards indigenous groups, especially indigenous women. Morgan and Roberts' (2012) concept of a moral regime is particularly salient in Mexico, given decades of efforts by the federal government to reduce reproduction among low-income, indigenous women. Stereotypes of indigenous women as rampant reproducers are clear throughout physicians' statements, such as Dr. Patricia and Dr. Isabella's remarks expressing disbelief that patients did not regularly utilize birth control. Physicians viewed women at their hospitals as both irresponsible and unknowledgeable, unable to control their reproduction or care for their health. These statements and actions illustrate the larger moral regime that physicians practice within; they believe that low-income, indigenous women should limit their reproduction by readily agreeing to birth control.

It is also important to consider these physicians' positions as middle-class physicians in these encounters. For example, Dr. Valentina and Dr. Juliana are both from urban, middle-class families. Dr. Valentina was born and raised in Mexico City, working here for several years before relocating to Merida. Dr. Juliana is from a large city in Southern Mexico; her mother is an architect and her father is an engineer. Thus, the middle-class upbringing and lifestyle of these physicians may contribute to these

physicians' moral regimes, viewing patients who resist contraceptives as acting irrationally and as acting contrary to their own wellbeing.

Additionally, an inherent power divide exists between physicians and patients. Brigitte Jordan (1997) argues that physicians hold "authoritative knowledge": a form of knowledge that possesses greater significance in the clinical encounter. This inequality in power also aids in illuminating this patient's inability to refuse the pressure from Dr. Valentina and Dr. Juliana to accept birth control.

Finally, the stress experienced by physicians in the public hospital system, facing a large volume of patients with limited resources, also may contribute to physicians' views. Working over 90 hour weeks, physicians may place blame on patients rather than the social, political, and economic hierarchies that structure the public hospital system.

Within the context of the public hospital, these factors intersect, resulting in microaggressions towards women they perceive to be acting irresponsibly by declining contraceptives. Race, class, education, and work environment all mutually interact to produce the clinical encounter with Dr. Valentina and Dr. Juliana I described above, harshly reprimanding a patient for acting negligently towards her health.

Conclusion

Intersectionality theory asserts that a multiplicity of sociocultural, political, and economic factors create a distinctive experience for particular actors, thereby shaping that individual's views and actions. This framework is particularly useful in understanding the number of factors that result in physicians' microaggression towards patients.

It is critical to consider Mexico's history of discrimination against indigenous women within the broader discussion of indigenous culture. To the physicians in this

study, their view of patients' cultures included several different beliefs tied to patient characteristics. As Dr. Patricia comments elucidated, language was one marker of culture that was deeply tied to racial beliefs about indigenous women as incapable of controlling their reproduction. Other physicians, like Dr. Sofia, utilized other patient characteristics that they associated with indigeniety, like education level, as a proxy for culture. Dr. Sofia believed that indigenous women lacked education, leading to their subsequent behavior as irresponsibility with family planning. Such ideas are reflected in physicians' moral regimes, as they felt that indigenous women must conscientiously limit their reproduction, and thus must utilize birth control in order to be a responsible mother. Within this moral regime, physicians viewed women with large families as irrational and acting against their best interest.

It is important to also examine the discrepancy in power between patient and provider in considering physicians' interactions with patients, as physicians hold a greater amount of power in the clinical encounter. When these physicians perceived that patient were not following their advice, such as agreeing to birth control, they often reprimand patients with microaggressions. This power divide is also important in understanding why patients may not respond to physicians' microaggressions, as in the case of Dr. Juliana and Dr. Valentina.

Finally, examining the institutional context in which physicians work is essential to analyzing why microaggressions occur. The chaotic, underfunded Mexican public hospital may exacerbate physicians' stress and reinforce their beliefs about race and class. Working exhaustive hours with limited resources, the public hospital environment serves to perpetuate existing prejudices. Just as the public hospital dehumanizes physicians,

patients are reduced to objects to be moved along in an overcrowded and underfunded system. As physicians are unable to keep up with the unreasonable demands of the public hospital system, patients are blamed for being problematic. Compassionate care and individual patient needs become secondary, as physicians struggle with the day-to-day challenges in this environment.

This article lends insight as to how particular groups continue to remain socially, economically, and culturally marginalized. Like Smith-Oka (2015), I found that racism and class-based discrimination are reproduced within Mexican public hospitals, as middle-class physicians experience intense stress working within the underfunded public hospital system. Smith-Oka asserts that such discrimination materializes in the form of microaggressions: derogatory physical or verbal interactions with patients (2015). This article documents such mechanisms through which cultural stereotypes of indigenous groups, along with the public hospital system, perpetuate prejudice. When patients did not meet physicians' expectations that they should control their reproduction and cooperate, physicians frequently admonished patients through microaggressions.

This research adds to literature regarding the conceptualization of indigenous culture in Mexico. In this article, I have illustrated that physicians' ideas of culture is shaped both by historical processes and the environment of the chaotic labor and delivery ward. Managing a large number of patients with limited resources, racial tensions were often exacerbated in the setting of the stressful labor and delivery wards. For example, physicians' views that indigenous patients are unable to control their reproduction is not only shaped by racial stereotypes of indigenous women, but also their anxiety at caring for an overwhelming number of patients. Thus, it is imperative to turn a critical lens

towards the Mexican public health system, and to observe how policies encouraging births in formal health institutions impact the relationship between physician and patient and perpetuate racialized ideas. This article intends to question whether such policies truly serve the needs of patients and providers alike.

Gender, race, social, and institutional variables all dynamically interact to produce microaggressions towards patients. Physicians' positions within the medical system, their social standing as middle-class and educated, and the daily stresses they undergo working in the public hospital system, distinctly shapes their views of patients. In order to work towards a more humane birth experience, it is critical to understand physicians' perspectives and the subsequent behaviors within the specific sociocultural variables of a particular setting.

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Notes

1. All names of locations and participants in this study have been changed.

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