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

Vania Smith-Oka

Anthropology Department, 611 Flanner Hall, Notre Dame, IN 46556, United States

A R T I C L E I N F O

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A B S T R A C T

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.

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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

E-mail address: vsmithok@nd.edu.

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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

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