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Cultural Collisions and Maternal Health: Latina Women's Experiences with the Medical Institution and the Effects on the Chicana Consciousness

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Reproductive practices and policies that target women in the United States have a complex and often contradictory history. Social, medical, and technological practices and inventions have proven both beneficial and detrimental to women's choices and sense of agency within the health care system. Some of the most controversial reproductive policies that were debated nationally in the 20th century (and continue to be debated today) include the medicalization of childbirth and prenatal care, the development and widespread use of hormonal contraception, the legalization and access to safe abortion, and regulations surrounding both forced and elected sterilizations.

This project aims to focus on the authority given to physicians and the medical institution in the context of a larger patriarchal frame of thought, and how this authority silences the voices of specifically Chicana women by answering the following questions: How has medicalization constructed cultural views of health and responsibility? How does a lack of social and political power, in the context of racial, ethnic, and class inequalities, affect Chicana women's interactions with medical institutions? How have these experiences impacted a Chicana consciousness in younger generations of women of Mexican heritage?[1] To what extent does medicalization affect how younger generations of Chicana women identify their experiences with maternal health?

[1] The Chicana consciousness being discussed in this paper refers to the thought and experiences of the *New Mestiza* as discussed in Gloria Anzaldúa's *Borderlands/La Frontera* (1987).

Crossing Borders

In 1968, with promises of a prosperous future ahead, Angelina Morales and her husband decided to move their family three hours north from Mexicali, Mexico to San Bernardino, California. Angelina's husband had been working at a local grocery store for the past two years on a work visa in order to be able to immigrate the rest of his family. When they arrived, Angelina worked alongside her husband at the grocery store. They had six children when they immigrated and two more within the following two years.

After each child's birth, Angelina's husband would bring the younger children to the courtyard of the hospital so that they could see their mother and newest sibling at a nearby window. Both times nurses commented on the large size of Angelina's family peering in through the other side of the glass.

The two children Angelina had in the US were born in 1970 and in 1971. This was during the same time frame in which some of the 180 Mexican women in Los Angeles (just 50 minutes west) were coercively sterilized.

Angelina largely identified her femininity with her role as a mother. This role for her began in her late teen years when she found herself responsible for the well being of her ten younger siblings after the untimely deaths of both her parents.

Angelina's ideas about female identity and motherhood were very prevalent in the messages she passed down to her four daughters. When interviewing two of those daughters, Delia and Maribel, the most important of theses messages appeared to be that the number of children they produced should depend on the number of children their husbands desired. Her daughters saw this as something fundamental to their mother's marriage and family; and it was

this, they believe, that was the embodiment of a good wife and mother in their mother's perspective.

Traditionally, the identity of a woman in Mexican culture is associated with her ability to bare children and care for her family. Children for Mexican women have represented personal strength. However, according to physicians and lawmakers in the US, children of Chicana women in the US represent irresponsible decision-making. This view consequently led to the mass sterilization of Mexican American women during the 20th century. These sterilizations systematically targeted poor women of all backgrounds, yet as race and poverty became more narrowly associated with each other, albeit falsely, in the eyes of the law, women of color were particularly subjected to the loss of agency over their bodies and reproductive choices.

Regulation of all women's bodies exercised by predominantly male medical professionals began with the institutionalization of allopathic medicine. Dictating women's bodies is a practice rooted in theories of female subordination and transcendence of nature by culture, or women by men.

Of culture, of men

Throughout the 19th and 20th centuries, the restrictions and regulations placed on women's bodies by predominantly male representatives of medicine and of the law grew exponentially. While poor women, wealthy women, women of color, and white women have had varying experiences within the institution of medicine over the course of the past two centuries, the struggle for many women to attain ultimate authority over their own bodies within the medical establishment persists. Because the professionalization of medicine is arguably a cultural manifestation, I look to Sherry Ortner's theoretical analysis of the nature versus culture,

female versus male binary system (1996), of which, she suggests, female subordination is derived.

Ortner describes female subordination as a universal practice enforced by male dominated socio-cultural constructs. She claims that all cultures subordinate women because of an overall perception of women having an innate connection to nature (Ortner 1996). Nature, she defines, is that which regards the natural processes of life and death, the functioning of the human species. The male narrative states that women are innately connected to this process, as their bodies are able to bear children, and experience menstruation, two functions and processes that effectively connect their bodies to the physical processes in other species. Men on the other hand do not experience the exact types of changes in their bodies that coincide with nature and the process of reproduction in the same way.

Instead, men appear to function in the more artificial sector of society, working on the development of thought and technology – on the development of culture. Because culture can be controlled and continuously developed, it is perceived to "transcend" nature, as Ortner notes, it is *aimed* to transcend nature (Ortner 1996, 25). Consequently, men, as representatives of culture, must, as the male narrative suggests, transcend women, as representatives of nature, by subordinating them in the cultural processes.

Ortner's theory constructs an important lens through which to view medicalization and subsequent regulation of the female body. If we look at medicalization as a manifestation of culture, and culture as a manifestation of male thought and ideas, the conceptions of superiority that appear to be held by men and reinforced by medical professionals (predominantly male and white) become clearer. The idea that one group of people demonstrates development and progress more than others explains why men justify (though perhaps unconsciously) the control

they practice over women. This process reflects the relationships between male physicians and female patients' bodies.[2]

A male- dominated cultural narrative and construct of gender has resulted in significant transformations in the relationships between women and the institutions of law and medicine, most specifically. How has this narrative defined proper and deviant social behavior, and how has it justified the regulation of that behavior by physicians and lawmakers?

Doctor knows best

> *"The term medicalization refers to two interrelated processes. First, certain behaviors or conditions are given medical meaning – that is, defined in terms of health and illness. Second, medical practice becomes a vehicle for eliminating or controlling problematic experiences that are defined as deviant, for the purpose of securing adherence to social norms."* (Riessman 1983, 47-48)

The history of medicalization in the United States clearly demonstrates how physicians have attained the power to define illness and monopolize treatment while also constructing social thought and political discourse. As particular experiences are deemed healthy (good), while others unhealthy (bad), medicine has the power to define acceptable and unacceptable behavior, constructing social norms and defining power (Riessman 1983, 48). This power has ultimately led to the medicalization of many women's experiences, most specifically in terms of their choices in reproduction and sexuality.

The restrictions and regulations placed on women's bodies that developed throughout the 19th and 20th centuries in the United States are largely a result of the growing relationship between formally educated physicians, state representatives, and bourgeois men. According to Carroll Smith-Rosenberg's article on the abortion movement and the American Medical

[2] This is not to say that the medical institution has not exerted power on the bodies of men.

Association between 1850 and 1880, very important cultural shifts occurred that resulted in the criminalization of abortion and subsequent increase in authority of husbands, doctors, and political representatives over the bodies of women (1985).

From the rise of formally educated physicians came a movement to publicize and criminalize the once very accessible (for the bourgeois at least) and private practice of abortion. Adherence to the Hippocratic Oath and medical malpractice regulations that became mandated with the institutionalization of medicine prevented many physicians from competing with holistic health providers who abided by no such laws or regulations (Smith-Rosenberg 1985, 223-224). Those working in the allopathic field of medicine lost business to selective (arguably empowered) women who sought abortions that midwives and other holistic practitioners would willingly provide. Because of the economic threat midwives posed to the allopathic health field, well-known scholars of the medical profession began developing an argument against the practice of abortion, especially among the bourgeois, largely by creating two contrasting images of women.

While proper bourgeois culture connoted a husband who "lavished the accouterments of his wealth upon his wife and upon *her* home," the increasing literacy, acculturation, and thus, sophistication demonstrated by bourgeois women outside of the domestic sphere challenged the order of political power by challenging the "insistence that women's biology was women's destiny" (Smith-Rosenberg 1985, 224-225). Therefore, by using the growing power of the media at the time, physicians targeted the fears of bourgeois men by demonizing the "unnatural" aborting woman (Smith-Rosenberg 1985, 235). The rejection of motherhood primarily represented a woman's rejection of social order and refusal to resist the decreasing birth rate of favorable citizens. These women were labeled self-indulgent and irresponsible while women

who happily fulfilled their duties as mothers represented the favorable bourgeois matron, as well as social order as understood by men. (Smith-Rosenberg 1985)

The success in criminalizing abortion led to the growth in dependence on institutional medicine as the safety and health in holistic practices continued to be questioned by formally trained physicians. In hopes of monopolizing other aspects of women's reproductive health, physicians began to stigmatize midwifery, a female-led trade that emphasized a "social childbirth" experience with the assistance of mothers, sisters, and aunts (Riessman 1983, 51: Wertz and Wertz 1979). Physicians effectively took control of maternal health care by defining conditions of pregnancy and labor as medical problems in need of professional assistance, ultimately resulting in women's decrease in control over their maternal health practices (Schoen 2005).

Initially, mostly upper-middle class white women were convinced to utilize allopathic services, as professional medical treatment became an elite *privilege* of the wealthy. Working class and poor women were stigmatized as primitive for using midwives and enduring seemingly more painful births. However, the tools and anesthesia thought to minimize pain, as well as decrease maternal and infant mortality rates, in reality subjected women to greater suffering and less control during childbirth. (Riessman 1983)

In hospital births, women were removed from all their familiar elements and subjected to invasive technologies. This was especially true with the use of "twilight sleep," a pain relieving sedative created with morphine and scopolamine, a hallucinogenic concoction used frequently throughout the 1950s and 1960s that proved traumatic for many women who gave birth under its influence (Riessman 1983, 52).

Originally, hospitalized maternal health care practices were widely rejected by not only low-income immigrant populations holding on to cultural traditions and ideals that were being contradicted by their white middle and upper-middle class, American peers, but also by poor and working class white women. However, in light of the high infant mortality rate that was significantly higher among poor women, the Sheppard-Towner Maternity and Infancy Protection Act of 1917 was passed and essentially was utilized as a tool to normalize hospital births for populations for which mortality rates were exceptionally high, making it less elite (Mink 1995, 54).

Under the act, the process of this normalization actually began with the education and training of nurse midwives who reached out to low-income women, promoting the health and education of all mothers and mothers-to-be. However, the act directly focused on "less civilized" immigrant populations who traditionally preferred homebirths and other traditional methods of child bearing, encouraging trust in the medical establishment. The act also used young girls in school as a vehicle for instilling messages of healthy motherhood (as defined by the state) in them as well as their mothers, effectively Americanizing immigrant women (Mink 1995, 58).

The underlying desire to Americanize immigrant mothers is arguably connected to Sherry Ortner's (1996) gender binary by representing a transformation in the perception of a group of women who represent the *more* natural, or primitive, set against another group who represent culture, or social development. White middle class women began to be identified as closer to culture than nature. Their practices transcended the practices of low-income minority and immigrant women.

Today, hospital births and physician-attended maternal health practices have been normalized to the point that straying from the medical establishment is perceived as irresponsible. The effect of medicalization throughout the years is further evidenced by the remarkably high rates of cesarean sections in the United States. The average rate of cesarean sections in the United States in 2007 was 31.8% (Roth 2012, 207). Although women in all groups experience cesarean sections in high numbers, black and Latina women experience cesareans at an even higher rate even with similar conditions and complications as their white or more affluent peers. Supporters and representatives of institutional medicine argue that this is due to poor prenatal care and subsequent risk (in other words, inconsistent medical treatment, or perceived negligence), although others argue that the efficiency in time and cost is what influences most health providers to determine cesareans a better fit (Roth 2012). This proves particularly unfortunate for low-income women whose health coverage, if any, is much less flexible in the medical care that they receive.

Poor, undereducated, and minority women, although more likely to have C-sections, are less likely to have one under medically necessary means, while educated white women are more likely to have previously scheduled cesareans. Women of color are less likely to experience outcomes in maternal health that reflect their initial preferences than their white and affluent peers (Roth 2012). This speaks to the discrepancy in both class and race that women face in the institution of medicine. The perception of one group of women being more capable of making decisions for themselves prevails.

Throughout the history of medicalization, black and Latina women in the United States have experienced regulation in a very different way than their white peers. This discrepancy was derived from various ideals about "good" and responsible mothering. In the effort towards

creating a female population of "good mothers," a definition of "bad mothers" was implemented. "Bad" mothers were those who did not seem to participate in the normalized American methods of prenatal care, childbirth, or infant care, as well as those who were seen as not positively contributing to society. Just as during the development of the anti-abortion movement in the late 19th century, good mothers were white and middle class, while bad mothers continued to be those who were irresponsible and selfish, and in the case of the mid 20th century, poor women of color. Good mothers were married women who stayed home to care for their children, while bad mothers could not afford to do that, or were unmarried and the sole supporters of their family.

With the influx of Americans accessing public assistance in the 1960s as a result of President Lyndon B. Johnson's War on Poverty, the subsequent integration of African Americans into the predominantly white workforce, housing market, and educational system, and the rise in immigration of Latinos, public opinion of the poor underwent a dangerous transformation. Poverty became synonymous with non-white. Prior to this it was generally poor and working class white women, specifically, who were unmarried and with children who were viewed as "bad" mothers. Yet, the racialized lens through which many white Americans began to view those who benefitted from public assistance gave way to the new distinction between the so-called deserving and the undeserving poor. (Stern 2005) From this developed terms like "pregnant pilgrims" to describe Mexican immigrants, or "welfare queens" to describe African Americans – both terms directed at women with children, who were perceived as undeserving individuals irresponsibly reproducing at the expense of the public budget (Kluchin 2007, 133).

A report written in 1968 gives insight to the true demographics of the poor at the time. In 1964, nearly half of all American families with four or more children were poor. These families were three times more likely to live in poverty than those with three children or less. Contrary to

national opinion, however, of all women aged 18 to 44 living in poverty, 15% were on public assistance, and only 30% were non-white (Jaffe and Polgar 1968, 233-234). Solutions, as determined by the state, for reducing poverty were rooted in the idea that decreasing the number of poor children born to poor women would increase economic opportunity. The ability to limit the number of children was a power that many women across racial and class lines had already been seeking.

As public discourse began to encourage increased access to family planning services for low income Americans in order to reduce poverty and the use of public assistance, racialized perceptions of poor and minority women as incompetent parents prevailed. Expanding access to birth control entered the political discourse as a mechanism to reduce impoverished and dependent populations. However, increasing accessibility to family planning was opposed by some wealthy white critics who claimed that poor people, because of their culture and lack of education, would not use birth control, and that they neither had the desire nor the discipline to manage their own fertility. This belief was rooted in the stereotype that poor people could not understand their own problems and therefore could not effectively fix them. (Jaffe and Polgar 1968, 235)

The rise of race and class based perceptions of good and bad motherhood is in part rooted in the decrease in demand for large groups of African Americans and Latinas in the labor force. African American women's ability to control their reproduction has been limited in a variety of ways in US history. Prior to legislation that protected their rights in medical institutions, and prior to the eradication of slavery in its traditional forms, African American women's ability to reproduce served their white owners (Orleck 2005). More children meant a growth in their labor force. When a mass of black labor was no longer desired, African American women's

reproduction, as well as that of other women of color during the middle of the century represented the growth of an unskilled, unemployable population – a burden rather than benefit to the state and economy.

Though women of color's reproduction no longer served the state in the same way it did in the nineteenth century, women of color's reproduction (viewed as excessive in the twentieth century), was still a topic of policy discussions as images of the public budget being ransacked by poor women of color with countless children dominated the public imagination. This conception contributed to the definition of poor women of color as "unfit" mothers (Kluchin 2007, 133). This definition was also reminiscent of the terminology used earlier in the century to describe institutionalized women characterized as degenerate or imbeciles. The demonization of poor women of color as "unfit" mothers resulted in the forced and coerced sterilization of poor women by physicians (still predominantly male and white), just as white institutionalized, "unfit" women were also sterilized earlier in the century. Saving children from poor parents (by making sure they were never born) became the goal of many physicians and health clinics, a practice most often exercised through coercive methods.

The "saving" of children from their parents was achieved through the practice of sterilization. Acting out of "social responsibility," physicians took advantage of in-labor, sedated, and sometimes non-English speaking women, subjecting them to "tubal ligation," the severance (in most cases) and tying of the fallopian tubes (Kluchin 2007, 139). Complete informed consent was not obtained and most women were not notified of the permanence of the procedure unless they persistently questioned their providers. Signatures for consent were often garnered from women in distressed, drugged out states, or were not solicited at all. Often, doctors would claim that a tubal ligation was medically necessary when that really was not the

case, but avoided the need for consent all together (Carpio 2004). In some cases, patients described being threatened by physicians and other medical staff to consent to the procedure (Carpio 2004). Some women were told they would lose their public assistance or have to go to another hospital. The majority of these records show no clear reason for a physician to perform a tubal ligation (Kluchin 2007).

One well-known case that expresses the crude nature of forced sterilization, especially in the South, is that of the Relf sisters. Twelve-year-old Mary Alice Relf and her older sister, fourteen-year-old Minnie Lee Relf were victims of coercive sterilization by the federally funded Montgomery Health Clinic in Montgomery, Alabama (Roberts 2007). Deemed "mentally incompetent," the two girls were initially subjected to Depo Provera shots to impair their fertility, although there was no evidence of either of the girls' sexual activity (Nelson 2003, 66). After the use of the drug was discontinued due to potentially cancerous side effects, the girls were both unknowingly sterilized. Their poor, illiterate mother signed an "X" to give her consent, although the procedure was never explained to her (Nelson 2003, 66). The case, *Relf v. Weinberger* in 1973, led to legislation barring federal funds from being used to perform sterilizations without informed consent (Roberts 2007).

Women throughout the United States were subjected to coercive sterilizations. Indian Health Clinics all over the country practiced sterilizations, as did public hospitals in New York and California with a large Latina clientele. Rates of sterilization during the 1960s and 1970s were significantly higher for women who were non-white, poor, less educated, public service beneficiaries, illiterate, not married, and non-English speaking – a drastic change from the population of single poor and working class white mothers whose reproduction was previously limited by the government.

Another infamous case from 1973 in Los Angeles, *Madrigal v. Quilligan*, focused on the sterilization of 180 women at LA County Hospital at University of Southern California Medical Center (Schoen 2005). The women's stories were discovered by a lawyer who found that each had given birth while Dr. Edward James Quilligan was head of the Obstetrics and Gynecology department (Gutierrez 2008). They had each delivered their babies through emergency cesarean sections although the majority had no medical reason to do so. The cesarean sections allowed medical staff to take advantage of women already in the midst of an operation to perform tubal ligations. When interviewed about their subsequent sterilizations, many women who had signed consent forms had not understood the permanence of the procedure (Gutierrez 2008). They claimed that they were not aware that their "tubes" could not simply be "untied." Those women who had not signed consent forms for tubal ligations described not knowing anything about their sterilizations until inquiring about contraception in check-ups following the births of their children. When informed about the the details of the procedures and their infertility, they were shocked. (Kluchin 2007)

Dolores Madrigal's experience best exemplifies the ruthless persistence and outright lies that women were told. During labor, after rejecting recommendations for a tubal ligation, she was told that her husband had signed the consent form. However, this was not the case; her husband knew nothing about the procedure. Ultimately, *Madrigal v. Quilligan* was the case of 10 immigrant, monolingual Spanish-speaking, low income women who had been coercively sterilized (Kluchin 2007). The defendants were the LA County Medical Center, 12 doctors in the obstetrics department, and the United States Departments of Health and Welfare (Stern 2005). The women argued that their "civil and constitutional rights to bear children had been violated," "...they had been victims of unwanted operations," and "coerced into signing consent forms,"

just before or after their children's births (Stern 2005, 1134). In three cases there was no consent. In one, the woman was threatened; and in all cases the women had had cesarean sections. None of these women were on public assistance. (Stern 2005)

Although strong evidence was presented proving Dr. Quilligan targeted these women based on their income and race, including the testimony of a staff member who claimed that he was heard saying "...poor minority women in L.A. County were having too many babies; that it was a strain on society; and that it was good that they be sterilized," the women lost their case (Gutierrez 2008, 45). They did, however, instigate an important change in hospital protocol and government spending. Because of this and the Relf sisters' cases, legislation passed regulating federally funded sterilizations. Also, Spanish language consent forms had to be provided at a sixth grade reading level for monolingual Spanish-speaking patients (Gutierrez 2008). The media attention of *Madrigal v. Quilligan* also instigated social justice organizations, like the Mexican American Legal Defense Fund, to focus political attention on the rights of women to determine the number of children they had and to fight against sterilization abuse throughout the country (Gutierrez 2008). This case encouraged many African American, Native American, and Puerto Rican women to also come forward with similar testimonies of sterilization abuse (Stern 2005).

Sterilization differs from temporary fertility prevention and abortion and therefore is a unique procedure to examine as a tool of control of physicians over women's bodies. Though some methods of birth control can result in harmful and damaging effects on reproductive abilities, they are meant to be a temporary method of controlling fertility. Similarly, abortion, when executed safely, is a practice not meant to permanently alter the abilities of an individual to reproduce in the future. According to Planned Parenthood's resource page on methods of

contraception, women who are considering tubal ligation are only recommended to do so if they do not desire children in the future (plannedparenthood.org). The procedure is not meant to be temporary and can be very difficult and often impossible to reverse.

For Latina women specifically, whose identities as women are traditionally associated with their abilities to bear children, this violation robbed them of a fundamental aspect of their identity. Although all Latina women may not link their identities to their reproduction, the act of coercive sterilization, systematically executed by doctors is still an incredible violation of human rights, and an audacious statement of power targeting not only women's bodies, but their culture as well.

The practice of systematic sterilization of poor women of color was not without pretense. By the 1960s the medical establishment already had an extensive history of practicing eugenics. In this next section I examine the similarities in justifying coercive sterilization throughout the century and how these justifications are derived from a predominantly white male cultural narrative, or a greater patriarchal frame of thought.

Good and Bad Animals

To understand these forced sterilizations, it is important to review the history and foundation of the eugenics movement. In the early 1900s it became legal to "asexualize" a patient or inmate to improve "physical, mental, or moral conditions," thus leading to high rates of sterilization in prisons and mental asylums (Stern 2005, 1129). As a part of the eugenics movement, sterilization was performed in hopes of eliminating "bad" genetic traits. It was seen as a public health issue and as promoting the well being of the nation as a whole. In 1927 in the Supreme Court case, *Buck v. Bell,* which named involuntary sterilizations in institutions such as mental asylums and prisons constitutional, Justice Oliver Wendell Holmes related sterilization

without consent to mandatory vaccination for smallpox, claiming that public health overruled individual rights (Oswald 1930). He claimed:

> *"It is better for the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough."* (Stern 2005, 1130)

The language used to describe those who were to be sterilized is a crucial element in its justification by physicians and lawmakers who encouraged the procedures. "Imbeciles," "vagrants," and irresponsible women were among the undesirable producers. Legal representatives worked together with physicians in defining health and exercising authority over perceived ailed bodies for the good of the population.

Defining certain populations as less fit to procreate by reasons of poor mental capacity was also exemplified in immigration law. In 1924, those not permitted entrance into the United States included, but were not limited to, "...all idiots, imbeciles, feeble-minded persons...chronic alcoholics, paupers, professional beggars, vagrants...[and those] who are found to be and are certified by the examining surgeon as being mentally or physically defective, etc." (Oswald 1930, 67). These exclusions stemmed from the theories expressed by Herbert Spencer, that "To be a good animal is the first requisite to success in life, and to be a nation of good animals is the first condition to national prosperity" (Oswald 1930, 71). Thus, the eugenics movement is largely a manifestation of the desire for national prosperity by the means of Social Darwinism. Defining individuals as defective in their health or irresponsible in their finances as justification for the elimination of their presence in the population was perceived as a positive

endeavor towards the creation of a nation of "good animals." It is this understanding of certain groups as "unfit" that also led to the forced sterilizations of minority women just decades later.

The coercive sterilizations of Mexican, Native, black, and Puerto Rican women in the 1960s and 1970s was all too reminiscent of what happened just decades earlier to the mentally ill and "societal deviants" of the past. The same language of superiority was used to deem these women unable to make decisions about their own bodies and families. Similar paternalistic views of middle class white women were also expressed by the government and by physicians in the 1960s. While women of color were fighting for their right not to be sterilized, middle class white women were fighting hard for their right to be able to choose sterilization for themselves, or access various other means to limit the number of children they had (Rooks 2006). This is all part of the eugenic discourse and frame of thought that is rooted in Herbert Spencer's idea of national prosperity and "good animals." If poor women of color were producing bad "animals," then by default white women were at the heart of "good animal" production. In both cases, the paternalistic and racialized institution of medicine, supported by government legislation, made the decisions for women.

What drew me to this topic originally was the perception of Latina women, specifically, as "bad" or incompetent mothers, reproducing unfavorable citizens in the United States. This perception led me to question how the medicalization of specifically Mexican American women's bodies affected younger generations of Chicana women's interactions with the institution of medicine. How does this represent a type of "cultural collision" between these women's cultural identities and the perspectives of the institutions of medicine and law? How does this affect a Chicana consciousness as discussed in Chicana feminist theory?

Norteada por todas las voces que me hablan simultáneamente

(Dizzy from all voices that speak to me simultaneously)

Gloria Anzaldúa, the founder of Chicana feminist thought, bases much of her theory in the literal and figurative borders that people of Mexican heritage often cross in their migrations and how those migrations often result in cultural collisions. In *Borderlands/La Frontera* (1987), she discusses the identity and dilemma of the "*new mestiza,*" whose primary inner-conflict is rooted in the combination of Spanish colonial and colonized indigenous heritage. In addition to this conflict, those *mestizas* face additional dilemmas when becoming *norteños* (northerners – of the US), foreigners with status lost, during physical migration. Anzaldúa theorizes that the conflict and cultural transformation creates a "state of perpetual transition," which undermines the strength of the Chicano man, challenges the identity of the Chicana woman, and develops a detrimental relationship between the Chicana and the institution (Anzaldúa 1987, 100).

The concept of *el machismo* in Mexican culture originally referred to a man's ability to care for and support his family. The term as it is known today refers to the exercise of sexism and hyper-masculinity of Latino men onto Latina women. This, Anzaldúa argues, is not negated by American culture – it is a consequence of it. "The Anglo, feeling inadequate and inferior and powerless, displaces or transfers these feelings to the Chicano by shaming him." (Anzaldúa 1987, 105) Language barriers and poverty prevent the Chicano man from embodying the true meaning of *machismo*, as it becomes more difficult for him to provide for his family. Subsequently, "...the Chicano suffers from excessive humility and self-effacement, shame of self and self deprecation," which ultimately leads him to displace his feelings, his aggressions, on to the Chicana woman (Anzaldúa 1987, 105).

While the Chicana woman learns to deal with these contradictions, a tolerance for ambiguity grows inside of her. She not only continues to struggle with her Indian heritage in her Mexican culture, but also must learn, "...to be Mexican from an Anglo point of view." (Anzaldúa 1987, 101) And it is this cultural collision that can prove the most threatening to her identity as a woman. The Chicano man's newfound inferiority results in the inferiority of the Chicana, effectively silencing her in the family unit. Because this subordination stems from white American exertion of superiority, the oppression applied to the Chicana woman is unique compared to that of her male peers. Her subordination in the home is multiplied in the mostly male and white dominated institutions of government and medicine that silence her further.

In the medical institution, Chicana women have been systematically silenced. Although all women have been subjected to a powerlessness, intentional or not, in the medical setting in the United States, Chicana women's subordination is important because of the underlying cultural collision that takes place. Chicana women are constantly receiving contradictory messages about who they are and who they should be as it relates to their gender and culture. Chicana women associate the size of their families with their identities as women within Mexican culture – fertility is arguably a source of empowerment. However, the institutions of law and medicine in the US challenge this identity by robbing Chicana women of their fertility – exercising their own source of empowerment.

This narrative compelled me to seek the voices of Chicana women whose mother and grandmother was part of the generation of women sterilized in the US. I interviewed four women from Angelina's family – two of her daughters, Delia and Maribel, and two of her granddaughters, Alicia and Lorena. I asked them about two very important aspects of their experiences, their interactions within the medical institution during their prenatal visits and

births, and their identities as mothers and how it might be connected to the ideas of motherhood that their mother or grandmother may have instilled in them.

Four Voices, Three Generations

Delia

Being able to have children was so fundamental to womanhood and the preservation of marriage that when Angelina's daughter, Delia, decided that she wanted to be sterilized at the end of her second pregnancy in 1993, her decision created tension in their relationship. Her mother's primary concern was twofold. First, Delia had only two girls, and according to her mother, every man needed at least one son. Secondly, although her husband may have been in agreement with her decision to be sterilized at the moment, in time he would change his mind, and her inability to produce more children would be detrimental to her marriage and family. "If you can't give him kids," her mother told her, "he will find someone who will."

When I interviewed Delia, she talked about her decision to depart from her mother's ideas of a woman's role in the family, her decision to embody a new kind of motherhood. Her decision to be sterilized stemmed from having grown up in a large family in which the oldest and youngest siblings were 20 years apart. She and her husband felt that a small family would be both economically and physically healthier for them in the future. Sterilization would eliminate the need for birth control, as well as the possibility of an unintended pregnancy.

Both Delia and her husband were willing to be sterilized. However, they decided that if their expected child's birth resulted in a cesarean section, Delia would go ahead and have the procedure. In the last months of her pregnancy, Delia ended up scheduling a cesarean section after her doctor explained to her that she would only have a 50% chance of having a natural birth. During the operation she was sterilized.

Her chance of having a natural birth was lower than normal because her first daughter's birth had ended in a cesarean section. After 14 hours in labor and only two centimeters of dilation, labor was induced. Subsequently, the baby stopped moving and had to be delivered surgically – the umbilical cord had been wrapped around her neck.

Despite her two cesarean sections, Delia stated that she felt that she had a rather strong sense of agency throughout her prenatal care, births, and sterilization. She had private medical insurance and was financially stable during both pregnancies and births and described having a very positive relationship with her doctor.

Maribel

I also interviewed Maribel, a 42-year-old mother of three, and the youngest of Angelina's children. In her early twenties she had begun working as a clerk for the state. She met her husband through this job. As both were covered medically, Maribel was able to have "double coverage" during her first pregnancy in 1997. According to Maribel, she had excellent service throughout her prenatal care.

After extensive reading about birthing methods and weighing the risks, when Maribel entered the hospital in labor she had every intention of having a natural birth. However, after several hours of labor with little dilation, the medical staff tending to her suggested that she "not suffer" any longer. After repeated resistance, Maribel remembers, exhaustion and annoyance swayed her. She was then injected with both labor inducing and pain relieving medications and promptly fell asleep. Shortly after, she was awakened by her doctor who explained that the baby's heart rate was dangerously irregular and that a cesarean was highly recommended. Although she had been adamantly against having a cesarean section she remembers that in her

groggy state she had glanced over at her crying sister and mother in-law and complied with the doctor's recommendation out of fear.

Frustrated with her compliance with medical staff's persistent recommendation to be medicated, she was determined to have a natural birth with her second child's delivery in 2000. However, after 19 hours of labor three weeks before her due date, her doctor explained to her the risk of infection and injected her with penicillin. Out of fear for the baby's health and pressure from medical staff, Maribel consented to another cesarean section. She claimed that her doctor made her feel that "waiting it out" a little longer would be "selfish on my part."

Reflecting on the circumstances that resulted in her previous two cesareans, Maribel decided to schedule a C-section for the delivery of her third child in 2004. She also decided that this would be her last child. Like her older sister, Delia, Maribel wanted to get sterilized. Medically covered by her government job, she was notified that she would have to attend "an informative class" prior to her sterilization. When she attended, she was told that the surgery would only be approved after a 72-hour waiting period. Her due date was in two days.

Maribel was not sterilized as a direct result of this regulation. Her husband, however, was – after attending an "informative class" for men 72 hours before the procedure. Unlike with Delia and her husband's decision to restrict the growth of their family, Maribel's decision did not stir controversy with her mother. In fact, Angelina thought it was fantastic that Maribel's husband would take it upon himself to be sterilized.

Lorena

Next, I interviewed Angelina's 24-year-old granddaughter, Lorena. Lorena has 3 children. During her first pregnancy, she had no health insurance. She did not apply for public assistance because the baby's father was fearful that he would then be mandated to pay child

support. She had her baby at a local county hospital and still owes $10,000 in medical bills. Following the birth, however, Lorena applied for Medi-Cal and was covered during her following two pregnancies.

During all her pregnancies, Lorena intended to have natural births, specifically, vaginal births. She was not opposed to pain relieving medication, but was very adamant about not having a cesarean section.

Her first and second children's births were uncomplicated. She elected to have an epidural during each of them, but during the second, the pain relief had worn off by the time she had given birth. With her last child she had entered the hospital with very high blood pressure, which badly affected the baby's health. She was given the choice to have labor induced or to have a cesarean section. She felt pressure to have a C-section, and out of fear, consented to the procedure.

Lorena claimed that with the exclusion of her last child, she felt that the decisions she made during the births of her children were hers alone and that medical staff respected those decisions.

Alicia

The last interview I had was with one of Angelina's older granddaughters, 38 year old Alicia. When Alicia was younger she had no medical insurance and used Planned Parenthood and other clinics for reproductive health services. During the time of her pregnancy in 2000 she was working for a company that offered her medical coverage.

As soon as she knew she was pregnant, Alicia decided that a natural, medication-free birth is what she wanted for herself and for her baby. Her grandmother and mother both had natural births -- she would too. However, after intense labor pains medical staff began

encouraging her to stop "putting [her]self through so much pain". After a few hours, she gave in to the pressure. She was injected with labor inducing and pain relieving medication and felt very drowsy. She slept for almost 6 hours. When she awoke, the pain medicine had worn off and she was fully dilated. She felt that the nurses "just wanted to shut [her] up" during labor.

Alicia has had just one child, and although she has no plans to have another, she did express her desire to seek alternative birthing resources as her insurance plan might allow, if she ever were to have another child. She was the only one of the interviewees who felt that her desires were blatantly disrespected during her child's birth and that physicians took advantage of her exhaustion at 17 hours of labor in order to speed up the process for their benefit instead of hers and her baby's. She is also the only one of the interviewees who suggested that her treatment was attributed to her identity as a woman of Mexican descent.

It is this connection between cultural identity and institutional experiences that I expected to learn more about in this project. I thought that because the low income, Mexican mother and grandmother of the interviewees had given birth in the US during the same time that other low income Mexican women were being sterilized without informed consent, and that their narratives would reflect that history in a more obvious way. As the women -- specifically Angelina's two daughters -- talked about the differences in their identities as women in the context of Mexican culture, I did see evidence of their connections to this history of medicalization and coercion, but they did not acknowledge it in the same way that Alicia did, for example.

Conclusions

Alicia is the only who said that her identity as a Latina, as a Chicana woman, resulted in treatment that intentionally disrespected her desires during the birth of her child. Maribel was the

only other interviewee to recognize the pressures of the institution that influenced her decisions, though she saw this as unrelated to her race and ethnicity.

I find this to be anomalous as low-income women of color struggle to access a variety of health care options within the professional institution of medicine. Because the holistic health field is seldom supported by insurance companies and public assistance (the ultimate achievement of physicians who worked to criminalize abortion in the 1800s?), all women, but especially low-income women today must depend on the allopathic institution to treat them. However, even when granted access to allopathic medical institutions, through either public assistance or private insurance, low-income women of color continue to be given less agency than their more affluent white peers.

None of the women I interviewed had their babies the way they had originally planned. All of them were either first or second generation Mexican Americans. When beginning this project I expected to find numerous anecdotes from the women I would interview in order to help further the arguments that I have laid out. However, I have found that I have stumbled onto a topic much more complex than I had imagined. I cannot simply state that first, second, and third generation Mexican American women, subjected to the practices of institutions constructed by predominantly white men, have clearly affected the Chicana consciousness that Anzaldúa discusses. There does not appear to be a linear trajectory to achieve that argument.

Perhaps this represents another "cultural collision" that Anzaldúa might have suggested is merely another component of the *new mestiza* identity, or maybe it reflects a new identity that Chicana women have embodied – one that has established a new relationship between the Chicana, her culture(s), and her body, especially in terms of reproduction and motherhood. Delia and Maribel, for example, felt a sense of agency in the hospital during the births of their children.

They also felt a sense of agency in their respective families and arguably in their cultures as well. Unlike their mother, Delia and Maribel do not define their femininity with motherhood. In fact, while their mother's peers may have been forcibly and coercively sterilized during the years that they were born, compromising their identity as women in the context of Mexican culture, they chose sterilization for their families, demonstrating empowerment over their own bodies.

When Delia and Maribel decided that they did not want to have any more children, the concerns of their mother largely surrounded the perspectives of their husbands. Angelina strongly objected Delia's sterilization because she was fearful that her husband would desire more children later and Delia would not be able to have them; she would not be able to fulfill her role as a woman. Yet when Maribel's husband was sterilized, Angelina was in support of that decision because it did not alter her daughter's fertility. This challenges the idea that motherhood defines femininity for Mexican women, suggesting that female identity in Mexican culture is much more complexly constructed as well. It also suggests that Delia and Maribel's decisions to sterilize do not necessarily reflect a rejection of their culture but another aspect of this "perpetual state of transition."

Perhaps Delia and Maribel's decisions to control their fertility are evidence of the types of cultural collisions that Anzaldúa discusses. Perhaps Delia and Maribel have embodied a new, *new mestiza,* and have found a balance between voicing their preferences within the institution and within their culture. Nevertheless, they have redefined the cultural context in which they were raised, expanding the definition of femininity and motherhood and the Chicana identity, as well as *el machismo*, creating a new set of borders and a new cultural route for their daughters to take.

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