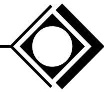
INTRODUCTION

The Darker and the Lighter Sides of Biomedical Maternity Care

Moving from Obstetric Violence, Disrespect, and Abuse to the Humanization and Decolonization of Birth

Robbie Davis-Floyd and Ashish Premkumar



This is the Introduction to Volume III of the three-part series *The Anthropology of Obstetrics and Obstetricians: The Practice, Maintenance, and Reproduction of a Biomedical Profession*, edited by reproductive anthropologist Robbie Davis-Floyd and by perinatologist and medical anthropologist Ashish Premkumar. The three volumes in this series are:

- Volume I. *Obstetricians Speak: On Training, Practice, Fear, and Transformation* (Davis-Floyd and Premkumar 2023a);
- Volume II. *Cognition, Risk, and Responsibility in Obstetrics: Anthropological Analyses and Critiques of Obstetricians' Practices* (Davis-Floyd and Premkumar 2023b);
- Volume III. *Obstetric Violence and Systemic Disparities: Can Obstetrics Be Humanized and Decolonized?* (Davis-Floyd and Premkumar 2023c).

An overview of the entire series (Premkumar and Davis-Floyd 2023d), which lays out its primary concepts and theoretical frameworks and provides an overview of each volume, can be found at the beginning of Volume I. This Introduction to Volume III mostly constitutes an overview of the chapters in this present volume, which focus on both the dark and the lighter sides of biomedical maternity care. The dark side is of course the obstetric disrespect, violence, and abuse that permeate much

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

of maternity care globally. Jenna Murray de López (2018:61) has defined *obstetric violence* as "a specific form of violence against women that violates their reproductive health rights and results in physical or psychological harm during pregnancy, birth or puerperium," explaining that obstetric violence can include: "scolding, taunts, irony, insults, threats, humiliation, manipulation of information and denial of treatment; pain management during childbirth used a punishment; and coercion to obtain 'consent' for invasive procedures; and even acts of deliberate harm."

Part 1 of this book focuses on those darker topics. (The middle, shades-of-grey aspects of biomedical maternity care are addressed in multiple ways in Volume II of this series [Davis-Floyd and Premkumar 2023b]). Part 2 focuses on the lighter side of biomedical maternity care, which consists of the efforts being made, from both within and outside of the obstetric profession, to humanize and decolonize the biomedical treatment of birth. Part 3 takes a different tack: it consists of only one chapter, which presents the ethnographic challenges faced by our chapter authors in finding, surveying, interviewing, and observing obstetricians. We note here that the chapters in Parts 1 and 2 of this volume are based on ethnographic research conducted in Canada, the Dominican Republic, Mexico, Peru, the United States, the UK, Russia and other former Soviet countries, Turkey, South Africa, and Aotearoa New Zealand. We divide our overview of these chapters into the three Parts into which this book is organized.

Yet since some of these chapters utilize Robbie Davis-Floyd's (2001, 2018, 2022) delineations of "the technocratic, humanistic, and holistic paradigms of birth and health care" (described more fully in our Series Overview at the beginning of Volume I), we first present a brief overview of these paradigms, just as we did in the Introduction to our second volume. We also offer a brief overview of "the 4 Stages of Cognition" and "Substage," which Robbie describes in full in her Volume II chapter (Davis-Floyd 2023), and which are utilized in some of the chapters in this present volume. And we summarize the findings of an important article on which some of the chapters in this volume draw: "Obstetric Iatrogenesis in the United States: The Spectrum of Unintentional Harm, Disrespect, Violence, and Abuse" (Liese et al. 2021).

The Technocratic, Humanistic, and Holistic Paradigms of Birth and Health Care

The hegemonic technocratic model, based on the *principle of separation*—of mind and body, practitioner and patient—metaphorizes the

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

human body as a machine, teaches practitioners to objectify their patients and their disorders, and relies on multiple technologies to manage, surveil, control, and intervene in the (usually) normal physiology of birth. This over-management and over-intervention exemplify the *obstetric paradox*: intervene in birth to keep it safe, thereby causing harm (Cheyney and Davis-Floyd 2019:8). These authors (Cheyney and Davis-Floyd 2020a, 2020b) have also argued for the replacement of TMTS (too much too soon) and TLTL (too little too late) forms of care (see Miller et al. 2016) with RARTRW care—the right amount at the right time *in the right way*—for *how* care is provided matters as much or more than what kind of care is provided and when.

The humanistic model, toward which many maternity care providers strive, is based on the *principle of connection*—the connections of mind to body, person to person. The humanistic paradigm heavily emphasizes this "right way," for it defines the body as what it is: an organism that responds well to kind and compassionate treatment, and poorly and defensively to what this organism perceives as unkind and hurtful treatment. A turtle retreats into its shell when threatened; a laboring woman can retreat into the "shell" of "learned helplessness" (Seligman 1972) when mistreated, in which she accepts that she is powerless, cognitively shuts down, and literally *learns to be helpless* when her agency and protagonism are completely denied and she sees no other option. This can easily result in severe, long-lasting trauma and postpartum depression (see Davis-Floyd 2022) as some of the chapters in this volume show.

Robbie (Davis-Floyd 2018, 2022) has been careful to distinguish between *superficial humanism*, in which compassionate treatment, including allowing the presence of a partner or doula, is just an overlay on multiple technocratic interventions in labor and birth, and *deep humanism*, in which the "deep physiology" (Davis-Floyd 2018, 2022) of birth is understood, honored, and facilitated. Because the differences between "superficial" and "deep" humanism are so essential to understand, Robbie (Davis-Floyd 2022) now considers that the paradigmatic spectrum should read: "technocratic—superficially humanistic—deeply humanistic—holistic." All childbearers want at least superficially humanistic treatment—they want to be treated kindly and with respect (see Davis-Floyd et al. 2009). Only some want deeply humanistic treatment, as many want epidurals, the administration of which de facto interferes with the physiologic processes of labor and birth (Davis-Floyd 2022).

On the "radical fringe" of this spectrum lies the holistic model, in which the body is defined as more than an organism but rather as an en-

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

ergy system in constant interaction with all other energy systems around it. This holistic model is based on the *principles of connection and integration*—of mind, body, and spirit; of "client" (a much more egalitarian word than "patient") and practitioner. Under this model, unlike in the other two, spirit and energy are brought into play, for example by having the parent(s) "call the spirit" of an unresponsive baby (before or while the practitioner performs neonatal resuscitation) to ask the baby's spirit to choose to come into its body, as many midwives (and some neonatologists) do, and/or by following the holistic maxim "Change the energy, change the outcome," which can mean keeping what Brazilian obstetrician Ricardo Jones (2009) has called the *psychosphere* of birth clear and clean, perhaps by asking people with fear-filled "negative energy" to leave the birthing room.

The 4 Stages of Cognition and "Substage"

In her chapter in Volume II, "Open and Closed Knowledge Systems, the 4 Stages of Cognition, and the Obstetric Management of Birth," Robbie (Davis-Floyd 2023) describes Stage 1, "closed" thinking in three categories: (1) naïve realism ("Our way is the only way, or the only way that matters"); (2) fundamentalism ("Our way is the only right way"); and (3) fanaticism ("Our way is so right that all who do not accept it should be assimilated or eliminated"). She codes Stage 2 thinkers as ethnocentrists ("Other ways are ok for others but our way is best"); and Stage 3 thinkers as cultural relativists ("All ways have value and human behavior should be understood within its sociocultural context"). She then codes Stage 4 thinkers as global humanists ("There must be higher, better ways that honor human rights, even when that goes against the sociocultural grain"), and describes some of the ongoing battles between Stage 1 fundamentalists and fanatics and Stage 4 global humanists, who are anathemas to each other. She goes on to show how many obstetricians are Stage 1 thinkers, often denigrating and persecuting Stage 4 humanistic obstetric practitioners who practice outside of the obstetric silo. She also describes "Substage"—a condition of cognitive regression, or "losing it," in which it is very easy for practitioners to take out their frustrations and stresses by mistreating or abusing others, most especially laboring people. And she describes how ritual can "stand as a barrier between cognition and chaos" by helping practitioners get out of Substage and cognitively stabilize themselves (see Table 0.1).

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

Table 0.1. The Stages of Cognition and Their Anthropological Equivalents. © Robbie Davis-Floyd and Charles D. Laughlin. This Table originally appeared in *The Power of Ritual* (2016), on which Charlie and Robbie hold the copyright, so we reprint it here with their permission. This Table also appears in the recently abridged version of that book, called *Ritual: What It Is, How It Works, and Why* (Davis-Floyd and Laughlin 2022).

Stages of Cognition	Anthropological Equivalents
Stage 4: Fluid, open thinking	**Global humanism**: All individuals have rights that should be honored, not violated.
Stage 3: Relative, open thinking	**Cultural relativism**: All ways have value; individual behavior should be understood within its sociocultural context.
Stage 2: Self- and culture-centered semi-closed thinking	**Ethnocentrism**: Other ways may be OK for others, but our way is best.
Stage 1: Rigid/concrete closed thinking, intolerance of other ways of thinking	**Naïve realism**: Our way is the only way, or the only way that matters; **Fundamentalism**: Our is way is the only *right* way; **Fanaticism**: Our way is so right that all others should be assimilated or eliminated.
Substage: Non-thinking; inability to process information; lack or loss of compassion for others	**Cognitive regression**: Intense egocentrism, irritability, inability to cope, burnout, breakdown, hysteria, panic, "losing it," abusing or mistreating others.

Obstetric Iatrogenesis: The Spectrum of Unintentional Harm, Disrespect, Violence, and Abuse

The article sharing the name of this section (Liese et al. 2021), on which some of the chapters in this volume draw, was written by practicing midwives Kylea Liese, Karie Stewart, and Melissa Cheyney, and was co-authored by medical/reproductive anthropologist Robbie Davis-Floyd. (We had originally planned to include that article in updated form as a chapter in this book, but were unable to obtain permission to do so; thus we summarize it here.) Taking off from Ivan Illich's (1976) term "medical iatrogenesis," and following Amali Lokugamage's (2011) original usage of the term *obstetric iatrogenesis,* these authors explore obstetric iatrogenesis along a spectrum that they acronymize as UHDVA.

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

This spectrum begins with the unintentional harm (UH) caused by interventions considered routine but are nevertheless harmful in that they interfere with the normal physiologic process of birth, exemplifying the "obstetric paradox" mentioned above (intervene to keep birth safe, thereby causing harm). This iatrogenic spectrum continues on to more intentional forms of disrespect, violence, and abuse (DVA), which can include utilizing demeaning words toward, yelling at, and even hitting the laboring person. This article also assesses how obstetric iatrogenesis disproportionately impacts Black, Indigenous, and People of Color (BIPOC), contributing to worse perinatal outcomes for BIPOC childbearers. Much of the work on obstetric violence that documents the most detrimental ends (violence and abuse) of the UHDVA spectrum has focused on low-to-middle income countries in Latin America and the Caribbean (see for examples Chapters 1, 2, and 5 of this volume). This article shows that significant UHDVA also occurs in high-income countries such as the United States.

One of this article's primary examples of the UHDVA spectrum is cervical exams during labor, which are often unnecessarily performed. The authors (Liese et al. 2021:5) state:

> The majority of U.S. births (69%) take place in teaching hospitals that train resident physicians (Fingar et al. 2018). Thus, much of the obstetric system is organized to facilitate physician education. Since cervical exams are a learned manual skill crucial to obstetrics, medical students and obstetric residents are encouraged to practice on patients . . . Cervical exams—which should be performed only when knowing the cervical dilation can impact care, such as before administering medications or at the patient's request—range from uncomfortable to excruciating . . . The pain is exacerbated when performed during contractions and/or on women with histories of sexual abuse; some childbearers experience or equate them to a form of rape . . . The practice moves from unnecessary to aggressive when exams are performed without provider introduction, consent, explanation, or heeding a patient's direct instruction to stop. Those who try to push the provider's hand away or yell "STOP!" may be responded to in ways disturbingly akin to the language used by rape perpetrators: "You're okay" and "I'm almost done."

Ashish Premkumar, maternal-fetal medicine specialist, co-editor of this volume and of this Book Series, and co-author of this Introduction, adds:

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

> I distinctly remember having a woman come up from our triage bay who was completely dilated and pushing, unanesthetized. She was nulliparous [a first-time mother], and as such was getting the hang of pushing and was also dealing with the fact that she was rapidly progressing through the second stage of labor. She was actively trying to not be on her back as she had an uncontrollable urge to push constantly, given how low the baby's head was in her pelvis. The charge nurse in the room kept yelling at her to not push in between contractions and became visibly angry when she would grunt and continue to bear down.
>
> I tried to pull the charge nurse aside to tell her that this was going to be uncontrollable, and that she should just let her push in any way that she felt comfortable doing so. The bedside nurse tried to auscultate heart tones with the electronic fetal monitor and noted that the fetal heart tones were low. Prior to getting a maternal pulse (which is standard to ensure that you're not picking up the maternal heart rate), the charge nurse immediately began to yell and snap at the patient, telling her to "get it together and PUSH." I began to raise my voice—something we do in emergency situations to have one clinician lead a situation where multiple voices might cause more disarray—and announced that she was already +3 and would have the baby in a matter of seconds. Sure enough, she had the baby, which came out crying and went right on mom! The fact that people lost it [went into Substage] because she was nulliparous, pushing uncontrollably, and that we couldn't really get heart tones despite her being five seconds from delivery, was completely unacceptable. This, sadly, is not the only time I've seen this scenario.

Premkumar's example, among many others (see Davis-Floyd 2022), shows that not only obstetricians (obs) but also labor and delivery nurses can be Stage 1 perpetrators of obstetric DVA.

Addressing other verbal forms of DVA, Liese et al. (2021:6) state:

> In our experiences, the language used by obstetricians to convince/coerce consent from patients ranges from subtly to overtly abusive, with BIPOC and gender non-binary childbearers being especially affected . . . Most egregiously, pregnant mothers can be threatened with endangering the lives of their babies if they don't accept the doctor's advice. This tactic is observed in both in emergency and non-emergency situations, and pits the mother against her unborn

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

baby, supporting a narrative of "good" motherhood in which the mother's needs are subservient to the child's.

For Robbie's revision and update of her first book, *Birth as an American Rite of Passage* (1992, 2003, 2022), Robbie, her colleague Melissa (Missy) Cheyney, and Missy's graduate students conducted interviews with 65 childbearers who had given birth since the year 2000. Here is a narrative from that dataset that exemplifies the UHDVA spectrum, in which Cate (a pseudonym), a white, heterosexual, cis-gendered women, describes:

> About six days past my due date, my water broke, and when I went into the hospital, I was only a fingertip dilated and my doctor was not on call—the other doctor came in and checked me—he didn't tell me his name—and he turned to the nurse and said, "Prep her, we're going to cut it out." I said, "Hold it, hold it—you're not doing anything until you tell me what is going on here." He said, "You're not dilating, you need a c-section." I said, "That will be fine as long as you can write down a medical reason why I need a section."

Knowing that, according to that hospital's protocols, she had 24 hours to deliver after her waters had broken, Cate "laid there all day" with the doctor repeatedly coming in to demand that she have a cesarean "because you need one." Just as repeatedly, Cate's response was the same. Later she found out that she was the only laboring patient in the maternity ward that day; apparently her ob just wanted to get her birth over with so that he could go home. (Of course doctors have lives too, but it is highly unethical to try to force an unnecessary cesarean on an unwilling laboring person.) Once Cate's labor picked up, she had the support of helpful nurses who kept saying "You're doing fine, the baby's fine, everything's fine," and of her Lamaze teacher Fran, who was acting as her doula, and she enjoyed her labor process when the obstetrician wasn't present. She said, "As long as I knew everything was fine, I could last forever." But:

> [the obstetrician] was very nasty. He would come in, send my husband out, check me, yell at me because I wasn't doing what he told me to do. He made my husband sign a form saying that we would take full responsibility for the death of my child. "You know," he said, "you're killing this baby because you won't have a section." I said, "I'll have one if you tell me why." He said, "Just because I say you need one," and I said, "That's not good enough."

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

> When she was born [at 5:36 a.m.], he cut a radical [unnecessarily large] episiotomy when her head was only 13 inches . . . and he didn't even say "It's a girl or it's a boy, it's a dog, it's a cat" . . . And he stitched me up with nothing. I kept telling him I could feel everything he was doing, and he kept saying "No, you can't feel that, you're crazy." I knew he did it just for spite. It was very enjoyable when he wasn't there, but he would come in and check me during a contraction and scare me to death . . . as soon as he would leave the room, my body would involuntarily tremble all over.

Cate's story, which also appears in *Birth as an American Rite of Passage* (Davis-Floyd 2022),

> illustrates many forms of UHDVA, including laboring in the supine position, verbal coercion and abuse, and physical violence via the unnecessary extensive episiotomy and stitching without local anesthetic. Cate stated that she was empowered to achieve a vaginal birth despite that doctor's demands because Fran was at her side, squeezing her hand while the doctor yelled at her, and her nurses were kind and supportive. Her positionality and social capital likely also facilitated her ability to resist. (Liese et al. 2021:8).

Citing various studies, Liese, Davis-Floyd, Stewart, and Cheyney (2021) state that "*The psychological cost to childbearers of overt DVA is high*" (italics in original). Interlocutors from Davis-Floyd's and Cheyney's dataset who had been subjected to such forms of DVA described themselves as deeply traumatized by their birth experiences. Like Cate, many suffered from postpartum depression and/or PTSD (as illustrated in Davis-Floyd 2022).

Having described the "technocratic—superficially humanistic—deeply humanistic—holistic" paradigms of birth and health care, the 4 Stages of Cognition and "Substage," and the UHDVA spectrum as background and context for the chapters in this book, we turn now to an overview of both Parts—the darker and the lighter—of this present volume.

Part 1. Obstetric Violence and Systemic Racial, Ethnic, Gendered, and Socio-Structural Disparities in Obstetricians' Practices

Chapter 1, co-authored by anthropologists Annie Preaux and Arachu Castro, provides an ethnographic account of obstetricians and the de-

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

livery of obstetric violence in the Dominican Republic. Arachu Castro and Virginia Savage (2018) have documented obstetric violence in public hospitals in the Dominican Republic; however, little has been known about this issue from the perspectives of obstetricians and of other hospital personnel. Thus Preaux and Castro conducted in-depth interviews with 97 obstetrician/gynecologists, attending physicians, residents, nurses, and administrative personnel in three public maternity hospitals in the Dominican Republic. These interviews addressed healthcare providers' perspectives on the concept of obstetric violence and their justifications for why it occurs. The interviews also included providers' reactions to past cases of maternal mortality in the Dominican Republic and their associations with obstetric violence. Through these interviews, Preaux and Castro saw how healthcare system constraints and long-standing traditions of discrimination based on gender, class, and race can both foment providers' acts of obstetric violence and serve as their justifications for women's complaints, complications, and sometimes even deaths. While some obstetricians and other personnel recognize and work against healthcare system limitations and ingrained biases that lead to obstetric violence, some deny any problems, and others use the limitations of the country's healthcare system to justify or rationalize their own harmful actions or those of their colleagues.

More "woman-blaming" is described in Chapter 2, "'Bad Pelvises': Mexican Obstetrics and the Re-Affirmation of Race in Labor and Delivery," in which anthropologist Sarah A. Williams links the historical development of gynecology and obstetrics in Mexico to contemporary patterns of cesarean overuse. In so doing, Williams unwinds racial myths about the smallness and inadequacies of Mexican women's pelvises and their inability to birth vaginally—myths that continue to influence Mexican obstetric decision-making. First, Williams traces the emergence of pelvimetry and gynecology in mid-1800s Mexico as a form of "race science," harnessed in service of the creation of a Mexican national identity predicated on a project of *mestizo* (mostly people of mixed Spanish and Indigenous descent) race-making and Indigenous erasure. Building on this historical analysis, Williams uses ethnographic data from fieldwork in the Yucatán peninsula to connect these race-making obstetric practices to the "hallmarks" of obstetric violence by both obstetricians and midwives in Mexico today—the routine use of techniques of obstetric management that manifest in burgeoning rates of cesareans and episiotomies and the continued use of "pelvimetric practices" (measuring the pelvis and usually concluding that it is "too small" for vaginal birth). As Williams's ethnographic research shows, obstetricians continue to draw on implicit and, at times, explicit theories of "race science" to justify

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

often unnecessary birth interventions and to uphold normative racialized framings of maternal comportment, which this chapter describes.

In Chapter 3, sociologist Lauren Diamond-Brown points out that there are many accounts of obstetric violence, disrespect, and abuse in the United States, but we do not understand *obstetricians' perspectives* on why these events occur. In this chapter, Lauren seeks to understand obstetricians' thinking about the role of patients in birth and to shed light on the motivations of some obs for rejecting patient autonomy in labor and delivery. Lauren's chapter draws on in-depth interviews with 50 US obstetricians about decision-making in birth; she divides these interlocutors into Groups 1 and 2, which are close to equal in numbers. Group 1 members reject patient autonomy, often in the form of complete disregard of the wishes that childbearers express in their birth plans, whereas the members of Group 2 respect and support patient protagonism, welcome birth plans, and do their best to support the desires expressed in those plans. About these Group 2 interlocutors, Diamond-Brown notes that "scholars have focused on biomedical training as the primary agent of professional socialization for physicians, while missing the opportunity to examine *resocialization* throughout doctors' careers." The Group 2 ob interlocutors said that they "practice like a midwife"—meaning that they practice the humanistic and holistic midwifery model of care. Diamond-Brown found that for some, this was their training—showing what a difference the type of training can make in forming obstetric ideologies—whereas for others, it was exposure to a more humanistic model of birth later in their careers, often via watching midwives practice. (See also Davis-Floyd's [2023] chapter in Volume II of this series.)

Focusing primarily on the ob interlocutors in Group 1, Diamond-Brown explores three dominant gender tropes that these Group 1 interlocutors used to police "good patient" status: (1) women as control freaks; (2) women as misinformed; (3) and women as selfish. She analyzes these gendered tropes through a feminist lens and suggests that sexism and "misogyny" (broadly defined) continue to underpin obstetricians' interpretations of their patients—even when the obstetricians are female—and especially underpin her Group 1 ob interlocutors' approaches to dealing with self-advocating patients.

In Chapter 4, anthropologist Genevieve Ritchie-Ewing investigates "Implicit Racial Bias in Obstetrics: How US Obstetricians View and Treat Pregnant Women of Color." She begins by noting that persistent racism in US obstetric practices creates barriers to safe, quality health care for many pregnant women. As the vast majority of US women still receive prenatal and postnatal care from obstetricians, rather than from mid-

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

wives, improving the relationships between pregnant Women of Color and their obstetricians is vital to empowering these women in making health-related decisions. In addition, as Ritchie-Ewing shows, the lack of quality prenatal care for minority women is one of the main reasons why the United States has extensive racial disparities in pregnancy and birth outcomes such as preterm birth and low birthweight rates. While much recent research explores the experiences of pregnant and laboring US Women of Color, no studies thus far have examined how obstetricians practicing in the United States view and react to their patients of various racial and ethnic backgrounds. Through an online survey and in-depth virtual interviews, Ritchie-Ewing investigates the racial and ethnic biases among obstetricians working in diverse biomedical settings, most of whom were unwilling to admit racial bias, preferring to talk in terms of "socioeconomic status" instead. She argues that recognizing how obstetricians view and treat childbearers of Color both subtly and overtly is essential to developing strategies for eliminating bias and increasing equality in healthcare interactions.

In Chapter 5, on "Censusing the Quechua: Peruvian State *Obstetras* in Light of Historic Sterilizations, Contemporary Accusations, and Biopolitical Statecraft Obligations," medical anthropologist Rebecca Irons begins by noting that, despite evidence that a Malthusian government health policy was to blame, individual healthcare workers, and particularly obstetricians, are increasingly being demonized in the ongoing case of Peru's more than 300,000 forced sterilizations of the 1990s—many of which were among the Quechua, an Indigenous group. Even before this blame, as Irons explains, the Peruvian profession of *obstetricia* (obstetrics) was in a position of precarity: it was, and remains, highly gendered, so female *obstetras* (obstetricians), who, unusually, are not allowed to perform cesareans, are subjugated to the authority of majority-male obstetrician/gynecologists and surgeons. Irons argues that while *obstetras* played a significant role in the condemnable forced sterilizations, even today the underlying push for "quota filling"—strongly recommending contraceptive use—as a condition of employment encourages similar coercive behaviors that seek to limit poor and Indigenous reproduction. Thus Irons suggests that a key role of Peruvian *obstetras* is to census and discipline the Indigenous Quechua population as a form of stratified biopolitical statecraft, resulting in health worker dissatisfaction, patient neglect, and obstetric violence. Only through exploring this situation from the perspective of the *obstetras* themselves does Irons find it possible to effectively understand how and why structural violence is perpetuated at a local level.

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

Part 2. Decolonizing and Humanizing Obstetric Training and Practice? Obstetricians, Midwives, and Their Battles against "the System"

Having exposed and sought to explain obstetrics' darkest aspects in this Introduction and in Part 1, in Part 2 our chapters turn toward positive efforts to decolonize and humanize obstetricians' practices via intentional changes in biomedical education and improved, more collegial relationships with midwives and the (humanistic/holistic) midwifery model of care, and with doulas and perinatal psychologists. These chapters in Part 2 address the struggles that this turn to decolonization and humanization often entail.

Chapter 6, by Amali Lokugamage, Tharanika Ahillan, and S. D. C. Pathberiya, addresses the crucial topic of *decolonizing medical education*, with a focus on that process in the UK. These authors begin by noting that the legacies of colonial rule have permeated into all aspects of life in multiple countries and have heavily contributed to healthcare inequities. They go on to explain that, in response to the increased interest in social justice, biomedical educators in the UK are thinking of ways to decolonize obstetric education—in other words, to replace its top-down colonialist hierarchy and produce obstetricians who can meet the complex needs of diverse populations. The authors investigate the implications of recentering displaced Indigenous healing systems and of *medical pluralism*, highlighting the concepts of "unconscious bias," "cultural competence," "cultural humility," and "Cultural Safety" in biomedical training. As Lokugamage, Ahillan, and Pathberiya describe, from a global health perspective, climate change debates and associated civil protests resonate with Indigenous ideas of "*planetary health*," which focus on the harmonious interconnections of the planet, the environment, and human beings. Additionally, these authors look at implications for clinical practice, addressing the background of inequality in health care among the BAME (Black, Asian, and minority ethnic) populations of the UK and an increasing recognition of the role of intergenerational trauma originating from the legacy of slavery. By analyzing these theories and conversations that challenge the biomedical view of health, the authors conclude that encouraging healthcare educators and professionals to adopt a "*decolonizing attitude*" can address the complex power imbalances in health care and further improve person-centered, humanistic care.

In Chapter 7, on "Teaching Humanistic and Holistic Obstetrics: Triumphs and Failures," Beverley Chalmers, a psychologist, sociologist, and childbirth expert, explains that after decades of work striving to-

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

ward the integration of humanistic and holistic approaches into perinatal care alongside technological advances, the progress that has been made in this area is both significant and woefully insufficient. Varying approaches to obstetric education have resulted in both triumphs and failures in Chalmer's attempts to train obstetricians to provide optimal care. Her chapter describes some of the educational models she has used in her training efforts in Russia and in other post-Soviet countries, presents theories for why obstetricians continue to provide the least respectful care of any other maternal healthcare providers, and describes which models offer optimal paths to follow. She details these optimal models and addresses the challenges of assessing the effectiveness of such teaching models in terms of implementing humanistic and holistic approaches to perinatal caregiving.

Chapter 8, "The Inconsistent Path of Russian Obstetricians to the Humanization of Childbirth in Post-Soviet Russian Maternity Care," describes the current situation in Russian obstetric care, almost 20 years after Chalmers' teaching and collaborative efforts in that country. The authors, anthropologist Anna Ozhiganova and sociologist Anna Temkina, consider the professional logics and strategies of Russian obstetricians. They conceptualize the post-Soviet system of maternity care as a "hybrid" of the legacy of Soviet bureaucratic paternalism and neoliberal reforms, which enhance managerialism and marketization in biomedical settings. On the one hand, from Soviet times to the present, the logics of bureaucratic control continue to play a decisive role in the Russian maternity care system. Russian obstetricians are not attributed the same power and autonomy as their counterparts in Western societies, and thus their knowledge often does not count as fully authoritative; biomedical professional organizations do not have much influence; and the economic interests of doctors are largely ignored. On the other hand, due to the maternity care reforms carried out during the post-Soviet period, partly as a result of Chalmer's work, the practice of "soft" or "natural" childbirth and the honoring of the post-birth "golden hour" are becoming more widespread.

Temkina and Ozhiganova show that in Russia, State and market demands often contradict each other, necessitating special efforts from obstetricians to cope with both inconsistent regulations and the growth of childbearing women's consumer needs and complaints. Based on extensive ethnographic research and in-depth interviews with obstetricians, the authors explain this hybridization and the forces that created it, and place particular focus on the special invisible mechanism of "personal hands-on care," which is meant to compensate for the rigid and inflexible regulation in the limited space of Russian obstetricians' professional

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

autonomy. Ozhiganova and Temkina also describe and analyze the ways in which Russian obs have tried to fight the government's bureaucratic and paternalistic system of maternity care by engaging with doulas and cooperating with homebirth midwives—informally, because homebirth midwifery practice is illegal in Russia. The authors demonstrate how, through personal and professional efforts, some obstetricians "reimagine" the normative authoritative knowledge in favor of more humanistic care.

In Chapter 9, based on 32 interviews with Brazilian obstetricians who have made paradigm shifts from technocratic to humanistic, and sometimes holistic, practices, Robbie Davis-Floyd and Eugenia (Nia) Georges describe the "pivot points" for these paradigm shifts, explicate their processes, and detail their effects—both positive and negative—as these effects often involved professional ostracism and persecution, along with much greater satisfaction and pride in their work, and extremely satisfied and grateful clients. These 32 obs and their like-minded colleagues call themselves "the good guys and girls," as opposed to the "bad" obs who perform far too many cesareans (56% nationwide). Some of these good guys and girls had cesarean rates of 7%–10%, as they primarily attended the home births of women who were "10,000% committed" to "natural childbirth." Others who attended the births of anyone who came to them had higher rates, ranging from 13% to 30%, as they believe that all women—even those who want to schedule an elective cesarean—are entitled to the kind of care they provide. Robbie and Nia also highlight a particular Brazilian hospital—Hospital Sofia Feldman—as an exemplar of humanistic practice. And they describe the efforts of these "good guys and girls" to support professional midwives, who are few in Brazil while obs are many, and to effect humanistic policy changes in their respective institutions, which many of them have managed to do with high degrees of success.

Chapter 10 takes us to Aotearoa New Zealand (ANZ). ("Aotearoa" is the Māori—the Indigenous people—name for this country. Placing "Aotearoa" before "New Zealand" signifies recognition of Māori settlement long before British colonization.) In this chapter, ANZ anthropologist Rea Daellenbach, midwives Lorna Davies and Melanie Welfare, neonatal pediatrician Maggie Meeks, and obstetricians Coleen Caldwell and Judy Ormandy address interprofessional education for both medical and midwifery students. They begin by explaining that in Aotearoa New Zealand, community midwives are the primary providers of maternity care, chosen as such by 94% of ANZ childbearers and giving continuity of care to women and families throughout pregnancy, birth, and up to six weeks postnatally. If needed, midwives refer clients to obstetricians.

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

Midwives also work in hospitals, providing support for community midwives and working as part of the maternity care team. Thus, interprofessional collaboration is a key aspect of ANZ maternity services, and failure by midwives and obstetricians to effectively communicate leads to poorer outcomes for women and babies.

In an effort to aid interprofessional collaboration, a multidisciplinary team organized a project involving final-year midwifery and medical students who were planning to choose obstetrics as their specialty, in which they had the opportunity to learn about each other's roles and about perinatal interprofessional collaboration by participating in emergency simulation scenarios. The discussions among the students in these workshops demonstrated how widespread and ingrained are some negative views of each other's professions. Developing a good model for interprofessional education for midwifery and obstetric students highlights how important it is to ensure that each profession has familiarity with the professional skills and roles of others to negotiate, cooperate, and advocate as a team for the best possible outcomes, as this chapter describes.

In Chapter 11, obstetrician Deborah McNabb explores "The Changing Face of Obstetric Practice in the United States as the Percent of Women in the Specialty Has Grown." Her belief when she finished residency training in the 1990s was that increasing numbers of women in the field of obstetrics and gynecology would lead to better reproductive health care for women. She notes that those in training at a time when female faculty in obstetrics were uncommon and when women were just starting to enter ob/gyn residency programs in larger numbers too often followed the male obstetrician paradigm by maintaining some distance in the patient-provider relations, speaking with authoritative voices, and being "tougher than tough" to prove that they could be just as good as the men. In this chapter, through interviews with female obstetric faculty members who have been in those positions for the last 30 years, McNabb explores the question of whether or not female obstetricians have, over the decades, developed their own practice models, hoping that the field may have become less authoritarian and more patient-centered. She notes in her chapter Conclusion that:

> The three biggest contributions that I think female obstetricians have made, and continue to make, to women's health care are women-modeled empathy, strong communication skills, and patient-centered behavior—all of which have now become the standard of care . . . Though it has taken decades to make this progress, I believe that female physicians' contributions to obstetrics and gynecology

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

have been remarkable and deserve to be fostered, supported, and valued.

Part 3. The Ethnographic Challenges of Gaining Access to Obstetricians for Surveys, Interviews, and Observations

In Chapter 12—the only chapter in Part 3—we present descriptions provided to us (via emails) from the chapter authors of Volumes II (Davis-Floyd and Premkumar 2023b) and III (this present volume) of this series of the challenges they faced in finding, surveying, interviewing, and observing obstetricians. (We don't present descriptions of such challenges from the authors of Volume I, because they are all obstetricians [see Davis-Floyd and Premkumar 2023a.]) These challenges are multiple and complex; thus we often use these authors' own words to describe them. We also describe the equally complex and often clever ways in which these researchers managed to overcome many of these challenges.

In our Conclusions to this volume, we present some of the theoretical concepts and frameworks that our chapter authors found most helpful and primary lessons learned, and in our Series Conclusions, we present some reflections on the entire three-volume series, yet primarily focus on the suggestions for future research provided by ourselves and many of our chapter authors—one of which is included in Robbie's bio below.

Robbie Davis-Floyd, Adjunct Professor, Department of Anthropology, Rice University, Houston, Fellow of the Society for Applied Anthropology, and Senior Advisor to the Council on Anthropology and Reproduction, is a cultural/medical/reproductive anthropologist interested in transformational models of maternity care. She is also a Board member of the International MotherBaby Childbirth Organization (IMBCO), in which capacity she helped to wordsmith the *International Childbirth Initiative: 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care* (www.ICIchildbirth.org). The ICI has been translated into more than 30 languages and has been implemented in more than 70 birth facilities, small and large, around the world, showing that transformative change is indeed possible. Researchers are needed to study the processes and effects of ICI implementation; if you are interested, please contact Robbie. E-mail: davis-floyd@outlook.com.

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

Ashish Premkumar is an Assistant Professor of Obstetrics and Gynecology at the Pritzker School of Medicine at The University of Chicago and a doctoral candidate in the Department of Anthropology at The Graduate School at Northwestern University. He is a practicing maternal-fetal medicine subspecialist. His research focus is on the intersections of the social sciences and obstetric practices, particularly surrounding the issues of risk, stigma, and quality of health care during the perinatal opioid use disorder epidemic of the 21st century. E-mail: premkumara@bsd.uchicago.edu.

References

Castro A, Savage V. 2019. "Obstetric Violence as Reproductive Governance in the Dominican Republic." *Medical Anthropology* 38(2): 123–136.

Cheyney M, Davis-Floyd R. 2019. "Birth as Culturally Marked and Shaped." In *Birth in Eight Cultures*, eds. Davis-Floyd R, Cheyney M, 1–16. Long Grove, Il: Waveland Press.

———. 2020a. "Birth and the Big Bad Wolf: A Biocultural, Co-Evolutionary Perspective, Part I." *International Journal of Childbirth* 09(4): 177–192.

———. 2020b "Birth and the Big Bad Wolf: A Biocultural, Co-Evolutionary Perspective, Part II." *International Journal of Childbirth* 10(2): 66–78.

Davis-Floyd R. 2001. "The Technocratic, Humanistic, and Holistic Paradigms of Childbirth." *International Journal of Gynecology & Obstetrics* 75, Supplement No. 1: S5–S23.

———. (1992) 2003. *Birth as an American Rite of Passage*, 2nd ed. Berkeley: University of California Press.

———. 2018. "The Technocratic, Humanistic, and Holistic Paradigms of Birth and Health Care." In *Ways of Knowing about Birth: Mothers, Midwives, Medicine, and Birth Activism*, Davis-Floyd R and Colleagues, 3–44. Long Grove IL: Waveland Press.

———. 2022. *Birth as an American Rite of Passage*, 3rd ed. Abingdon, Oxon: Routledge.

———. 2023. "Open and Closed Knowledge Systems, the 4 Stages of Cognition, and the Obstetric Management of Birth." In *Cognition, Risk, and Responsibility in Obstetrics: Anthropological Analyses and Critiques of Obstetricians Practices*, eds. Davis-Floyd R, Premkumar A, Chapter 1. New York: Berghahn Books.

Davis-Floyd R, Barclay L, Daviss BA, Tritten J, eds. 2009. *Birth Models That Work*. Berkeley: University of California Press.

Davis-Floyd R, Laughlin CD. 2016. *The Power of Ritual*. Brisbane, Australia: Daily Grail Press.

———. 2022. *Ritual: What It Is, How It Works, and Why*. New York: Berghahn Books.

Davis-Floyd R, Premkumar A, eds. 2023a. *Obstetricians Speak: On Training, Practice, Fear, and Transformation*. New York: Berghahn Books.

———, eds. 2023b. *Cognition, Risk, and Responsibility in Obstetrics: Anthropological Analyses and Critiques of Obstetricians' Practices*. New York: Berghahn Books.

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale

———, eds. 2023c. *Obstetric Violence and Systemic Disparities: Can Obstetrics Be Humanized and Decolonized?* New York: Berghahn Books.

———. 2023d. "The Anthropology of Obstetrics and Obstetricians: The Practice, Maintenance, and Reproduction of a Biomedical Profession." In *Obstetricians Speak: On Training, Practice, Fear, and Transformation*, eds. Davis-Floyd R, Premkumar A, Series Overview. New York: Berghahn Books.

Fingar KF, Hambrick MM, Heslin KC, Moore JE. 2018. "Trends and Disparities in Delivery Hospitalizations Involving Severe Maternal Morbidity, 2006–2015." *HCUP Statistical Brief #243*. Agency for Healthcare Research and Quality, Rockville, MD. www. hcup-us.ahrq.gov/reports/statbriefs/sb243-Severe-Maternal-Morbidity-Delivery-Trends-Disparities.pdf.

Illich I. 1976. *Medical Nemesis: The Expropriation of Health*. New York: Bantam Books.

Jones R. 2009. "Teamwork: An Obstetrician, a Midwife, and a Doula in Brazil." In *Birth Models That Work*, eds. Davis-Floyd R, Barclay L, Daviss BA, Tritten J, 271–304. Berkeley: University of California Press.

Liese K, Davis-Floyd R, Stewart K, Cheyney M. 2021. "Obstetric Iatrogenesis: The Spectrum of Unintentional Harm, Disrespect, Violence, and Abuse." *Anthropology & Medicine* 28(2): 1–16.

Lokugamage A. 2011. "Fear of Home Birth in Doctors and Obstetric Iatrogenesis." *International Journal of Childbirth* 1(4): 263–272.

Miller S, Abalos E, Chamillard M, et al. 2016. "Beyond Too Little, Too Late and Too Much, Too Soon: A Pathway towards Evidence-Based, Respectful Maternity Care Worldwide." *Lancet* 388(10056): 2176–2192.

Murray de López, J. 2018. "When the Scars Begin to Heal: Narratives of Obstetric Violence in Chiapas, Mexico." *International Journal of Health Governance* 23(1): 60–69.

Seligman MEP. 1972. "Learned Helplessness." *Annual Review of Medicine* 23(1): 407–412.

Obstetric Violence and Systemic Disparities
Can Obstetrics Be Humanized and Decolonized?
Edited by Robbie Davis-Floyd and Ashish Premkumar
https://www.berghahnbooks.com/title/Davis-FloydObstetric
Not for resale