Understanding Autonomy and Positionality in Obstetric Care Outcomes for Queer Individuals

Juliana K. Upchurch
jupchur4@vols.utk.edu

Follow this and additional works at: https://trace.tennessee.edu/utk_chanhonoproj

Part of the Arts and Humanities Commons, Medicine and Health Sciences Commons, and the Social and Behavioral Sciences Commons

Recommended Citation

This Dissertation/Thesis is brought to you for free and open access by the Supervised Undergraduate Student Research and Creative Work at TRACE: Tennessee Research and Creative Exchange. It has been accepted for inclusion in Chancellor's Honors Program Projects by an authorized administrator of TRACE: Tennessee Research and Creative Exchange. For more information, please contact trace@utk.edu.
Understanding Autonomy and Positionality in Obstetric Care Outcomes for Queer Individuals

Juliana Upchurch

College Scholars Program

Chancellor’s Honors Program

Reproductive Healthcare from an Interdisciplinary Perspective
Abstract

Homophobia is a pervasive problem within the heteronormative United States that reinforces patriarchy while maintaining Judeo-Christian binary gender roles and sexual orientations. This study seeks to outline the interdisciplinary research that is required to better understand disparate healthcare outcomes in the United States with reference to homophobia in obstetric care. While there is current research working to understand the relationship between stress from racism and poor healthcare outcomes in the Black community, that same research is underrepresented from the lens of Queer individuals in regard to homophobia. The case study for this project found a significant increase in reported stress levels on the grounds of perceived homophobia both systematically and individually. While it is important to note that this discrimination experienced was described as covert homophobia, it is important to consider differences between Queer patient treatment and heteronormative patient treatment. It is also important to note that the impact of perceived homophobia is still stress, whether actions and words were meant to be homophobic or not. Further research is needed to correlate negative outcomes for maternal and fetal health with this discrimination.

Interdisciplinary Literature Review

Existing Research

Currently, there is a wealth of research that exists to better understand the causes of disparate healthcare outcomes for Black individuals receiving obstetric care. Black women are at an especially high risk of maternal and fetal mortality (Joseph et al, 2021). There is also currently ongoing obstetric research that demonstrates a
correlation between stress from racism and higher rates of negative birth impacts for both mother and child. This research indicates that Black mothers frequently give birth to children with lower birth-weights, and these births frequently occur prematurely (Dominguez et al, 2008).

A large source of this elevated risk comes from elevated stress levels due to racism (Davis, 2019). This racism, as Davis dissects in her paper, is largely covert and difficult to directly identify. Because of this, Davis defined racism as the following, "I define racism as the institutionally and state sanctioned practices that make particularly designated groups of people vulnerable to harm and premature death" (Davis, 2019). Davis then goes on to identify certain experiences that she claims can be linked with racism, despite lacking overt nature. These examples of “obstetric racism” included limiting the number of guests allowed in the patient’s room, refusal to allow modifications to the Western medical obstetrics practice that are often used in Indigenous, midwifery, and doula practices, medical complications that led to the admission of the child to the Neonatal Intensive Care Unit (NICU), preterm birth induced by doctors without patient consent, and violation of direct patient requests. It is important to note that at no point was this discrimination accompanied by language that the patient could use to constitute claims of specifically racist bias. This is the difficult nature of identifying individual and structural oppression; it is often administered in a way that works within oppressive structures to avoid eradication. While the relationship between racism and negative birth outcomes has been clearly demonstrated, it is essential to also examine negative, or even traumatic, birth experiences with ongoing mental health impacts.
There is research that finds that there is a significant increase in rates of postpartum depression in marginalized women (Maxwell et al, 2019). This research examines specifically the impacts on people who identify as low-socioeconomic status, migrant status, and racial minority status; however, it does not study the impact on Queer individuals.

While there are factors that have the potential to skew results due to the nature of intersectional oppression, this paper seeks to understand how the relationship between raised stress levels from discrimination via homophobia might impact people within the LGBTQIA+. It is important to note that this paper does not seek to equate the experiences or insidious nature of racism with the oppressive structure of homophobia. Both structures operate oppressively, but they are significantly different in historical context, current application, and impact. They do share a commonality of being structural forms of oppression existing within the United States, including the healthcare community, that can and do induce stress (Balsam, 2001).

**Bioethics**

While the field of ethics has existed for a significant time, bioethics is a relatively new concept. Ethics study different philosophical perspectives on what is the right or moral thing to do. Thus, bioethics looks deeper into what decisions and actions can and should be made by humans within the fields of science and medicine. This study applies to many different occupations, but it is largely focused on the medical field. Initially, the field of medicine was operating with largely paternalistic processes. However,
researchers, practitioners, and patients have come to agree that this is not the correct way to deliver patient care. The importance of consent from patients is quintessential in modern medical practice.

Philosophers set the standards for acquiring patient consent using four key principles. Nonmaleficence, Justice, Beneficence, and Autonomy are those commonly agreed upon four principles, and they continue to set the standard for Bioethics today (Ashcroft et al, 2007). Nonmaleficence is the idea that physicians should do no harm to patients. This particular principle is often widely debated in applications like assisted suicide and abortion (Kuta, 2010). It could be argued that any operation with a chance of risk creates more harm than good, such as elective surgeries, because they all pose a risk of infection or worse. However, this introduces the importance of interpretation. While these four concrete principles may exist concretely in theory, they are more difficult to apply in actual medical settings. The second principle is justice, and it is the idea that risks and benefits will be balanced appropriately and that patients should be treated equally. This principle is often hotly debated when considering organ donation and whether all recipients should be treated equally despite various concerns over patient ability to thrive, varying levels of need, and varying levels of patient misconduct in relation to organ health. Beneficence is the idea that physicians should be doing their work in order to improve the health or quality of life for patients. This trait is intricately linked to the concept of paternalistic care, and it is often used to defend less autonomous and informed decisions on the grounds that actions were taken for the patient’s wellbeing. That brings us to the final of the four main principles: Autonomy.
Patient autonomy is the idea that the will of the patient is respected above all else. While this may seem logical, historically this has not been the case. Over time, medicine in the United States especially has shifted from extremely paternalistic care to more autonomous care (Maehle et al, 2018). However, that courtesy has been given very slowly, and it is still lacking significantly in particular areas of healthcare. The central focus for this paper will be the applications of patient autonomy violations in obstetric care leading to patient discrimination and stress.

Because women have been a historically oppressed population, they bear a significant brunt of paternalistic care due to the sexist impacts of a patriarchal society (Keating et al, 2009). Patients must be fully informed, not in a state of distress, and not coerced in any way in order to autonomously provide their consent for a procedure. With the increasing capitalization of healthcare that took place in the 1900s, patients were often kept drugged and their births were induced without consent or concern for patient autonomy (Wolf, 2009). During the multiple waves of reproductive healthcare reform, women fought back against these unethical practices in order to regain the right to consent and control over their own bodies (Wolf, 2009). Despite these ongoing efforts, obstetric care in the United States is still fraught with violations of patient consent. While patients are in labor, they are often not fully informed about the procedures they have been asked to sign off on; this is especially true of cesarean sections (Wolf, 2009). Additionally, these patients are frequently in a state of distress when asked to make these decisions in addition to being coerced by doctors who inform them that they must undergo a cesarean to save the life of their child. Some argue that this is an unavoidable consequence of the nature of obstetric care; however, it is clearly
being abused based on the obscene rates of cesarean sections occurring each year in the United States.

**History of American Obstetrics**

The history of medicine is fraught with sexism and an intersectional oppression of minority and low socioeconomic communities. In American medical practice, births had initially taken place in the home of the pregnant patient. Overtime, hospitals gained popularity because they allowed for doctors to work from a central location and have extensive access to operate paternalistically (Wolf, 2018). Before the turn of the century, and the beginning of the 1900s, home births prioritized the health and safety of the mother. Mothers had some feeling of autonomy within the context of obstetric care. As births shifted to hospital settings, women lost all traces of autonomy, and, over time, they lost their preferential treatment over the fetuses that they carried. Since this shift, women, as well as others who receive reproductive healthcare, have been fighting to regain that autonomy, with some success.

The capitalization of American medical practices, particularly birth, is what these changes can largely be attributed to. In hospital settings, mothers often experienced what is known as “twilighting,” at the convenience of the doctor’s schedule (Wolf, 2009). This means that women were kept drugged to the point of unconsciousness, and doctors would only seek consent from husbands before injecting patients with pitocin and inducing birth (Wolf, 2009). Doctors could thus plan their schedules to make more births take place at once in order to maximize their profits. This maximization of profits
also extended into the marketplace for medical gynecological and obstetric equipment, despite any known negative consequences.

The fetal heart rate (FHR) monitor was introduced in 1968 to be used in extremely risky pregnancies in order to observe the heart rate during the birthing process (Wolf, 2018). However, it was quickly adopted by hospitals before studies had even been completed on its accuracy and efficiency. Because hospitals had already invested so much money in its implementation, they ignored the findings that their FHR monitor was more harmful than helpful, commonly exhibiting false signs of fetal distress (Wolf, 2018). Additionally, hospitals were motivated to make this switch from fetoscope to FHR because the FHR meant a significant decrease in costs from a decreased number of required nurses for monitoring (Wolf, 2018). This apparent elevated level of fetal distress was then used to justify an overwhelming number of unnecessary cesarean sections that put the health of the mother at risk (Quintero et al, 2003).

Cesarean sections have grown in popularity over time in the United States to a level that is considered dangerous and negligent. The recommended percentage of pregnancies that should be concluded using a C-section is 10-15% (WHO, 2015). 10% marks the low end, and 15% marks the largest percentage before the practice is considered medical negligence. The United States has a current C-section rate of approximately 33% (CDC, 2022). This means that between 2-3 times the number of appropriate c-sections are being performed. These C-sections are commonly taking place as a result of paternalistic care that violates modern bioethical and medical standards. A disproportionate number of those c-sections are being performed on minority populations (New Orleans CityBusiness Staff, 2005).
Biology

The human body is a complex system of organs working together to keep life in motion. An essential part of the maintenance of the human species is reproduction that creates future generations. The conception, gestation, and birth of human beings is one fraught with complications that can significantly impact human development. One area of concern for researchers is the impact of epigenetics on future progeny. Epigenetics are changes that take place at the cellular level and alter the way genes are expressed (Jaiswal et al, 2020). These changes often take place in response to a significant stressor, and they remain altered in the expression of future genetic production (Bond et al, 2007). While these expressions are acquired during socialization and adulthood and are not present at birth, they are still heritable to future generations. This means that populations exposed to severely stressful environments have the potential to pass on stress-induced epigenetically expressed or repressed genes. During pregnancy, stress experienced by patients can also lead to epigenetic expression directly within the fetus, regardless of whether those genes were mutated at the time of conception (DeSocio, 2019). While some effects of epigenetic mutation are more or less harmful, there is a significant correlation between prenatal exposure to stress and mental health disorders such as anxiety, depression, attention-deficit/hyperactivity disorder, and autism to name a few (Glover, 2020). DeSocio explains that the stress that can lead to mental health disorders has the potential to occur in progeny via genetic heritance during conception, stress during pregnancy, and stress during development. DeSocio also elaborates that this epigenetic exposure to stress during pregnancy can lead to other harmful biological
developments outside of the realm of mental health (DeSocio, 2019). Stress can also pose a number of direct threats to the fetal development and maternal health.

Stress is physiologically maintained within the hypothalamic - pituitary-adrenocortical (HPA) axis, and pre- and perinatal stress can significantly impact the development and functionality of this system within the body (Doom et al 2013). As a part of this physiological modification, children who experienced adverse stress during development (pre- and/or postnatal), developed less glucocorticoid receptors and more cytosine methylation of glucocorticoid receptors in neurons (Doom et al, 2013). These receptors are essential for the management of stress responses because cortisol, a hormone released in response to perceived stress, binds to these receptors to determine how the body will respond. Without the same number of receptors, the body will not be able to properly process cortisol or manage stress responses. Methylation is a process within the body that causes certain genes to be switched on and off, so the increased presence of structures that can methylate glucocorticoid receptors means yet another factor contributing to the physiological inability of offspring to manage stress responses due to exposure to stress.

Elevated levels of cortisol from stress perception have the ability to cause immediate harm to both maternal health as well as fetal health, in addition to long-term developmental issues. The inhibition of glucocorticoid receptors has the potential to result in natural abortion processes within the body due to the physiological interaction between these receptors and the bodies perception of stress (Doom et al, 2013). If stress levels are too high in pregnancy before the fetus is self-sustaining, the expulsion of the fetus may result in fetal mortality. Additionally, the prolonged exposure to the
chemical nitric oxide from decreased glucocorticoid receptor functionality may result in maternal hemorrhaging that could also result in maternal mortality (Miech, 2007). If the body undergoes significant stress and premature birth is induced, the life of the fetus is also at significant risk, and this process is increasingly well documented within oppressed socioeconomic communities and peoples of color (Baharani et al, 2018).

**History of Homophobia in American Clinical Settings**

Historic trauma is an idea that a certain group of oppressed individuals have accumulated trauma over time that inflicts cumulative effects on individuals identifying within that oppressed community. This concept is deeply rooted in studies of historical wrongdoings to a specifically oppressed group, and this varies from epigenetic or intergenerational trauma because it is shared by that group with a shared identity over the course of generations (Mohatt et al, 2014). The traumas that Mohatt et al research introduces the history of the term originating from studies of Holocaust survivors, but they emphasize that the term has expanded to better understand impacts on all sorts of different racial, ethnic, and minority communities. This extends to previously discussed research from Davis about medical historical trauma within the Black community regarding Sims’ research on enslaved Black women’s reproductive systems (Davis, 2019). Davis and Mohatt et al explained that these shared historic and generational traumas have the ability to negatively impact health and healthcare practices in the present.

Same-sex attraction has been pathologized in Western clinical settings since the nineteenth century under the academic discipline of “sexology” (Wuest, 2021). This type
of study sought to identify causes of supposed sexual deviance, treatments options, and general pathology of Queerness. From its origins in the nineteenth century until reform efforts in the 1960s and 1970s, Queerness was considered a disease and was heavily researched within the medical field, with a large popularity in psychology and psychiatry (Wuest, 2021). Many Queer individuals wrote during periods of reform about the feelings of self-blame and despair generated by clinicians and even declared psychiatry the “Arch-Enemy” of civil rights for Queer people (Mitchell, 2002). Anything that deviated from heteronormativity was pathologized, studied, and it was considered for an array of experimental treatments. Sexology and its pathologizing of Queerness evolved into the practice of conversion therapy that included treatments like, “institutionalization, castration, and electroconvulsive therapy” (Fritz, 2016). According to Fritz, more modern approaches to conversion therapy include aversion therapy techniques where Queer individuals are exposed to pain or noxious smells followed by homoerotic images, group shaming, and attempts to identify childhood traumas that caused sexual orientation to deviate.

The United States relies on the Diagnostic and Statistical Manual (DSM) for official psychiatric diagnosis. Until 1974, same-sex attraction was listed within the DSM as a diagnosable and treatable pathological disease (Fritz, 2016). Despite a large social transition in clinical studies from pathology to normal variation of human sexuality, Queerness is still considered a disease that qualifies for harmful conversion therapy by many pediatric, psychiatric, and Christian organizations that actively advocate against bans on conversion therapy (Wuest, 2021).
The accumulation of generations of persecution by the medical profession, as well as legislative persecution, has led to sufficient grounds to generate historic trauma between Queer individuals and clinicians. It is clear that homophobia is an ongoing and pervasive social force, and the idea that Queerness is a pathology is still alive and well in recognized medical organizations today. When visiting a pediatrician, for example, one still can be recommended conversion therapy in response to expressions of Queerness, despite the harm that may cause to the child’s mental and physical health (Unknown, 2013). Thus, it is reasonable, based on the grounds of historic and ongoing prejudice within the field of medicine, that Queer patients might perceive physicians’ actions as homophobic and experience severe stress, whether that homophobia is overt or covert.

Systematic Oppression

Heteronormativity is the social expectation in Judeo-Christian societies that people will be cisgender and heterosexual. It is a pervasive ideology rooted in religious beliefs that set strict gender roles, and the result of violating those roles is known as gender policing. Gender policing may come in many different forms, but it is always the result of someone attempting to violate heteronormative gender roles. Queerness and its expressions are often met with harsh and occasionally violent forms of gender policing, and they are rooted in homophobic ideology. Being Queer is a broad term used to refer to the LGBTQIA+ community, as well as culture resulting from within that community.

Christian gender roles strictly define the binary roles of men and women, with women in a subservient position to men. Women are meant to serve their husbands as
the church serves Jesus Christ according to Biblical passages (Johnson, 2015). Queer couples often violate these gender roles and expectations in many different ways, and they are subjected to social discrimination for existing within a minority community that counters Christian ideology. This homophobic policing is often a major stressor for Queer individuals and couples alike.

In addition to gender policing, Christian ideology also enacts a patriarchal power structure that oppresses women and femininely-presenting individuals in an androcentric fashion (Bailey et al, 2019). Patriarchies work to empower men at the expense of women, trans, and nonbinary populations through structural oppression.

In hospital settings, Queer individuals are usually treated as abject. This means that they are not given object or subject permanence, and it is as if they are not meant to exist. Obstetrics in particular operate on heteronormative assumptions and practices (Dean et al, 2016). Forcing Queer people to out themselves repeatedly and advocate for their right to exist is a form of epistemic exploitation. Epistemic exploitation is a form of structural oppression that operates by forcing an oppressed group to spend their time, money, and energy advocating for their right to exist (Berenstain, 2016). This happens across all intersections of oppression, and it is extremely common with Queer oppression. Within structures like the American medical system, patients often find themselves being forced to advocate for themselves.

Reproductive healthcare is often subjected to the whim of legislators and shifting public opinions. The laws that are put in place surrounding reproductive healthcare restrictions often harmfully impact certain populations more than others. This concept that certain people experience more harm than others as a result of structural
oppression is referred to as Intersectionality (Crenshaw et al, 2019). According to Crenshaw’s theory, people with more than one oppressed identity will experience exponential harm rather than simply additive. This theory is especially relevant to obstetric care because obstetric patients typically already fall into the category of gendered oppression. Thus, patients of color find themselves receiving exponentially lower quality of patient care and outcomes. This theory is reflected in actual medical results across the country (Garcia, 2015).

Positionality is the concept of awareness of one’s identities in reference to a specific frame of examination. For example, oppressed identities—race, socioeconomic status, sexual orientation, etc—have the ability to shape a person’s lived experiences in an intersecting and unique fashion (Chou et al, 2018). This may look like a combination of race, socioeconomic status, religion, sexual orientation, gender identity, etc. It is important to note that one area that intersectional theory does not account for is the idea that there is depth that is not represented within simple two dimensional representations of oppression. Colorism, for example, is not included in the examination of racial hierarchies, but it has a significant impact on levels of experienced discrimination (Dixon et al, 2017). This is also true of Queer individuals where certain members experience more threats of physical violence and hate crimes than others (Lund et al, 2020). Thus, it is important to keep in mind that positionality is not as simple as intersectional theory. It seeks to define lived experiences on an individual level. Some people may share a particular positionality, but it is important to note that one person’s experience cannot be used to represent an entire community because that person often has more than just that one identity contributing to their experiences. This
is important to keep in mind when examining the results of this study because information is generalized and thus cannot be representative of the whole LGBTQIA+ umbrella.

*Current Economic Structure*

Neoliberalism is an economic model that endorses the deregulation of the market under the presumption that the market will self-regulate. Milton Friedman was the leading economist in developing this theory, and it was largely put into practice after Chilean experimentation in shock economics led by the “Chicago Boys” and the United States’ government in the 1970s (Whyte, 2019). Shock economics is the theory that large-scale crises within an economy can be used by governments to endorse deregulation of the market under the guise of economic recovery. However, the theory is based on the idea that players within the market will act altruistically to benefit consumers. Unfortunately, capitalist systems work to maximize profits for producers at the expense of both consumers and raw material providers. Thus, the combination of neoliberalist deregulation with a capitalist economy leads to extremely detrimental economies that only benefit those who hold the means of production or political power.

Within neoliberalist settings, capitalist medicine has become increasingly dedicated to producing profit at a minimum cost, whether that be time or money. This has led to increasingly less provider to patient consult times, decreased quality of care, and poor healthcare outcomes for people on low-income or public insurance plans (Weech-Maldonado, 2012). On the opposite side of the spectrum, patients are often given too many services at unmanageable costs that reproduce cyclical poverty (Gale,
This is where the intersection of paternalistic care and capitalist fee-for-service medicine have created a massive profit off of discriminatory and dangerous practices. For example, cesarean sections are known to be significantly more dangerous than vaginal births, have longer recovery times, and decrease the patient’s ability to have future vaginal births (Wolf, 2018). By increasing the cost of the procedure and necessary equipment, the medical system is thus generating a larger capitalist profit while putting the health of an individual further at risk. This is an unethical violation of a patient’s right to autonomy and a doctor’s obligation to do no harm. On top of those increased costs, patients must also pay for longer hospitalized recovery time and more medications that generate profit for the American pharmaceutical industry.

Studies have shown that the United States, when compared to ten high-income countries with public healthcare, has the lowest life expectancy, highest maternal and fetal mortality, and almost twice the rate of annual healthcare spending (Papanicolas et al, 2018). The burden of these poor outcomes disproportionately falls upon those of lower socioeconomic status.

**Oppression and Mental Health**

Studies have shown that both experiences of homophobic harassment/violence in addition to the threat of potential harassment/violence has a significant impact of the mental health of Queer individuals (Balsam, 2001). There is currently very little research available on the impact of mental trauma accrued in the birthing process within the LGBTQIA+, and most of that existing body of research comes from outside of the United States. While the available international literature is valuable, it does not give the same
perspective of the ways in which the capitalist, Judeo-Christian medical structure that is featured in the United States might encourage that trauma.

Sociological Perspective

The concept of heteronormativity and compulsive heterosexuality come from the sociological and anthropological perspective of Queer Theory (Schilt et al, 2009). Queer Theory is a body of interdisciplinary work that seeks to identify connections between sex and gender in sociocultural power structures (Graham, 2014). In the realm of Western studies, this power structure is thus identified as the aforementioned heteronormativity. Heteronormativity is the perception that gender is binary and only heterosexual attractions are meant to be felt. Anything outside that realm is heavily policed. Thus, members of the LGBTQIA+ umbrella fall into the category of social deviants. Trans individuals violate the false perception of cisgender sex assignment. Lesbian, gay, and bisexual individuals violate heterosexual sexual orientations. Nonbinary individuals contradict the idea of binary gender and sex. The entire LGBTQIA+ is thereby populated by individuals who are in direct contradiction of heteronormativity, and they face harsh gender/sex policing as a structural result. These episodes of backlash are neither individual nor isolated. They happen extremely commonly in legislative and bureaucratic systems, especially in the realm of healthcare. For example, there is very little legislature in place to protect Queer employees from discrimination, there is an ongoing epidemic of violence against Queer individuals, and Queer individuals are often exposed to religious and sociocultural discrimination (Sullivan, 2003)
Methods

In order to obtain a better understanding of personal experiences with the impacts of homophobia during obstetric care in the American allopathic care system, a case study was conducted via interview with a white, cisgender, lesbian woman who identifies within the LGBTQIA+ and had given birth within the last decade with her partner present.

An application was submitted to the University of Tennessee Institutional Review Board with the application reference: UTK IRB-22-06763-XM. The study was approved, and all researchers complied with the required CITI Human Subject Research Training.

The participant was a known contact who agreed to participate in the anonymous study. The participant was asked the following nine questions over Zoom video conferencing services with only the audio being recorded on the interviewer’s private device.

1) The LGBTQIA+ community is expansive and constantly evolving, how do you see yourself as a member within this community?

2) Did you undergo fertility treatments to conceive, and, if yes, what was that process like?

3) Was your partner present at the time of your birth, and how active of a role did they play in the birthing process?

4) When in the medical facility to give birth, did you feel as though you were treated with respect and without discrimination on the basis of your gender identity, gender expression, and/or sexuality?
5) How stressful was the process of giving birth in relation to the ways in which the healthcare providers and staff interacted with you?

6) Did you feel as though your consent was valued and your autonomy was respected?

7) Were there any medical complications that occurred before, during, or directly after the birth and how well did you feel those were handled by medical professionals?

8) Was there any conflict or difficulty with paperwork or visitation rights?

9) Was there anything that could have been done to make the experience less stressful?

Before questions were asked, verbal consent was obtained from the case study’s subject. Upon the completion of the interview, the participant was asked if there was any information that she would like to redact from the interview transcript, and she responded that there was nothing she objected to being reported. After the interview was transcribed by the researcher, the original audio recording was deleted in order to ensure the anonymity of the subject. Additionally, any potential identifiers were removed from the transcript to further those efforts. All information reported in the case study comes directly from the participant and was given with consent.

**Case Study**

As previously mentioned, the study’s subject identifies as a member of the LGBTQIA+, more specifically identifies as a lesbian woman within the Eastern Tennessee region. She is a white woman, but her socioeconomic status was not
disclosed. Both she and her partner are actively employed and were at the time of the birth. The subject described difficulties during the initial stages of the obstetric process while undergoing fertility treatments, and she reported only a single doctor in their area was willing to treat Queer patients at that time in 2012. She reported having to undergo a surgical treatment, known as a “cerclage,” in order to seal her cervix shut so that she could carry the child to term. The participant reported, “I had had to have a surgery that basically, I can’t remember what it’s called, but it like sealed my cervix shut because otherwise, halfway through my pregnancy, the baby would have been born, and we went to another doctor somewhere else, at (REDACTED), and they were like, ‘You know, this guy, this person that stitched you up here, this cerclage, did a really great job but like please, please, please, please, when you give birth make sure that they undo that cerclage.’” She also reported being on bed-rest for half of the pregnancy as a result of this surgery.

The participant went into labor prematurely, and her regular physician was not available to carry out her birth, so she was assigned a different attending physician. Her partner was with her throughout the birthing process. The participant reported that the physician assigned to her did not make her feel comfortable, as if her consent mattered, or that her autonomy was respected. When she informed the physician that her cervix had been sewn closed and needed to have the sutures removed, he denied her request. He told her that the force of the birth would rip open the sutures on their own, despite the fact that these sutures were meant to last in her cervix undisturbed for the entire pregnancy. She informed the physician that multiple physicians and nurses had informed her of the importance of the removal of those sutures, but she was denied that
request without any other explanation. The participant also reported that when she attempted to shift into another birthing position to assist with labor, that she had seen used in her partner’s previous birth, that the provider refused to continue the labor process, saying, “He just sat down at like the guest table and was like, “When you’re ready to keep working again.” The participant did not wish to elaborate further on the actual labor, needing a moment to pause and recollect herself after finding difficulty in continuing the description of the experience which she indicated that she did not often recount. She mentioned that the child had an extended stay in the Neonatal Intensive Care Unit (NICU).

The participant also noted significant stress during the process of obtaining a birth certificate for her child, as well as the child her partner had previously carried. In both instances, they were forced to go to court to argue before a judge, with a lawyer, that they wished their partner’s name to be listed as the “father.”

In response to the final question asking whether there was anything that could have been done by medical professionals to make the process less stressful, the participant said, “I think that the other things… the things that are sort of more hidden or more insidious, like the assumptions that get made, and yeah like the, you know, you’re sort of Othered by the medical community who expects like this straight white couple, and they can be as nice as pie to you. But, you know, unbeknownst…You just don’t really know where they’re coming from. So, and, you know, there’s that disconnect. They don’t know you. And that’s always an issue, but, of course, if they see you as someone who’s different then they’re not gonna have the same level of empathy, you know?” The participant indicated that the attending physician was definitely a
source of stress for her during the birthing process, and she also indicated stress from her employer during the pregnancy, mentioning that her employment was impacted.

**Discussion**

The participant mentioned that there were multiple very stressful experiences within the pre-, peri-, and postnatal process. Due to the correlation found between increased stress and increased cortisol levels, as found in previous studies of racism and cortisol, it is plausible to suggest that there might be a correlation between homophobia and negative healthcare outcomes that are typically associated with elevated levels of cortisol. The participant reported premature birth, medical complications, post-natal intensive care for her child, and incredible difficulty in recounting the events of the birth experience.

In addition to correlation between perceived experience and stress, the participant reported additional medical procedures that are not typical for a healthy pregnancy, threatened financial stability from her employer, extended hospital stays for herself due to medical malpractice under the refusal to remove her cervical sutures, against medical advice, and her child had to spend weeks in an intensive care unit because of the premature birth (which was previously discussed as a potential outcome of elevated cortisol). The combination of all of those factors most likely lead to a stressful financial burden on the participant and her partner that made the pregnancy difficult to maintain and enjoy.

It is important to note that this study was limited to one case, and this field of research required much larger studies in order to demonstrate a large-scale correlation.
In order to conduct those larger studies, common experiences from smaller qualitative studies may be reflected in surveys sent out to larger groups in order to gather information of frequency of occurrence within the Queer population. The study does center around a cisgender white woman, so, while confounding variables are minimized, there is very little demonstration of intersectional oppression within the study.

**Conclusion**

The United States needs to work to remove structural oppression as well as individual discrimination within the healthcare community as a whole, but it especially needs this change in the field of obstetrics. The obstetric healthcare system does not cater towards Queer individuals, as clearly indicated in this case study. If anything, the system is a source of significant harm and trauma for patients who identify as Queer. It is also important to note that the participant was a white cisgender woman who does not experience transgender or racial oppression. This means that members of different racial or trans identities might find themselves experiencing even more traumatic obstetric care. It is important to continue this line of research with reference to intersectional identities to better understand areas of healthcare that need to be addressed. This has the potential to improve healthcare outcomes for the United States that are desperately needed for maternal and fetal mortality rates to improve. Healthcare in the United States should work to provide quality care for everyone, regardless of their positionality.
References


https://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf?sequence=1


https://doi.org/10.1097/AOG.0000000000004361


https://doi.org/10.1016/j.midw.2007.08.009


New Orleans CityBusiness Staff. (2005). Tulane University study finds minorities receive highest rate of C-sections. *New Orleans CityBusiness*, 1–.

[https://doi.org/10.1001/jama.2018.1150](https://doi.org/10.1001/jama.2018.1150)

[https://doi.org/10.1016/S0029-7844(02)03131-9](https://doi.org/10.1016/S0029-7844(02)03131-9)

[https://doi.org/10.1177/0891243209340034](https://doi.org/10.1177/0891243209340034)


https://doi.org/10.1097/MLR.0b013e31825fb235


https://doi.org/10.1093/jhmas/jrx053

https://doi.org/10.1017/S1537592720002881