UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

NATIVE SUBJECTIVITY, REPRODUCTION, AND THE POLITICS OF ETHNOGRAPHY

A THESIS

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

Degree of

MASTER OF ARTS

By

ARIAN DAVIS
Norman, Oklahoma
2017

NATIVE SUBJECTIVITY, REPRODUCTION, AND THE POLITICS OF ETHNOGRAPHY

A THESIS APPROVED FOR THE
DEPARTMENT OF ANTHROPOLOGY

BY

_____
Dr. Paul Spicer, Chair

_____
Dr. Lucas Bessire

_____
Dr. Misha Klein

Table of Contents

Abstract..... v

Introduction……...1

Chapter I……..10

Chapter II…….28

Chapter III..…….61

Conclusion……...76

Bibliography…….82

Abstract

Birth and child-rearing have long figured as premiere sites for social scientific research. As Rapp & Ginsburg (1995) argue, anthropological inquiry into reproduction provides a unique opening for the study of socio-political processes more generally. Through closer attention to the intimate registers of reproduction, we are able to envision how cultural forms and processes are created, negotiated, and inscribed onto bodies, and to account for what is at stake in the ways such dynamics change over time. The concept of subjectivity provides a particular lens through which to explore these questions of reproduction. While anthropologists have frequently engaged the topic of how reproduction relates to social or communal, less work has been done on how women are individually created as social and legal subjects through their reproductive experiences. The question of how reproductive subjectivities are formed and negotiated takes on an additional layer of complexity within the context of Native peoples undergoing continued settler colonialism and the colonial category of Nativeness itself. The ongoing governmental management of Nativeness means that mothers of Native children are the reproducers of not just flesh and bone and blood but also of specific biopolitical structures and categories of being. This thesis questions how interwoven systems of bodily and cultural intervention exist in tension with women's own reproductive subjectivities, particularly for Native women. I detail how the multiplicity of Native reproductive subjectivities makes it difficult to define exactly what Nativeness is, how it is reproduced, and what it means for larger questions about the nature of personhood and community in Native contexts. Additionally, through an exposition of my ethnographic journey, I illustrate both the limitations of ethnographic

inquiry in contemporary biomedical contexts and the ways in which such a methodology allows a unique opening into the nuances, challenges, and potentials of larger systems of modern life. Finally, by engaging the concept of subjectivity in relation to Native reproduction I aim to demonstrate how moving from identity towards subjectivity can open up new ways of understanding reproduction as a socially, politically, and technologically fraught experience.

INTRODUCTION

I AM NOT Native but I am the mother of a citizen of the Chickasaw Nation. My son does not yet know he is a citizen of this tribe and he had no say in the matter. This curious situation is surprisingly typical for many new mothers in Oklahoma. A place shaped by a complicated legal and political history, here Nativeness is often an open-ended question. The ways in which this concept are experienced and articulated reflect the disperse ways that Native personhood and community are constructed here. For me, the question of how this loose notion was related to the intimate transformations of reproduction began to take shape in the foggy days after the birth of my son.

MY FIRST FEW weeks as a mother are difficult for me to describe, both because the memories are hazy and because the English language does not seem to have the necessary words to describe my affective state during this time. Within the swirl of displacement that encompassed those early days of motherhood are splintered memories: floods of summer sunlight, the warmth of my son's skin against my chest, the cool tumble of ice water down my throat, a dim blue night light in the corner. Days ran into nights and back into days. My son was a generally calm newborn. This spared my husband and me the torment of weeks of screaming cries and granted a peacefulness to those early days of parenthood. Existing simultaneously within these serene memories of light and smiles are the feelings of confused detachment that also filled those days. My son's tranquility allowed us to drift through the changing motions brought on by the simple presence of a new being in our home. Despite the seeming

fluidity, the motions were nonetheless shifting – both physically and emotionally, subtle and stark. I was not able to get myself out of bed without my husband's help due to the weakness caused by the incision across my abdomen that I had fought so hard to avoid. Visitors slowly streamed in and out of my home, often oblivious to the fragmented process happening within me, a result of both too little sleep and the seemingly disjointed way in which I had been thrust into this new role. Even attempting to eat my standard breakfast of toast and eggs – now subject to happen at any hour of the day – required that I develop new strategies for the simple act of bringing my fork to my mouth, as the old method nearly always resulted in eggs landing on the face of the baby that I often refused to allow out of my arms.

During one such attempt at breakfast my mother-in-law arrived for a visit. My husband's family is fairly large and very close, a result of several generations growing up within sight of each other on the same chunk of original allotment land in southeast Oklahoma. Although I had always been friendly with my mother-in-law, I never had been able to fully embrace that familiar connection that was characteristic of her family. Desiring privacy and space during a vulnerable time, I had months earlier informed her we did not want anyone present during my labor and that it would not be necessary for her take a week off work afterwards to stay at our home. This had placed a strain on our relationship that I had not expected and was still trying to mend. Therefore, despite the fact that I would have preferred not to, we agreed to let her stop by one Sunday afternoon.

I remember the floral scent of detergent wafting in as my mother-in-law rushed through our front door. Her blond hair bounced as she made her way towards our dining table and pulled a chair close to mine while depositing a pile of papers on the dining table. Her blue eyes locked onto my son as she leaned forward and stretched her arms towards him. I instinctively lifted my elbow and turned from her slightly, causing her to lean back in her chair but never break her penetrating stare. Without acknowledging me or my husband, she casually waved towards the papers she had brought and informed us that they were tribal enrollment forms. We had only to sign the forms, as she had already filled them out with all the necessary information. "Just sign on the lines and I'll take those and the birth certificate down to the office." Two small requests and my son would become legally recognized as an American Indian[1] and citizen of the Chickasaw Nation.

After cleaning the bits of food off my son's face, I reluctantly surrendered him to his grandmother's arms. While my mother-in-law paced deliberately around our house, softly cooing to the baby while always keeping her back between him and me, my husband moved to the piles of hospital bills and medical paperwork that had accumulated on his desk. He retrieved the birth certificate, precious and hard won proof of the events I had recently endured, and transferred it to the stack of enrollment forms that would be leaving with my mother-in-law. I moved to the couch, distracted by a fatigue that permeated my deepest muscles, the disorientation of the preceding weeks,

[1] Throughout the course of this paper I will use the terms American Indian, Native, and, rarely, just Indian interchangeably to refer to individuals and communities. I rely on the term Nativeness to refer to the concept of Native identity and subjectivity that I attempt to grapple with in my argument.

and the overwhelming sensory presence of my mother-in-law. Distracted yet intrigued by the idea of free books and clothing for my son, I signed the enrollment forms on the places marked by post-its and passed them to my husband. Within a matter of weeks, we would receive an envelope in the mail containing two documents that would prove instrumental in shaping this research: a piece of paper declaring my son as a certified member of the Chickasaw Nation of Oklahoma and a federally-issued Certified Degree of Indian Blood card listing his blood quantum as 5/512.

Looking back now, what is striking is how the simple action of signing tribal enrollment forms was a seemingly innocuous one of many. I was hardly aware of it at the time. But later it would come to represent a mystifying transition in my experience of motherhood – from that point forward, I was a reproducer of the loose and confusing thing that is Nativeness in Oklahoma.

BIRTH AND CHILD-REARING have long figured as premiere sites for social scientific research. More recently, feminist anthropologists have re-engaged reproduction as a key moment where wider forms of meaning, power, and personhood are realized and expressed. This attention to the complexities of reproduction is based on two insights. First, such attention to the topic rises from the recognition that reproduction remains one of the most common female experiences, although certainly not universal, and one of the most culturally specific characteristics of the female body, for better or worse (Inhorn 2009). Second, it also grapples with how reproduction – and life itself – is increasingly open to social and technological redefinition in the

contemporary. As Rapp & Ginsburg (1995) argue, anthropological inquiry into reproduction provides a unique opening for the study of socio-political processes more generally. Through closer attention to the intimate registers of reproduction, we are able to envision how cultural forms and processes are created, negotiated, and inscribed onto bodies, and to account for what is at stake in the ways such dynamics change over time.

Such discussions about reproduction are inseparable from wider conceptualizations about the body as an interface between physical processes and social interpretations (Martin 1987, Scheper-Hughes and Lock 1987). Biehl et al. (2007) highlight the crucial role of the body in the formation of specific subject positions. They call attention to the ways the body has come to be understood as a lens through which the defining characteristics of modern life – such as medico-technical regimes, postcolonial political economies, and fractured social relations – are mediated, inscribed, and altered. Such conceptualizations of the body as a conduit for cultural forms and processes creates an opening for further questions about how the possessors of these bodies understand their relationship to these larger systems. Biehl et al. explain that by acknowledging the "importance of somatic processes," or processes relating specifically to the body, anthropologists can move beyond more symbolic interpretations of culture to develop deeper understandings of the relationship between corporeal selves and social and political institutions (2007:8).

By taking into account the role of the physical body in negotiating the relationship between individual lives and complex institutions, anthropologists are able to achieve a deeper level of engagement with the notion of subjectivity. Sherry Ortner defines subjectivity as "cultural and social formations" that interact with and organize "modes of perception, affect, thought, desire, fear" (2006:31). Biehl et al. further define subjectivity as the ways in which "institutional processes and cultural forms" mediate identity as it is "patterned and felt in historically contingent settings" (2007:5). These definitions illustrate the ways in which the theoretical tool of subjectivity allows anthropology to move beyond the concepts of identity or the self. Whereas identity can presume cohesion and continuity within populations, subjectivity creates space to explore how individual subjects are uniquely formed by and contribute to the formation of the larger systems with which they interact (Good et al. 2006).

The concept of subjectivity provides a particular lens through which to explore questions of reproduction beyond identity. While anthropologists have frequently engaged the topic of how reproduction relates to social or communal identity (see Bridges 2011, Davis-Floyd 1992, Fraser 1995), less work has been done on how women are individually created as social and legal subjects through their reproductive experiences. As women reproduce biological entities and cultural systems at the same time, how do their own inner lives become entangled within, resistant to, or contingent upon these larger political, economic, and medical realities? Examining these processes allows a more nuanced view of the relationship between reproductive

experiences and notions of the self and gives rise to the idea of specific reproductive subjectivities.

The question of how reproductive subjectivities are formed and negotiated takes on an additional layer of complexity within the context of Native peoples undergoing continued settler colonialism and the colonial category of Nativeness itself (see Simpson 2014). The category of Native is one that is racialized and regulated through a legal system that has been abandoned for all other ethnic groups in this country. Native peoples continue to be marked through the pseudo-biological system of blood quantum and the colonial project of the Dawes rolls, which grants the federal government an outsized role in the legitimization Nativeness (Sturm 2002). The ongoing governmental management of Nativeness means that mothers of Native children are the reproducers of not just flesh and bone and blood but also of specific biopolitical structures and categories of being. When a child is born from a Native parent and enrolled in tribal membership or precluded from enrollment based on the colonial principles of blood quantum and Dawes roll membership, they become complicit in the perpetuation of those colonial structures that aim to validate particular forms of Nativeness.

As such, the governance of Nativeness adds a distinct register of contingency to questions about reproductive subjectivity and its stakes. Yet little scholarly attention has been dedicated to this process.[2] How do such specific legal classifications of

[2] Very little ethnographic engagement with Native reproduction has been done at all, let alone regarding questions of subjectivity. See Cruz-Begay 2004, Gurr 2014, and Gonzales 2012 for the few examples available.

reproductive experiences uniquely impact how women understand their body and its role in the perpetuation of these categories? In a social context in which some women are deemed more capable or worthy of reproducing future generations, others are dispossessed of their reproductive abilities, both bodily and otherwise, while their actual reproductive futures are scorned, creating systems of "stratified reproduction" (Ginsburg and Rapp 1995:3). How might Native women be particularly subject to such systems of *stratified reproduction* built around their proximity to Nativeness? Where do the women who reproduce Native subjects fall along this continuum of valued and devalued reproduction?

These hierarchical and legalized systems of classification all exist in tandem with biomedical regimes that seek to govern what Biehl et al. refer to as "the remaking of culture as well as the inner transformations of the human subject" (2007:5). And so, while Native mothers and the mothers of Native children are subjected to certain politico-legal systems, they are also confronted with specific biomedical institutions that have the capacity to impinge on their interior lives in an attempt to maintain predetermined categories of Nativeness. This regulatory process surrounding the reproduction of Nativeness is accomplished through a variety of technologies that, as Biehl and Moran-Thomas (2009) explain in another context, force a kind of malleability onto biomedical subjects. As our biological lives become increasingly dependent on and mediated by technology, Biehl and Moran-Thomas argue that this creates a kind of "mechanical intimacy" whereby individuals and technology become entangled in ways that fundamentally influence what it means to be human. This opens up new forms of

subjectivity, as biomedical patients are confronted with yet another external regime of influence.

Reflecting on my own positionality as the mother of a tribal citizen, I question how interwoven systems of bodily and cultural intervention exist in tension with women's own reproductive subjectivities, particularly for Native women. How were women and children created as biopolitical subjects through these regimes of reproduction? And how did these women make sense of their reproductive experiences in relation to their individual biographies as well as their position as Native subjects?

This thesis describes my journey of attempting to locate the spaces in which these tensions between biomedical regimes and individual Native subjectivity exist, gain meaning, and unravel. In crafting an ethnographic account of these processes, I argue that the notion of a specifically or homogeneous Native reproductive experience is deceptively simple. I detail how the multiplicity of Native reproductive subjectivities makes it difficult to define exactly what Nativeness is, how it is reproduced, and what it means for larger questions about the nature of personhood and community in Native contexts. As I chronicle my repeated attempts to locate such communities and understand the subjective reproductive experiences of their members, I reveal how my predetermined categories of Nativeness and the variety of birth ideology I expected to find within those categories were insufficient. Through an exposition of my journey as an ethnographic fieldsite, I illustrate both the limitations of ethnographic inquiry in contemporary biomedical contexts and the ways in which such a methodology allows a

unique opening into the nuances, challenges, and potentials of larger systems of modern life. Finally, by engaging the concept of subjectivity in relation to Native reproduction I aim to accomplish two tasks. I seek to contribute to the anthropology of Native reproduction, which is surprisingly sparse, and to demonstrate how moving from identity towards subjectivity can open up new ways of understanding reproduction as a socially, politically, and technologically fraught experience.

I

DURING THE SPRING following my mother-in-law's visit, I found myself driving my small SUV towards the green hills of rural Oklahoma. The contrasting beige exteriors of new banks and loud primary colors of Sonic Drive-Ins that mark the periphery of any notable Oklahoma town gradually gave way to uninterrupted stretches of pasture and the occasional pre-fabricated warehouse housing heavy-duty equipment. I was swerving slightly, my arm bent behind me at an unnatural angle in an attempt to calm the screaming infant in the backseat. We were less than 20 miles from home and had many more miles to go, yet my now seven-month-old son's tolerance of the car seat had already vanished. Caving to his anguished cries and the tears I could feel dampening his cheek, I pulled over into the empty parking lot of a manufactured building, a country bar that was the only building in sight. I shimmied between the driver and passenger seats and swung myself around to sit in the space next to his car seat. I unbuckled him and allowed him to nurse briefly, the only thing I knew would immediately comfort

him. Only a fraction of the way into this drive, I was already beginning to doubt my decision to bring him along.

My son and I were headed to a tribally operated hospital that I hoped would be the site of the research project I was in the process of developing on the role of tribal health systems in the creation of reproductive Native subjectivities. Regardless of the drive, I was excited to visit the hospital. I was eager to meet some of the certified nurse-midwives (CNMs) who operated the labor and delivery ward there and was hopeful that they would be receptive to facilitating my research. I had tried to contact two of the CNMs already but had received no response. Despite my failed attempts thus far I imagined myself walking confidently into the lobby of the OB/GYN department with my adorable infant and making a charming first impression that would immediately endear everyone to my work. However, ever present beneath these visions of success was a near-crippling self-doubt: about the goals of the project itself, my capacity to build the necessary relationships, and, perhaps most of all, the moral implications of researching questions of Nativeness as a white woman. I questioned my ability to convince people that my interests in the topic of Native reproduction came from a position of genuine curiosity based on my own experiences and struggles and not from any desire to extract or appropriate knowledge to which I had no right.

After granting myself a moment to daydream, I made my way back to my place behind the steering wheel. As I continued practicing my introduction in my head, I tried not to dwell on the significance of the outcome of the trip. The preceding weeks and months

had been leading up to this visit. The research I expected to grow out of this visit would represent the culmination of several semesters of readings and preparation, as well form the basis for the thesis that would hopefully propel me to the next phase of my academic career. I had deadlines looming and the financial support that made this process feasible was dwindling.

I had also been in conversation with my academic advisors regarding the best ways to move forward with this project. As a result of these discussions, I had been put in touch with members of the tribal Institutional Review Board (IRB). Institutional Review Boards were developed in the mid-twentieth century to oversee and regulate human-subjects research. This was a response to various cases of research abuse, including cases such as the Tuskegee Syphilis Experiment, the Milgram Obedience Experiment, and the Stanford Prison Experiment (Schrag 2010). The abuses that resulted from these and other studies led to the creation of the National Research Act of 1974 and ultimately the development of Institutional Review Boards. The goal of these boards is to govern any human-subjects research undertaken with federal funding and to protect research subjects from potentially harmful research practices. Most major educational institutions operate their own IRB, but several other entities do as well. In an attempt to move from research subjects to active research partners, many large tribes, as well as Indian Health Service, have also implemented their own IRBs(Dixon and Roubideaux 2001). As I began this project, I was familiar with my university-led IRB but had never interacted with or submitted research to a tribal board. Nonetheless, I was confident that this tribal IRB, which also provided research navigation for investigators interested

in working with the tribe, would be an appropriate place to begin a dialogue about the development of a collaboratively designed project.

My goal with these communications was to gain research approval and, subsequently, access to the hospital. Although I had a clear set of research questions regarding the relationship between biomedical regimes, reproductive subjectivities, and Nativeness, it was also important to me that I not perpetuate colonial research practices by imposing my own agenda onto a population with potentially divergent concerns (Smith 1999). I aimed to find an intersection between by my own research interests and any larger concerns or questions the tribe itself might have. And so, in dialogue with tribal IRB, I began to explore where these connection points could be found.

A pivotal moment in that process occurred during one specific phone call that was arranged between myself and the two tribal IRB members who also facilitated research navigation. During the course of the call, I learned more about how tribal health systems operate, the models of care they use, and the challenges facing the maternal health unit of this particular hospital. From there, I was able to develop a set of tribally-guided research questions: what were patient perceptions of care in the maternal health unit? How did women prioritize their expectations of medical care versus other aspects of the reproductive experience, such as cultural concerns? And how was this specific system of reproductive care different, or not, from other hospitals in the region? Ultimately the tribe was interested in the relationship between patients and the larger health systems that served them. By exploring this relationship, I would be able to

observe the tensions that existed between individual patients and the biomedical clinics that produced and shaped their reproductive subjective states.

CLINICS HAVE BECOME popular sites of ethnographic inquiry in recent decades. After the breakdown of the stability-granting political systems of colonialism and the Cold War in the 20th century, and the subsequent loss of many traditional ethnographic fields, anthropologists began contemplating what sites of culture existed in communities closer to home (Long et al. 2008). Hospitals and clinics emerged as spaces that actually possessed many of the attributes of previously preferred distant field sites – highly structured, often socially isolated and isolating, governed by unique yet generalizable sets of rules and paradigms, and, more specifically, capable of shaping medically- and technologically-mediated relationships between patients and the world outside the hospital. While hospitals were previously imagined as "islands" of biomedical intersubjectivity separate from the broader social practices surrounding them, they are now seen as systems that are actively shaped by the values and priorities of the societies they serve. Hospitals create a demarcated line between medical and non-medical realms of experience but these seemingly commonplace spaces also represent both micro and macro cultural systems – isolated and reliant upon their own peculiar structure yet reflective of and influenced by the social world immediately around them.

Hospitals and clinics are also frequently the site of culturally important rites of passage, another important concern of anthropological research. The liminal nature of the events that occur in hospital settings have the ability to magnify the core beliefs of the society

or cultural group running the daily hospital operations. For many, the life and/or death nature of being a hospital patient involves all three phases of the ritual process. Upon entering the hospital, individuals are separated from the normalcy of everyday life and placed into a position of liminality as they await the outcome of whatever condition brought them to this space – the birth of a child, the diagnosis of an illness, death – and before they leave, they have assumed a new social and personal identity. The weight of these events has the capacity to distill the social meanings of daily life down to their essence and create a sense of urgency regarding these transitions. As people undergo these often intense identity transformations, the biomedical context of the hospital takes on a religious or other-worldly connotation adding a layer of spiritual authority to the clinic space (Long et al. 2008). In the context of reproduction, I wondered how this spiritual authority worked in tandem with broader medico-technical powers to shape women's subjective experiences.

The idea of hospital as cultural microcosm was also compelling to me when considering a tribally operated health system. Technology dependent biomedicine as it is practiced today is often viewed as a development stemming from the colonial powers of Western Europe during the 19th century (van der Geest and Finkler 2004). From there biomedicine spread throughout the globe, reaching and eventually replacing many other forms of care, and acting as a frontline of globalization and modernization by propagating Western modes of health and medicine. Hospitals offer unique sites from which to investigate the homogenizing forces of globalization and the hegemony of science and technology as the drivers of "progress". When a hospital is operated by a

semi-sovereign government within a settler colonial state, the role of globalization and notions of progress and modernity are further complicated.

A site of one of the most liminal and culturally shaped experiences many women will experience, as well as a system that has accepted and integrated the technological model of biomedicine, a maternal health ward in a tribally operated hospital brings together all of these interwoven yet often contradictory aspects of the biomedical world. All hospitals are subject to certain regulations and governing boards, one of the homogenizing forces exerting pressure on biomedical regimes. For example, Oklahoma hospitals are required to comply with federal HIPPA laws, maintain up-to-date licensing with the Oklahoma State Department of Health, and ensure all practitioners have current malpractice insurance. Tribal hospitals in this state must also comply with all of these standards. However, they also have the potential to reflect specific priorities and expectations regarding care more strongly than other hospitals precisely because they are designed with a particular population in mind and operate under the auspices of tribal sovereignty. Although the actual differences between tribal and other private hospitals in terms of the services delivered is open to debate, this does not change the fact that these hospitals are operated by sovereign entities with the purpose of serving a clearly defined population – namely citizens of tribal nations.

Clinical spaces and the medico-technical apparatuses within them have an undeniable role in the social and political realities of the contemporary world. Far from being extraordinary spaces, experiences of clinics and hospitals are exceedingly common. As

such, they become sites for the production of subjectivity as individuals are increasingly exposed to the political and technological power of such biomedical zones. The sovereignty which guided the operation of the tribal hospital created additional idiosyncrasies from which to approach the topic of subjectivity, particularly in the context of Native reproduction. How do these sovereign spaces contribute to or push against the construction of the specific category of Nativeness? Does the use of this presumably culturally distinct hospital affect how Native women articulate and understand their reproductive experience? And how might the systems of physiological and social intervention used by this hospital impact the reproductive subjectivities of Native women and the mothers of Native children?

EVENTUALLY, AFTER A wrong turn that landed me on the opposite side of town, I arrived at the campus of the hospital. Out of sight of the main road, the hospital was settled into a green valley. The steel and glass exterior of the hospital created a stark contrast with both the scrappy rural hub that I had driven through to reach this place and the surrounding lush landscape. Nestled amongst mounding hills and snaking, crumbling roads, the geometric lines and sharp angles of the complex were disorienting. Following the long driveway down from the crest of the main road, I made my way towards the sprawling parking lot. Despite the fact that it was still early in the summer, the Oklahoma sun created waves of heat that radiated up from the asphalt and distorted the scene in front of me. I parked my car and unbuckled my son from his car seat, both of us relieved to be done driving for the time being. Part of my basis for bringing my young baby with me on this visit was tactical. For reasons that are still somewhat vague

in my mind, I had decided that bringing my own baby with me to a maternal health ward would create an ethnographic opening as not just a pesky student researcher, but as a mother with a genuine interest in the health of women and infants. In hindsight, I realize that bringing my son may have done just the opposite.

Regardless, I headed resolutely towards the heavy wooden bows that marked the main entrance to the hospital. My resolve faded quickly as I passed through the automatic doors and realized I had no idea where I was going. I stood awkwardly in the doorway, looking for a map or sign to point me towards my destination. I eventually located a marker that informed me that I needed to head up and to the right. As I walked down the hallway, my whiteness and middle-class status made me feel out of place. This was, after all, a tribal hospital in an economically depressed rural area and I neither qualified for its services nor was in need of them. Nervously avoiding what I imagined as the critical gazes of hospital patients, I took note of the hospital itself. Large framed artwork consisting of mixtures of cherry hued wood and blocks of color decorated the hallways and bubbles of sunlight floated in from the massive windows that dotted every exterior wall.

After traveling through a maze of similarly light dappled corridors and sweeping staircases, I eventually found my way to the maternal health unit and walked through a set of double doors into a surprisingly large waiting area – my son and I were the only ones in an amply appointed space that could have sat a hundred people. A bank of windows ran one of the long edges of the room and made it feel as though it was

suspended above the verdant fields and forests below. When I arrived, the registration window was vacant and the only other set of doors in the room were locked from the other side. This was a preliminary visit and no one was expecting me. Unsure what to do, I wandered around the room, taking note of the posters on the wall touting the benefits of breastfeeding and urging expectant moms not to induce labor before 39 weeks gestation.

Eventually a nurse came to the registration window and asked what she could do for me. I attempted to explain to the young nurse why I was there – I had been in communication with two tribal IRB members about developing a research project and wanted to introduce myself to the midwives. I let her know I had tried to contact two of the midwives via phone and e-mail over the preceding weeks but had received no response. I was hopeful that I could make a quick introduction in person. The young nurse, with a raised eyebrow and tilt of her head, explained to me that the midwives were busy with patients all day. They would not have a break to speak with me. I tried to regain some of the resolve I left in the parking lot and pushed back gently, letting her know I would be happy to wait. However, the nurse stood her ground and I quickly retreated to my usual hesitant self, conceding to a simple tour of the department in lieu of the introductions I so desperately wanted to make.

Distracted by my frustrations over failing to initiate a relationship with the midwives themselves, I nonetheless followed the nurse through the maternal health ward. Listening to her standardized soliloquy about the mother-friendly birthing rooms, the

role of midwives in their medical hierarchy, and the newly released Oklahoma Healthcare Authority report touting the hospital's comparatively low C-section rates I did my best to ask as many questions as possible about not just the systemic processes of the maternity ward itself, but about the experiences of the women who utilized it. While the hospital is operated by a specific tribe, its maternal health services are open to any woman who either has a federally-issued CDIB card or is pregnant with a child who will be eligible for one. Not only was this unit open to members of other federally-recognized tribes, but to women such as myself – non-Native mothers of children eligible for tribal enrollment - as well.

When it comes to healthcare, most tribes have one of three options in how to ensure their members have access to adequate services. They can rely on the federally managed Indian Health Service (IHS) to provide healthcare and operate clinics and hospitals in or near their service areas; they can accept funds from IHS to construct and manage their own health care delivery systems; or they can utilize some combination of these two options (Dixon and Roubideaux 2001).[3] Many tribes in Oklahoma, like this one, have chosen to operate their own extensive health care systems, utilizing the IHS mechanism of compacting to provide financial support to patients that need services beyond the scope of the tribal health network.

[3] If an individual tribes wishes to manage its own health system, there is a process in place which must be followed. The tribe will initially enter into a contract with IHS to show that they are capable of health management. After three years and a positive record, a compact is developed which grants the tribe more extensive authority over management and funding allocation.

Maternal and infant health services are one of the programs that can be provided by tribal health. Like most of the larger tribal health centers in Oklahoma, this hospital relied predominantly on CNMs for delivering reproductive care, as opposed to the OB/GYN physicians which are now the only labor and delivery option in all other hospitals in the state. Both tribal health systems and Indian Health Service clinics and hospitals have relied on certified nurse-midwives for decades – IHS employed their first CNM in 1969 (American College of Nurse Midwives) and tribal hospitals in Oklahoma began employing CNMs as early as 1980 (personal communication). The use of CNMs as primary care providers was one of the noteworthy differences between this hospital and most others in the state.

After I had been guided through the majority of the ward and asked every question I could think of, the nurse led me back to the waiting room. I asked once more if any of the midwives happened to be free before I left and, without breaking eye contact with me, she apologized and said no. She handed me a scrap of paper and said I could leave my name if I'd like. I wrote out my name and contact info on the torn three-inch sheet and handed it back to her.

I wound my way back towards the main hospital entrance, absorbing as much as possible from the visit. I was perplexed by the way the afternoon had unfolded. Although I was disappointed I had not been able to meet any of the midwives, I was also frustrated by the sense that I had failed to adequately communicate my goals. Whether through e-mails, phone calls, or during this visit, what had I said or not said

that had created and maintained this distance between myself and those I was attempting to reach?

CONDUCTING ETHNOGRAPHIC RESEARCH in a hospital or clinic setting presents a number of distinct challenges. From cajoling clinicians into taking time from their busy patient load to talk with someone to whom they have no obligation or responsibility, to convincing administrators and clinicians of the value of ethnographic research, to simply adapting standard anthropological methodologies to the unique structures and hierarchies of hospital settings, clinical ethnography demands attention to a very specific set of details. The related but often competing levels of bureaucratic regulation not only have a profound impact on how fieldwork is conducted in these zones but can also complicate questions of ethnographic access itself.

Gaining access to clinical gatekeepers often requires navigating a complex bureaucratic system in order to ensure that collaboration happens with the appropriate people in the appropriate way. I had begun this process in what I believed was the appropriate way. The tribal IRB members I had been in communication with were, as I saw it, ultimately responsible for deciding if my research with the hospital could move forward. However, they were far from the only gatekeepers in this hospital. In this instance, gaining access also meant gaining the support of hospital administrators and the actual clinicians with whom I was hoping to work. This meant that it was necessary that I explain the relevance of my research interests to each of these stakeholders.

The initial challenge of creating an ethnographic opening necessitates presenting research goals to would-be collaborators in a way that avoids any perceptions of "doctor-bashing" (Long et al. 2008:76) and allows clinicians to imagine the benefits of having an outsider intrude on their day-to-day practices. One way that has been presented to clear this hurdle is to use clinical ethnography to engage not just with patient experiences but with the concerns and struggles of the institutional actors as well. Collaboration again becomes crucial to bridging these gaps – by working with clinicians and providers to determine what questions they want answered, perhaps access to these highly regulated spaces becomes less difficult.

Hospital ethnography also presents a challenge to one of the foundational tenets of anthropological research – participant observation. How exactly does a researcher participate in the daily occurrences of a specialized medical setting when they cannot act as a doctor, nurse, or patient? In other words, how can they gain an emic perspective of any part of hospital life? Anthropologist Gitte Wind (2008) argues that such a task is almost always impossible and instead presents a methodology of "negotiated interactive observation" that involves doing fieldwork without the presumption of "becoming one" of those you are conducting research with. She argues that while participation may not be feasible in hospital settings, interaction typically is. Additionally, interaction creates space for those with whom the ethnographer is interacting to engage in their own observations of the research process itself. In this way, the relationship between object and subject can be continually negotiated as the

field shifts and changes. As new patients are admitted or new nurses clock-in, the type and depth of interaction is able to adapt.

Even this more adaptable methodology assumes access to the field itself has been granted. As I left the hospital that day, I began to doubt that I would be successful in creating the necessary ethnographic opening to make this my field site. This informative yet ultimately disappointing visit would be the first of many lessons I would receive during this journey on the complicated nature of conducting anthropological research in a biomedical setting. As I had embarked on this project, I had done what I felt was my best to proceed in a respectful and collaborative manner, assuming this was what would be necessary to begin investigating my larger questions. By utilizing a variety of contacts and angles – from early consultation with IRB to in-person introductions with clinicians to a shameless exploitation of my chubby-legged infant – I presumed that the necessary pieces would fall into place. I envisioned my questions as rather straightforward – a set of inquiries regarding Native women's reproductive experiences and how specific subjectivities were constructed from those processes. Driving home from the hospital, however, I was forced to consider that the sites where these subjectivities were created and given meaning were in fact regulated and negotiated by a biomedical system of relationships that was far more complex than I had anticipated. Nevertheless, I persisted in attempting to navigate this somewhat foreign ethnographic terrain.

SITTING AT MY desk at the end of September, six months after my visit to the hospital, I looked out over the clutter in front of me towards the street outside. Enjoying the disordered familiarity of my home, I gazed absent-mindedly out the window as I opened my laptop for the day. I waited for my computer to boot up then mechanically opened my e-mail. There it was. An e-mail that, unbeknownst to me at that moment, would force me to reevaluate all of the work I had done up until this point.

I had spent those previous six months in near constant communication with the tribal IRB. The two men who ran this tribal IRB and served as research navigators had played crucial roles in the development of this hospital ethnography project that was to be the basis of my Master's thesis. Our communication began in earnest in the preceding March and had plodded along since then. The approval process was slow but nonetheless appeared to be moving forward. Since my research goals involved questions related to the use of clinical spaces, I needed approval not only from the tribal IRB office but also from the hospital itself. In order to satisfy both of these entities, I was asked to complete a variety of different tasks. I created numerous research proposals, each slightly different from the previous, until one was finally agreed upon by all of those involved. I developed lists of interview questions for each of the different groups I expected to be working with. The hospital required I submit copies of my driver's license, health insurance card, and vaccination record, all of which I had gathered together, photocopied, scanned, and e-mailed to the appropriate people. I had even completed a packet of paperwork designed for medical students applying for internships at the hospital. Despite the fact that I had to leave all but the most basic

sections blank, I was sure to provide as much information as possible and sign on every required line. Cumulatively, all of these actions took weeks. Coordination had to occur between multiple individuals, all with conflicting schedules and obligations. By early August I had done all that I could do and was left to await the final approval from the hospital and IRB, which I was reassured was imminent.

As I sat down to my computer on that morning, I expected a simple reply to what had become an almost weekly request from me for an update. However, this e-mail was unlike the typical responses guaranteeing me things were moving forward. Beginning with "I wish I had better news", the e-mail recommended that I begin looking elsewhere for a research site. The two men I had been in communication with had been able to gain the tacit approval of the full Institutional Review Board. However, the approval process had stalled out when they had attempted to gain the support of the hospital administration and clinicians. The tone was apologetic yet no alternative paths forward were offered. After more than half a year of collaborative correspondence, this five-line e-mail effectively ended my project before it began.

I sat at my desk slightly dumbfounded. Eventually, I completed the necessary communications to follow-up from this e-mail and was left to reflect on this outcome.

THIS DENIAL FORCED me to think about what it meant to have the tribal sovereignty I sought to respect actually exercised against me. While any clinical setting could have denied my research, the sovereign status of the tribe contributed an additional layer of

complexity to the situation. Ultimately, this outcome demanded that I consider what other spaces might be able to teach me about Native reproductive subjectivities. Sitting at my computer, re-reading this email, I began to reconsider my original research questions and to contemplate what exactly such a denial meant for the ethnographic project I was attempting to undertake.

The practice of ethnography has changed in many ways from its earlier forms. Researchers today must navigate interwoven and sometimes conflicting regimes of intervention which regulate access to specific spaces. There are now what anthropologist George Marcus (2010) has termed "overlapping zones of representation" mediating the relationship between ethnographer and ethnographic field. These zones or structures of representation, according to Marcus, are typically made up of experts and elites who are more invested in issues of policy than in the actual experiences of those they often represent. As researchers are expected to negotiate such zones or systems and work through these experts, the anthropological norm of "lone operatives" is shaken as researchers are now required to negotiate with actors other than those with which they want to do research.

Such structures of intervention present obvious challenges for contemporary ethnography. However, they also serve as important mechanisms of protection for often vulnerable and exploited populations, as well as provide an interesting perspective from which to reflect on the modern ethnographic project. As Marcus argues, the metanarratives that are produced from such structural representatives are often

insufficient for describing the subjective experiences of the individuals who interface with these regimes. Ethnographers are then put in the frequently tenuous and often contradictory position of having to maneuver their way into the systems they wish to interrogate while also being regulated by those systems.

This was the position I found myself in as I reflected on this e-mail. Ultimately I had been unable to achieve the balance between the two ethnographic duties of interrogating a system and submitting myself to the regulations of that system. The question then became not only how to proceed with my research, but if there was something about the question of Native reproductive subjectivity itself that was problematic. What political or social barriers might be in place that precluded me being able to witness to the interplay between Native women's interior lives and the biomedical regimes that mediated their reproductive experiences? And so, without the clearly defined "field" of a clinical space, I began to consider where else these subjectivities may reside. In what other modes might Native women articulate these experiences?

II

AFTER I RECEIVED notice that I would not be able to pursue research within the tribal hospital, my focus shifted to locating different sites where Native reproductive subjectivities were created, shaped, and understood. Not able to investigate these topics from within a biomedical space meant that I would not be able to witness the medically mediated processes of pregnancy and childbirth as Native women experienced them.

However, I remained interested in learning more about the intimate ways that reproductive experiences shaped and were shaped by women's understandings of Nativeness.

Native women's reproductive experiences are something that have received little attention outside of biomedical literature. Sociologist Barbara Gurr (2014) explores the topic of reproductive health for women on the Pine Ridge reservation in South Dakota who rely almost exclusively on IHS for care. In this account, Gurr details the often tumultuous relationship between Lakota women and the IHS clinics and clinicians tasked with providing their reproductive care to describe the way that Lakota women articulate a particular kind of political identity surrounding reproduction that is centered on concepts of justice. In another account, R. Cruz Begay (2004) provides a detailed description of the traditional rites and practices surrounding Navajo childbirth and the significance placed on those practices in perpetuating specific understandings of Navajo personhood. Both of these works helped to inform my own research questions. However, neither of them directly addressed my specific concerns or translated to the context of the ethnographic fields in which I was attempting to work. These authors both dealt with reservation populations, which tend to be more culturally and geographically bounded than the Native communities I was encountering. Additionally, these works were engaging different questions from what I ultimately was attempting to understand – how individual Native women's interior lives interfaced with particular political and biomedical regimes around reproduction. The work of Gurr and Cruz

Begay helped provide context to my own research but I ultimately had to develop a new way forward based on my own experiences and perspectives.

Without the structure of a medical regime in which to explore Native reproductive subjectivity, I turned instead to individual women themselves and the stories they told. My recruitment methods were somewhat arbitrary. Unsure exactly where or how to delineate a specific population of women, I simply spoke with everyone I encountered about my project. I reached out to in-laws, friends in the medical and birth fields, and social and professional groups asking to be put in touch with any Native mothers who would be interested in speaking with me about their reproductive experiences. Over the course of several months a small handful of women agreed to meet with me.

In *The Woman in the Body*, Emily Martin (1987) describes a research process that involves bringing together women from different communities and economic realities to understand how their experiences may coalesce around reproduction. Informed by this methodology, I conducted extended individual interviews with the three women who reached out to me. These women shared a small set of subjective realities, namely of having experienced childbirth and having some degree of proximity to Nativeness, but otherwise represented different social, cultural, and economic situations. Acknowledging the potential limitations of a small set of seemingly disconnected participants, I nonetheless aimed to develop an understanding of what women's birth narratives might reveal about the relationship between Native subjectivity and biomedical regimes. How might these patient biographies illuminate the unique ways

that women conform to or push against certain legally and medically predetermined categories (Biehl and Moran-Thomas 2009)? These were the questions I had in mind as I walked into the home of a woman named Mallory.[4]

MALLORY WAS INTRODUCED to me by one of my professors who was familiar with my interest in Native experiences of childbirth and reproduction. Mallory is a citizen of the Choctaw Nation and had utilized a tribal hospital a considerable distance from her home for the birth of her young daughter. Aside from those snippets of information, I knew very little about Mallory. I had initially contacted her at the beginning of my research process but had put off any further communication as I awaited tribal IRB approval to begin my project. After my research with the tribal hospital had been foreclosed, I reached back out to Mallory in hopes that she and I could work together as I attempted to develop a new research protocol built around women's biographies of reproduction.

Mallory and I had spoken on the phone several times and had already rescheduled a number of meetings; it was cold season and it seemed either her child or mine had been sick for weeks. Talking to her on the phone one afternoon after she had missed one of these meetings, she told me "I'm SO sorry!" Mallory's daughter had fallen sick yet again and she had completely forgotten about our meeting. "Coffee and Jesus, I'm running on coffee and Jesus these days!" she laughed.

[4] All of the women referenced and quoted in this thesis gave written consent to have their names used and did not request the use of pseudonyms.

Two weeks after that phone call I sat across from Mallory at her small dining table in the eat-in kitchen of the apartment she shared with her husband and then-10 month old daughter. This was my first time in her home and marked, in some ways, the "official" beginning of our work together. The apartment was full. Bursts of color spilled from the corners, as toys were stacked in an attempt to make things tidier. Boxes of Gerber snack foods filled the open cabinet shelves of the kitchen next to piles of empty baby bottles. Mallory's apartment also served as her husband's workspace – he was both a music minister at their church and offered music lessons from their home – and therefore was also home to a variety of musical instruments stacked in the corners. Despite the fullness of the space, it did not feel messy or cramped. It just felt lived in.

The small apartment seemed to have a life force all its own, bolstered by Mallory's presence which filled any remaining space and seemed to rise above everything else around her. Her laugh was loud and genuine and her porcelain cheeks dimpled when she smiled. On this particular evening, she was wearing leggings with a loose fitting sweatshirt, her dark hair up in an unruly bun. I remember thinking her somewhat disheveled appearance and erratic movements around her apartment were like a mirror of all the hidden chaos of my own life as a busy student and parent. However, despite the disarray of her physicality, Mallory had a frankness about her that demanded both attention and respect. Her emotions always seemed to be right at the surface, available to anyone who was willing to notice. I felt drawn in by her blunt sincerity and wondered why I frequently worried so much about my own emotional appearance. Mallory treated me with the warmth and openness of an old friend, casually placing her

hand on my arm as she gently teased me about my height (I am not a tall person), a joke I have become accustomed to in my life, and offered me a glass of sweet tea. I was struck by the realization that not only was I truly welcome in her home but that she was also sincerely excited to talk with me.

Buoyed by Mallory's enthusiasm, I began our interview by asking her to tell me about her pregnancy. I was not prepared for the landslide of information that streamed from Mallory's mouth, instigated by one simple question. Mallory jumped right into the interview, immediately sharing details of her life that, if it were me, I would not feel comfortable sharing with my own mother. The discussion moved naturally from pregnancy to birth to motherhood and back again with little to no prompting from me. As Mallory's story leapt back and forth in time and space, I struggled to keep up with her narrative. Eventually I gave up and accepted that letting her share her story in her own way would not only grant me the most information about Mallory's experience, but would also be the best manner in which to reciprocate the layers of generosity I was being shown. Surrendering to Mallory's zigzagging account allowed me to sit back and enjoy the process of the interview as a kind of mutually exchanged gift. However, it also forced me to avoid any in-the-moment critical analysis. It was not until after the fact that I began to replay the interview in my head.

After I left Mallory's home that evening, there was one theme that stood out to me, and which I would notice even more clearly in hindsight. That was Mallory's anxieties and vulnerabilities surrounding the process of birth. During the course of this first

interview, as well as subsequent conversations, Mallory's intimate emotional responses to these events were never inaccessible to me. Not only did she share that part of her experience with me verbally, but her entire body was involved in the performance of her narrative. As she described her interactions with her husband, her annoyance with hospital staff, and her own internal battles during labor, Mallory's speech was punctuated by abrupt pauses, precipitous changes in tone, and bursts of hearty belly laughs. Her hands fluttered around with a nervous excitement as she told me of the moment just before her daughter was born: "And um, I, I remember panicking. Thinking I've gotta do this now. Like it's all on me." With the recognition of this responsibility, Mallory's voice broke as she continued:

> And um, I was horrified. And uh, I kept thinking I can't do this. There's no way. I wasn't built for this. Like I baked the baby, I can take care of the baby. But this part I don't want to do. I don't want to have any part of it. And um, I got really sick. And they had to change, literally, my gown, the sheets, cause my anxiety just went through the roof and my heart rate went up and they were like you've gotta calm down, what's wrong? I was like I have to push, I don't know how to push, I didn't practice pushing. Like this wasn't in like the tutorial, like what do I do?

Her shoulders slumped and pulled in as tears streamed down her face. "And the midwife walks in and she goes why are you freaking out? And I said I don't know what to do. And she goes 'good, that's my job'. And I thought you better be good at it lady!" With tears still in her eyes, Mallory let out one of her typical room-filling laughs, her hands settled onto the table in a puddle of tears, and a worshipful calm came over her as she went on to describe hearing her baby's first cry. As Mallory's story moved past the actual moment of birth, her entire physical demeanor changed as she

returned to the confident, light-hearted woman I had come to know. However, the intensity of Mallory's anxiety as she detailed the moments just before she became a mother made clear the vulnerability she felt at this apex of transformation.

ANTHROPOLOGISTS HAVE LONG understood that childbirth is one of the few universal rites of passage. Although the ways in which societies ritualize the process differs, nearly all cultures have some way in which they mark this transformational event. Since the experience of childbirth represents a rite of passage for the birthing woman, it moves through the same three ritual phases as any other rite – separation, transition, and reintegration. The transitional, or liminal, phase is represented by the condition of being "betwixt and between" two opposing social roles (Turner 1969). While pregnancy itself can be seen as a liminal condition, labor is the climax of this ritual phase. Laboring women are no longer who they were – a single individual – and are not yet who they will be – the mother of a young child.

Part of the nature of liminality is that it places people on the threshold between two different realms of experience and creates instability in how both society views the person and how the liminal individuals view themselves. This creates a kind of opening during which outside pressures and influences become more powerful. For laboring women, this opening is both literal and figurative. While there is a physical opening of the woman's body, whether her cervix or her abdomen, there is also a symbolic opening of her identity. As women move through this liminal state, there tends to be a resulting disorientation that arises from the combination of the increased pressure of outside

forces with the climactic slippage between a previously understood identity and the one that will replace it. This results in a sense of vulnerability as women are left to negotiate their shifting status amidst a wave of societal influences (Davis-Floyd 2003).

For Mallory, the inherently liminal, and therefore vulnerable, condition of being a woman in labor triggered a certain reaction in response to the biomedical system within which she was located during this experience. Anthropologist Robbie Davis-Floyd (1992) describes how for most women in America, rituals surrounding childbirth are bound to the authority and tools of obstetrical biomedicine. She explains that American society has a deep-seated fear and distrust of the natural process of reproduction which it seeks to manage through these obstetric methods. By employing specific medico-technical interventions, Davis-Floyd argues that both patients and providers are seeking to transform the unpredictability of birth into a manageable process that reinforces the American ideal of the superiority of science over nature. In so doing, these interventions become normalized as part of the rite of passage of childbirth and are thought to lessen the distress caused by the liminality of the experience.
Mallory's physical and psychological discomfort with the unruly process of birth was clear. She was comfortable with both the degree of liminality she had experienced up until this point and the functional ability of her body to carry a baby. However, at the climax of this rite of passage she was panicked to the point of being physically ill. She did not trust her body to perform as needed and was only comforted by the presence and authority of her midwife, who represented obstetrical science and control. It was not until a representative of this regime interceded to facilitate the process of birth that

Mallory was able to relax and allow the events to unfold. As such, Mallory's reproductive subjectivity was conditioned by the ways in which she was guided through this moment. Her escalating vulnerability, reflective of her own internal doubts and fears surrounding childbirth, interwove with the external medico-technical systems of the hospital to shape Mallory's transition to motherhood and create a unique reproductive subject.

AS I REFLECTED on my interview with Mallory over the weeks that followed, I tried to make sense of how she related her reproductive experience back to her subject position as a Native woman. Mallory was fairly explicit about what being Native meant to her as she contemplated her birth experience. As I was talking with Mallory about the birth of her daughter, she repeatedly told me she was "being stubborn" about using the tribal hospital. There were a number of reasons why Mallory could or should have utilized a different healthcare facility. Although tribal health was free to Mallory as an enrolled tribal citizen, she also qualified for SoonerCare, Oklahoma's version of Medicaid, and therefore could have received 100% subsidized care at any qualifying facility. Her husband also expressed some reservations to her about the quality of the care at the tribal hospital, which Mallory appeared to occasionally project during our conversations. However, perhaps the most compelling reason for Mallory to use a less distant hospital was the simple fact that when she went into labor, her midwives were concerned she would not be able to make it to the hospital before her daughter was born. When Mallory and her husband called the midwives to let them know they were on their way, they informed Mallory that, based on the frequency of her contractions,

she should turn around and head to the nearest hospital instead of making the hour-long drive to the tribal hospital.

Despite this, Mallory insisted that her husband continue driving. Somewhat baffled by all of this, I asked Mallory why using this particular hospital was so important to her. She explained:

> My mom had me at the Indian hospital. So for me it was a heritage thing. Um, it was really important because three of my four grandparents have passed and one of those being, was my grandfather. And he was unbelievably active in the tribe. And he did a lot of work with the reservations and those kind of things around the state and around the US. So for me, I felt like I had been given something that not everyone has. And if it's there, why would I squander that gift? And everything I had heard about other hospitals I, I didn't like that they took them to the nursery, I didn't like that you didn't get the, the skin to skin time, you didn't, and I, and they, or they would give them a bottle or a paci. And with the Indians, they don't even have that, I mean they have pacis but they don't give them to the newborns, those are for babies that are, that come in sick. I, I intentionally chose the Indians. Because I wanted my daughter to have the gift that not many people have. And I wanted her to be born into her heritage. And not grow up knowing about her heritage. Um, I guess it's a pride thing. But I know that not many people can say oh, I'm this Native American. And to me it's, in history, it's, it's frowned upon at times. It's sadly a race thing but for me it's a pride. And I wanted her to one day say, no, I, I was born in a Native American hospital and I, my mom and dad saw the importance from time of conception till I'm adult and I have these wonderful tribal leaders that are here for me to grow and to see and I wanted her to start out with her heritage. I wanted her not, I didn't want her to read about it in the history books. I wanted her to be part of the history. So, it was, I was very stubborn. I really wanted, I want her, I want her to be proud of who she is.

Mallory's insistence on using the tribal hospital was wrapped up with several interwoven priorities. She began by discussing the fact that her family has what she views as a kind of legacy with this particular health system that Mallory relates back to her family heritage. To Mallory, access to this healthcare facility, and the superior care she feels they provide, is a gift borne partially out of her grandfather's years of service

to their tribe. And while she mentions specific aspects of care that she liked about the hospital, she does not connect these preferences back to the notion of heritage. For example, Mallory did not imply that there was a connection between having an immediate skin to skin experience with her baby and the heritage she sought to honor. However, the availability of that skin to skin experience was nonetheless a priority that she believed could be met by the hospital. Instead Mallory explains that she felt the hospital was a gift of her heritage that she could bestow upon her daughter, granting her infant daughter a sense of pride over her Nativeness from birth.

For Mallory, the way that she connected her birth experience with her Nativeness was through a sense of place and kinship. In terms of the attributes of the hospital itself, Mallory's priorities were on the type and quality of care delivered, not on how the hospital could provide something uniquely "Native" to her birth experience. When I explicitly asked Mallory if she felt the tribal hospital offered something distinctive because of its tribal status, she explained "It's the same thing. It's saving lives and progressing medicine. At the end of the day, it's just a great hospital." The "gift" that Mallory and her daughter were the recipients of was the gift of exceptional care at no cost. Nonetheless, she clearly made a strong connection between her personal history as a Native woman and the importance of using a tribal hospital. It was important for Mallory that this pivotal experience in her life take place within the confines of a space she deemed as personally and culturally important. Doing so allowed another way for her and her daughter to embody their Nativeness.

This conversation with Mallory provided a lens through which I could begin to visualize how Native reproductive subjectivities were developed and given meaning. Mallory's articulation of this process was different from what I expected. Like other tribal hospitals in the state, the hospital Mallory used relied on CNMs for most reproductive care.[5] The use of CNMs is atypical for hospitals in Oklahoma. However, Mallory gave indication that this significantly altered her experience, stating at one point that on the single occasion she met with an obstetrician instead of a midwife, "They did exactly the same thing." She still had access to all of the standard obstetrical interventions - including epidural pain management, Pitocin induction, electronic fetal monitoring, and others – and took advantage of many of them.

Additionally, the hospital is owned and operated by the tribe for the benefit of tribal and other Native citizens. As such, it acts as a representation of tribal sovereignty by claiming authority over and responsibility for the health of the tribe itself. However, while there are these two noteworthy differences between the tribal hospital Mallory used and others in the state, neither appeared to create or even contribute to what I expected to be a distinctly Native birth experience. For Mallory, her reproductive subjectivity related to Nativeness through a sense of kinship and politics that, while still significant, was much looser than what I expected.

[5] The midwifery model of care is often described as being significantly different than more medicalized models of obstetric care. The Midwives Association of North American describes their care model as "woman centered" with a focus on providing nurturing, hands-on support to women before, during, and after pregnancy (https://mana.org/about-midwives/midwifery-model). Interesting ethnographic work has been done on the role of authoritative knowledge in midwifery (Davis-Floyd and Davis 1996, Fleuriet 2009), the history and gentrification of midwifery (Fraser 1995, Burton and Ariss 2014), and some of the concerns surrounding the emphasis on the "natural" in midwifery care (Abu Lughod 1995, MacDonald 2006). A thorough investigation of the role and history of midwives in Native reproductive subjectivities is needed but is unfortunately beyond the scope of this thesis.

EACH TIME I met LiErin was in the windowless space of her campus office. Only a few years older than myself, her blond hair was typically pulled back in a loose waterfall. Her expansive green eyes dominated her face and her frequent smiles tended to pull her top lip to the right ever so slightly. LiErin was from New England yet her measured voice reminded me more of my Midwestern relatives. She was always dressed in clothing that just toed the line between comfort and professional – loose slacks, flat slippers, flowy cardigans. The worn grey industrial carpet and large plywood desk of her community college office belied her academic credentials – the framed PhD from Princeton hanging on the wall was barely noticeable among the bookshelves, stacks of ungraded student papers, and photos of her husband and young son. The husband and young son were what brought me to this office. LiErin's story did not fit with my original goal of working with Native women who had used a tribal health system for prenatal and delivery care. However, her husband and son were Native and she was willing to speak with me about a fairly personal experience when I was finding, for reasons that were not quite clear to me, others were not.

Although LiErin's husband had also been raised on the East Coast, his family was originally from northeast Oklahoma. In fact, his grandmother, similar my own in-laws, had retained her original allotment land and passed it down to her children after her death. Although he spent the majority of his life hundreds of miles away, LiErin's husband had spent his childhood summers with his grandmother on that allotment land. As LiErin told me, "Grandma's farm is home." When his grandmother began to age,

his parents left Maryland and returned to their family home in Oklahoma to care for her. Now, his own parents were in the same position and LiErin and her husband had also made the move to Oklahoma. Having been in Oklahoma for several years by the time we met, LiErin explained to me that they had begun to develop a relationship with her husband's Creek relatives, as well as slowly develop an identity as a Creek family. They attended Creek language camps every summer with the intention of teaching the language to their son, had begun visiting stomp grounds, and were making a point to learn more about the Creek rituals that were important to their friends and family.

And so, despite the fact that LiErin herself was not Native, nor had she delivered her son at a tribal hospital, I was hopeful that her experience would still be relevant to my project. Therefore, I once again sat down in the gray tweed and plastic-armed chair in her office and awkwardly dove right in to the visceral subject of childbirth.

With a meandering that I was realizing should be expected from these stories, LiErin began telling me about her experience of pregnancy, relationships with family, priorities for her care, and eventually about the birth of her son. Being married to a Native man, LiErin was eligible for the services at any of the tribal hospitals in the state. Although she and her husband explored that option, they learned that her care would end shortly after her son was born since LiErin herself was not a tribal citizen. Concerned about the lack of continuity of care, LiErin decided to take advantage of her private insurance to find a healthcare facility she was more comfortable with. At the time that LiErin was pregnant, there was one non-tribal hospital in the state that offered nurse-midwife care

(although that program eventually moved to another hospital and was ultimately shut down). When I asked why she chose that specific hospital, she explained:

> Um, I knew from the very beginning that I wanted to work with a midwife. Uh, because I have a friend from high school that's a midwife. And sort of heard about her journey to become one. And just, [it] was really cool so like when we started trying I found the midwives at Hillcrest[6], plus it was perfect for me because it was at a hospital. But also a practice of midwives. So it was kind of the best of both worlds. Like the science-y part of it and the safety if there's something awful that happens but then the kind of different kind of care and a different philosophy, not totally different but little bit different philosophy of care.

LiErin's priorities for her care were quite clear. She was interested in the midwifery model of care, which she was familiar with because of her high school friend, but also wanted the security that she felt the hospital provided. The concerns LiErin expressed about safety and the possibility of "something awful" happening would prove to be a prominent thread of her narrative. At times these concerns were explicit, such as when, after checking into the hospital for labor induction, a new nurse accidentally mixed up the doses of saline and Pitocin, a labor-inducing medication. This caused immediate symptoms for LiErin and momentarily threatened the safety of her baby as well. LiErin described this event as "terrifying" and explained that everyone in her room was "panicked". While the mix-up was quickly resolved, it was clearly a case in which the vulnerabilities inherent in childbirth were made obvious. However, this sense of vulnerability to the process of birth showed up in other much more subtle ways as LiErin continued her story.

[6] Hillcrest is a pseudonym for the hospital LiErin used. While a pseudonym may be unnecessary, I am choosing to use one anyway to err on the side of caution to protect any providers that could potentially be identified through LiErin's story.

Unlike Mallory who was so eager to share her story with me, I had to prompt LiErin more than once to tell me about her birth experience. "I was induced. But it ended up being very, very fine. Like, I had one of those labors where I don't really talk about it with anyone because I didn't, it didn't, it was really easy" she told me. Shifting uncomfortably in the chair usually reserved for her students and feeling some unease at the upending of the normal power dynamic between professor and student, I asked her "Do you mind talking about it with me?" LiErin laughed, seeming to remember why exactly it was that I was there, and agreed to share more details with me. However, as LiErin and I talked, it became clear that there were certain parts of her birth story from which she either wanted to maintain a degree of distance or was reluctant to share with me. Anytime the conversation moved towards the actual moment of the birth of her son, LiErin's narrative would either become detached from her own experience or simply stall out. When explaining the medication mix-up that happened early in her labor and her reaction to the responsible nurse's subsequent apology, LiErin said "Why are we doing this? I'm about to have a, like." Although it was clear she meant she was about to have a baby, LiErin never finished that thought. Perhaps most telling of all was the way in which LiErin described the actual moment of her son's birth: "Um, it started getting harder and I thought that I needed to push but turns out we weren't ready. So the midwife suggested a different position and then another and then it got more and more and more. Um, the baby was born at 1:24 in the morning." In the space of a few sentences, LiErin jumped from a fairly detailed first person narrative past the actual moment of birth to a detached third person account. "More and more and more"

stood in for both the emotional and physical experiences of birth while the baby that was birthed from this event was no longer hers but simply "the baby."

As I listened back to this interview a week or two later, this sudden narrative break confused me. My initial thought was that LiErin was simply uncomfortable sharing the gritty details of the biological processes of birth with a relative stranger. However, as I listened past this particular point, it became clear that this was not the case. LiErin's story quickly returned to her more typical detailed account as she described the discomfort of delivering the placenta and the way her body twitched with each perineal stitch she received. If this abrupt depersonalization of her story could not be attributed to a squeamishness about gory details or a sense of decorum surrounding a physically intimate event, what exactly prompted this switch? What was it about this moment of birth, the moment when LiErin was transformed into a mother, which seemed to make her feel so exposed?

When LiErin completely skipped over what I expected to be the climax of her story, I began to wonder how the vulnerability created by this liminal condition played in to her narrative. Was this highly liminal moment simply too weighty for her to communicate? Therefore, instead of searching for the words with which to illustrate what is often considered a momentous transformation, she simply allowed herself to detach from the experience? In that moment of telling, she became a performer of her own story, as opposed to the subject of the story. In fact, from the beginning of our conversation, it was clear that LiErin felt some unease about sharing her birth story. Davis-Floyd

explains that the emotional and physical intensity of labor is often enough to cause "category breakdown" (1992:39). LiErin attributed her hesitance sharing her story to the fact that her birth was rather straightforward. However, perhaps the intensity of the experience was simply too great for her to articulate to me. Regardless of the reason, the difficulty LiErin demonstrated in articulating her story left me wondering how exactly she integrated the social, political, and medical components of her experience with her own affective state.

DURING OUR CONVERSATION, LiErin spent a considerable amount of time discussing the Creek part of her son and husband's lives. This question of Native subjectivity took on a different context in regards to LiErin's experience. Unlike Mallory, LiErin was not Native and had not delivered her son at a tribally operated hospital. Although her husband was Muskogee Creek, my expectations for how LiErin might connect childbirth with Nativeness were different than what I expected from Mallory. However, because of the ways in which LiErin and her husband have engaged with his Creek background, LiErin was able to discuss not only childbirth in the context of a Creek subjectivity but also what reproducing Nativeness meant to her. During our conversation I asked LiErin if there were certain aspects of her proximity to Nativeness that impacted her reproductive experience or her priorities for her care. She responded by telling me about her Creek friends that were very tradition-oriented:

> So when they had a baby, they were very careful to practice medicine in a very particular way. And so when we were with them I asked them what - if they'd

> be willing to share what they'd done. And it became really, really clear from what they were saying that the message was if you haven't been doing this all along you should not be doing this now.

For LiErin and her husband, they made the explicit choice to not engage Creek traditions during the course of LiErin's reproductive experience. While they initially had some interest in specifically Creek medicinal practices related to pregnancy and childbirth, they accepted that they were not in a position to properly honor those practices. For LiErin, addressing Nativeness in the framework of her reproductive subjectivity meant recognizing that she was not properly situated within larger Creek contexts to make that connection. She felt that the best way to acknowledge the role of Nativeness in her life was to accept that she could not make space for that part of her biography with her experience of pregnancy and birth.

LiErin was not, however, naïve to the questions about what Nativeness would mean for her young blond haired, blue eyed son. When her son was around four months old, LiErin's in-laws hosted a Creek naming ceremony for him, anchoring him not only to their family land and the terrestrial plane of the earth, but also grounding him in his Creek heritage. At the same time, LiErin expressed ambivalence about what it would mean for her son to experience both Native subjectivity and white privilege:

> I think that the issue of like racial and ethnic identity for him is one that I think about a lot. We don't live in a community of Creek people, it's like a two hour drive to get there. Which is closer than when my husband was in Maryland I guess, right? We know his grandmother is teaching him the language but it's just once a week. And we've been learning the language for seven years and we barely speak a lot of it. And he's going to have white privilege and look white

> and so what does that mean? And I just see so many Native people who struggle with the question of authenticity.

LiErin seemed to deflate a bit with this thought, as she slumped back in her chair. She sighed and told me "I just don't want that anxiety for him."

As LiErin and I wrapped up this interview, I was excited to have finally had a conversation in which I felt like the connections I had been looking for were more obvious. However, at the same time I recognized that this excitement may have been misplaced. As a social scientist, it is perhaps unsurprising that LiErin would express concern about identity and privilege in this explicit way. Her training in social theory had enabled her to think about these issues in a manner similar to myself, as well as possibly primed her to give me the kind of answers she knew I was looking for using language that she knew I would respond to. That being the case, I cautioned myself against assigning more value to LiErin's articulations of these questions than I would to other women who were generous enough to talk with me. LiErin's perspective was compelling, as well as vaguely reflective of my own, yet I questioned to what extent it was generalizable to other mothers of Native children. Did other women feel the same level of uncertainty regarding their children's position as Native? Both Mallory and LiErin had expressed varying degrees of disconnect between their Native subjectivity and their reproductive experiences. Was one of these responses more common than the other? And if so, what could that tell me about Nativeness and reproduction? I had been contacted by one other woman who was interested in speaking with me. I hoped that her story could provide some further context.

COURTNEY HAD CONTACTED me through a post I made on social media looking for Native women who had used a tribal hospital to share their birth stories. Courtney was Cherokee and had delivered both of her children at the same tribal hospital that Mallory had used. However, as we started communicating via e-mail, one of the first things she told me was "You should know that I am very little Native American though, you don't need much to be able to get the benefits. Just in case you are needing someone closer to the heritage!" Unsure what to make of that comment, I decided it would still be worth meeting with Courtney to get an additional view on the questions I had.

The first time I met Courtney was in the lobby of a Chick-fil-a on the dusty west side of Oklahoma City. A part of town where industry meets agriculture, the air is gritty from the soot of semi-trucks and the surfaces are tinted to the color of rust by the dirt from western fields. Courtney and her family lived near here in an RV park, where they docked their fifth wheel trailer while her husband's job kept him in the area. Chick-fil-a was Courtney's idea. Being a vegetarian, I had not set foot in a Chick-fil-a since childhood, but Courtney figured her older daughter would have a place to play while we talked. I arrived before she did and took a seat, my senses immediately assaulted by wailing children and the scent of overused fry oil. I looked through the clear wall separating me from the swirling plastic tubes of the children's area and into the pink mouth of a toddler smearing his face across the glass. Doing a mental calculation of the

number of germs entering the toddler's mouth, I gave a brief thanks that it was not my child in there.

Courtney arrived shortly after I did, a small ball of pink fluff curled on her chest and a little arm wrapped around her thigh. The arm was connected to a young girl of about four peeking out from behind her mother's leg and the ball of fluff unraveled to reveal a squishy newborn. Courtney greeted me with a simple yet drawling "Hi!" Our table rattled a bit as Courtney set herself down with a sigh. Bits of dark hair had escaped her barely contained ponytail, framing her face in a wreath of frizz. A few more strands seemed to slip loose with the effort of settling herself into the confines of the plastic booth.

We made some small talk, both of us nervous and awkwardly trying to make the other feel comfortable. Courtney's accent publicized her origins in rural southern Oklahoma, the place she still considers "home," and reminded me of my on-going tensions with my mother-in-law. Unlike my own rural in-laws, however, Courtney was neither religious nor politically conservative. When asked about the values she hoped to pass on to her own children, she quickly but confidently moved past the topic of religion and explained that she just wants her girls to be happy: "If they want to marry a lady, that's fine with me." She described the family's current but temporary residence in the RV park and I immediately saw scenes of single-wide mobile homes with loose siding and peeling paint. However, far from the working class country girl image that took shape in my mind, her current stop at the RV park in Oklahoma City was part of a larger plan

for her family. Her husband travels frequently, working long hours and making good money as an electrical high-liner, and their fifth wheel travel trailer allows the family to stay together during those travels. Their trailer was nearly the size of my own house but, unlike mine, equipped with a mobility that allowed Courtney and her family to explore the United States while also making a sizeable income.

Courtney's voice was soft but also seemed to have a coarseness about it that I couldn't quite place. When she spoke, she habitually brought her hand to her mouth, covering her slight smile and making me wonder what exactly she was guarding. The frequency of this gesture would only increase when I pulled out my digital recorder for our first interview.

I started the interview by asking Courtney to share her most recent birth story with me and she slowly began to describe fragmented pieces of her experience. Her unhurried account allowed me to engage with her story more so than I had been able to do with Mallory. Therefore, when Courtney, in passing, mentioned "They come in and broke my water", I was able to quickly insert myself into Courtney's narrative and ask her to tell me more about this moment. "So, did they give you options? Like if you didn't want your water broken was that discussed with you?" I asked. She explained:

> No, it's just something they come in and did. It happened so fast. She just come in and she said she was checking me [for dilation] and she did. And then she was like well now I'm gonna break your water. And I was like, OK well go ahead and - but she was already in there doing it so there wasn't a lot I could've done if I wanted to do it differently.

For Courtney, having her membranes artificially ruptured without her prior consent was representative of her larger experience with her care providers at the tribal hospital where she gave birth. Her first daughter's birth there had been a very positive experience where she felt her concerns were addressed and she was respected as an individual beyond her status as a birthing woman. However, her more recent time there had been marked by what Courtney repeatedly categorized as demanding, impersonal, and hierarchical interactions with hospital staff and her midwife. She was frequently excluded from conversations about what was happening with her own body and baby and was subjected to routine interventions, such as the rupturing of her membranes, without any discussion. Although Courtney was not enthusiastic about the ways in which her midwife and nurses exercised their authority over her birthing body, she was nonetheless accepting of it. She dutifully fulfilled her role as the compliant patient subject to the authoritative knowledge of the biomedical system of the hospital.

THE TERM AUTHORITATIVE knowledge refers to the ways in which particular systems of knowing become normalized as valid and superior while alternative forms are disregarded as naïve, unsubstantiated, or unreliable. Anthropologist Brigitte Jordan developed the term to explain the "ongoing social process that both builds and reflects power relations within a community of practice" (Jordan 1993:152). As authoritative knowledge is constructed from institutional systems of social power, it both grants legitimacy to the decisions of those who hold it and contributes to ranked categories of knowing.

In terms of reproduction and birth, this authoritative knowledge is typically vested in the medico-technological realm of the obstetrical field and naturalized as seemingly irrefutable. In this realm, technologies such as ultrasound machines, fetal monitors, and anesthesia are used as mechanisms through which the authority of the medical is both expressed and reinforced. Jordan argues that these technologies are more than just machinery but are instead the very methods through which obstetricians maintain their authority over the birthing body (1997:65). The ongoing acceptance of the obstetrician and accompanying technology as the authority on reproduction and birth allows for the reinforcement and reproduction of that authority, thus creating a self-perpetuating hierarchical system of knowledge valuation. The situating of this authoritative knowledge within the male and technology-dominated realm of obstetrics contributes to the creation of what anthropologist Robbie Davis-Floyd (1994, 1997) calls the "technocratic body", whereby normal (especially women's) bodies are seen as pathological and in need of management through medico-technical means. Female bodies and their associated cultural representations are viewed as dirty, primitive, and "natural" by American society, while male bodies represent science, cleanliness, and progress (Davis-Floyd and Sargent 1997).

In Courtney's case, the authority she was subject to was that of her midwife, not an obstetrician. Nevertheless, the midwife's authority was representative of the power of the hospital as an institution to manage women's reproductive subjectivities. Courtney was frustrated that there seemed to be little to no conversation about the clinical processes she was subjected to, explaining her midwife "hardly ever talked to me, she

was talking to the other girls in the room." She told me she felt like "just a placement in their situation." Despite Courtney's own internal objections to this treatment, her body was deemed unruly and in need of management by the medico-technical systems of the hospital.

The way that both Mallory and Courtney articulated their birth narratives provided interesting insights into the structures of prenatal and delivery care within a tribally operated hospital. While the presence of nurse-midwives as the primary care providers had the potential to create a different type of patient-provider dynamic, this was not a foregone conclusion and Mallory and Courtney's stories otherwise illustrated no discernible differences between the ways that tribal and non-tribal hospitals prioritized care. Furthermore, despite the fact that this hospital was owned and operated by a Native tribe, neither woman commented on how that impacted the way they felt they were treated as both women and patients.

Additionally, neither Mallory nor Courtney related the type of care they received back to their Native identity at any point. They did not have specific beliefs or traditions that were a part of their Native upbringing that could only be honored through a tribal hospital. There were not particular medical practices that made the tribal hospital in some way unique. Both women had different reasons for using the hospital that were related to their Native subjectivity but these reasons did not fit with my initial expectations. Rather, I was struck by the fact that being Native had little to no effect on how Mallory and Courtney prioritized their care. While Mallory articulated her

preference for this hospital as a method of social and cultural embodiment of her history, Courtney's reasons were much more straightforward.

For Courtney, her status as a tribal citizen had no bearing on her birth experience aside from the fact that it made her eligible for tribal health services. Courtney told me from the beginning that she had very little connection to her Nativeness and she would continue to make this clear during our conversations, despite my repeated attempts to find some thread. When I asked Courtney what priorities she had for her pregnancy and birth experiences, she explained "I just wanted it to not hurt. That was the main thing, like as long as I didn't - I've always been real concerned about tearing but that's not anything they can control but - uh, no. Not really." Although this response was interesting in its own way, it simply reinforced what Courtney had told me from the beginning – she was not close to her Native heritage and it was not a consideration for her as far as where or how she received care. Courtney's priorities, at least as far as they were expressed to me, centered instead around the physicality of her experience.

Knowing that Courtney's husband was also Native and had family members who were actively involved in some tribal traditions, I continued to probe a similar line of questioning, asking "I wondered if your husband had any specific requests [regarding the birth of his daughters] that related to the Native part of his upbringing?" Again, Courtney dismissed this idea with a quick "Oh, no. He does not care about any of that at all." Like Mallory, Courtney had access to other health systems during her pregnancy. Nonetheless, she chose the tribal hospital. For Courtney, using the tribal

hospital came down to a simple matter of comfort – it was the health system she had grown up using and she was familiar with the way things were handled there. So while this particular hospital was not the most convenient for Courtney and her family, who like Mallory had to drive some distance to get there, her familiarity with the associated health system outweighed any inconvenience caused by the travel. For Courtney, her reproductive subjectivity was shaped by the relationship between her level of familiarity and comfort with a politically and historically contingent biomedical institution.

MALLORY, LIERIN, AND Courtney all shared stories that were captivating and informative in different ways. Through listening to their birth narratives I learned more about a system of healthcare with which I was unfamiliar; details about particular Native traditions related to birth; and the variety of ways in which women generally ascribed meanings to their birth experiences. I was also confronted with the realization that the distinctly Native reproductive experience I was looking for perhaps did not exist. I went into these conversations eager to learn about how Native women in Oklahoma experienced childbirth and what those experiences illuminated about Nativeness. However, I learned that, at least amongst these three women, this connection was not an important aspect of their birth experience in the ways that I expected. Although each of them claimed some varying degree of Nativeness, whether it was a strong sense of heritage like Mallory or the complicated condition of being the mother of a Native child like LiErin, their birth experiences were only occasionally linked to Nativeness and in ways that were not often straightforward.

However, this collection of narratives also highlighted the ways in which my questions regarding Nativeness and reproduction could not be answered in the terms I was using. Each of these women, or their children, had a differing degree of connection to their tribal traditions and ancestry yet were each still able to not only claim Nativeness but also were eligible for tribal health benefits during the reproductive cycle. As I talked with these women, I realized that these varying depths of connection were indicative of what it means to be an urban American Indian, particularly in Oklahoma.

Part of the reason for this somewhat disperse Native identity in Oklahoma is the way in which the five largest tribes in Oklahoma determine membership. These five tribes – Cherokee, Choctaw, Chickasaw, Seminole, and Creek – all trace their membership through lineal descent back to original Dawes Roll enrollees. Unlike many other tribes in Oklahoma and other states, none of these five tribes have a minimum blood quantum that is required for membership. That means that even individuals with a very small quantum, such as my own son's 5/512ths certified degree of Indian blood, can gain status as tribal members, be federally recognized as American Indian, and be eligible for all of the benefits and services available to that category of people. Additionally, it means that a large number of people in Oklahoma identify as Native, whatever that may mean to them.

Reflecting on different ways that Nativeness is understood in Oklahoma, I considered how that context influenced my ability to ask the kinds of questions I wanted to ask. Being home to numerous tribes with membership numbers in the tens to hundreds of

thousands, defining an ethnographic Native community in Oklahoma had a unique set of challenges. There are certainly tribes and specific tribal communities in Oklahoma where members have defined traditions and a collective tribal identity. However, each of the women I spoke with were affiliated with one of these large tribes and lived outside of these more defined communities. That meant that my search for some kind of essential Native birth ideology became problematic.

Native ideologies and practices surrounding childbirth are not things that are easily defined or contained, particularly in the context of urban Native women. There are actually very few ethnographic accounts dealing with these questions, particularly as they pertain to any kind of "traditional" birth practices. The work by R. Cruz Begay (2004) dealing with traditional Navajo rituals surrounding childbirth is one of the few available examples. In this piece, Cruz Begay, a Tohono-O'odham woman who married a Navajo man, describes some of the traditional birth practices of Navajo women - the ceremonial use of fires to keep laboring women warm, the singing of origin story songs to encourage the baby to descend the birth canal, and the use of juniper tea and branches to promote the contraction of the uterus after birth. While Cruz Begay's description of traditional birth is fascinating, I realized it represents a rather singular experience that has very few counterparts in many contemporary Native societies. Even by the time that Cruz Begay delivered her own children in 1985, most Navajo women were giving birth not in traditional hogans but in nearby IHS hospitals[7],

[7] Cruz Begay does mention that at least one hospital on the Navajo reservation in Arizona eventually incorporated traditional Navajo sashes into labor and delivery rooms in an effort to show support for and respect of past birthing rituals.

reflecting both a decades-long and nation-wide trend towards more medicalized births and the continued influence of U.S. policies of assimilation. There are now a handful of Navajo midwives in New Mexico working to bring back some of these more traditional birth practices detailed by Cruz Begay.[8] However, in this case, these midwives are working to serve a culturally and geographically defined Native community. For the women I spoke with, and many others in Oklahoma, the cultural and historical meanings they ascribe to their Nativeness are much more loosely defined than those of the Navajo midwives or Cruz Begay's family. That being the case, I recognized that attempting to make some kind of comparison to Navajo birth practices and the way that these practices served to embody Navajo personhood would never be possible.

Part of the goal in engaging these three women and their reproductive biographies was to gain a more complete understanding of how individual subjects are created both outside of and through their interactions with biomedical regimes (Biehl and Moran-Thomas 2009). By asking women to reflect on their experiences of childbirth and the role of the clinical settings in which those experiences occurred, I was attempting to envision a different way to understand how subjectivities were constructed through reproduction. Because while reproductive subjectivities can originate and be shaped within the context of biomedical systems, the ways that those interactions are integrated into women's interior lives and narratives can also reveal something about the nature of the reproductive experience in the contemporary. I therefore attempted to allow the women I interviewed to not only frame their own accounts of their experiences but to

[8] See Changing Woman Initiative, http://www.changingwomaninitiative.com/

let that framing guide my analysis of their words. While I acknowledge my role as the ethnographer in prompting these stories, I also hope that through an engagement with these women's actual narratives, and not only the details I expected or wanted to hear, I was able to grant them the space to theorize their own experiences before I attempted to do so for them (Biehl 2013). This approach enabled a consideration of the more intimate and nuanced aspects of Mallory, Courtney, and LiErin's experiences alongside, and in some cases instead of, more general questions about Native identity and the biomedical institutions governing reproduction.

However, aside from being mothers to tribally-enrolled children, I also knew that there was very little that connected Mallory, Courtney, and LiErin, making it difficult for me to draw any kind of conclusions about birth and Native subjectivity from their stories alone. The combination of a lack of familiarity with potential participants and a research topic dealing with a particularly intimate event made identifying a more clearly defined population problematic. A Choctaw woman with a strong familial Native connection, a white woman with a Creek child, and a Cherokee woman with a self-defined distance from Nativeness seemed to represent very diverse experiences that were hard for me to connect. I was grateful for the time and depth of experience that Mallory, LiErin, and Courtney had been willing to share with me but also recognized that I still wanted to find some kind of ethnographic community in order to develop a deeper understanding of how childbirth mediates the relationship between biomedicine, subjects, and the category of Native. These women allowed me a view of biomedical systems from outside the confines of institution-specific populations. However, my

conversations with them also demonstrated the need for a different angle of analysis from within such populations in order to more fully engage with my questions.

III

WONDERING IF I was in the right place, I pulled up to a looming industrial building feeling as though I was about to walk into Dunder Mifflin Paper Company. A discreet brass sign, nearly lost in the sea of glass and concrete, reassured me that I was indeed at the urban Indian clinic I was looking for. As I got out of my car, I was immediately but momentarily blinded by the setting sun reflecting off the wall of tinted brown windows in front of me. I walked into what appeared to be a pitch black lobby that slowly came to life as my eyes adjusted. The sign on the wall led me down a dimly lit hallway towards another smaller sign that read "Public Health". Hanging at the ceiling, this marker, like the one on the outside of the building, was again inconspicuous to the point of being nearly invisible. I thought to myself that it was a small miracle that any new patient finds their way into this office. I followed the arrow on the sign into a small waiting area, a confusing mix between a doctor's office sterility and the faux-comfort of a relative's cheaply furnished suburban home.

I took a seat in one of the overstuffed brown armchairs of the lobby and reflected on why I was there. After spending time with Mallory, LiErin, and Courtney, I realized that I still had questions about the relationship between Native subjectivity and reproduction that were not being answered through these conversations about childbirth. These women's stories had been fascinating to me in as far as they expressed some of

the different ways in which women prioritize their birth and articulate their experiences. However, I was still left wondering how particular regimes of reproduction interfaced with women and how those interactions produced distinct subjectivities while potentially perpetuating categories of Nativeness. These three women each had a complex connection between their personal biographies as they related to Nativeness and their reproductive subjectivities. Nonetheless, they did not form any discernible community, whether of a medical or cultural nature, and I remained curious about how reproductive experiences could be particular to such groups.

Therefore, I had once again began looking for another way in which to explore these issues. A trail of phone calls, e-mails, and personal pleas had eventually connected me with the department whose lobby I was then occupying. Although the public health department in this clinic, which was funded through IHS and served exclusively Native patients, did not see pregnant or postpartum women for clinical visits, they nonetheless had a number of support programs designed for expecting women who were patients of the medical portion of the clinic. They hosted a four-part weekly prenatal education program for pregnant mothers, called Strong Start, with the incentive of a free car seat for each woman that completed the course. The department also offered a home-visit nurse program, where a nurse would meet with patients either in the office or at their homes once a month from the point of conception until their children were three years old. This program focused on things like supporting a healthy family unit, promoting breastfeeding, teaching proper nutrition, and ensuring a home was safe for an infant or toddler, among other things. Like the education program, the home-visits were also

frequently incentivized, with most visits including a small gift for mother or baby, such as a bib or baby book, and the possibility of receiving a free pack-n-play if women participated regularly.

This clinic was interesting to me as an ethnographic site for a number of reasons. First of all, the idea of Native women receiving reproductive health care from Indian Health Service was particularly compelling. One of the most controversial periods of the history of IHS involved the surgical sterilization of Native women. An outgrowth of the eugenics movement of the earlier part of the twentieth century, the 1960s and 70s saw anywhere between 25-50% of Native American women sterilized under the care of IHS physicians, typically through irreversible procedures such as hysterectomies and tubal ligations (Lawrence 2000). These procedures were frequently performed with improper, coerced, or no consent. Jane Lawrence (2000) details accounts of women receiving supposedly reversible hysterectomies while undergoing treatment for alcoholism; women receiving tubal ligations while undergoing unrelated yet routine surgeries; and women reporting being coerced into signing consent forms for surgical sterilization procedures. According to a report published by the Government Accounting Office (GAO), physicians often failed to fully inform their patients of the risks and irreversible nature of the procedures they were performing (Comptroller of the United States 1976). This same report also states that during a period of less than three years in the mid-1970s over 3,400 sterilizations occurred just in the IHS services areas of Aberdeen, Oklahoma City, and Phoenix. There are nine other service areas that were

not included in that report, indicating that the total number of sterilizations performed was probably much higher.

The goals of the sterilization programs, as stated by IHS physicians in the GAO report, were ostensibly social and economic. After the problem of forced and coerced sterilization became public, a number of studies were conducted to determine the exact extent of the issue and what was motivating it. When asked why they supported sterilization physicians cited a number of concerns. These included wanting to improve social wellbeing by reducing the number of women and children utilizing government support systems such as Medicaid and welfare; reducing the problems caused by activist groups such as the American Indian Movement; and improving the lives of the women being sterilized by reducing their economic burden. Between 1970 and 1980, the average number of children born to women of all tribal enrollments did indeed drop from 3.79 to 1.3. Although other factors were involved, such as increases in the use of birth control, the decline was sharper than that of other populations who saw similar increases in birth control use. Therefore, the role of sterilization must be taken into account. These programs and the subsequent decline of Native birth rates had devastating effects on Native communities, often amplifying the problems that physicians allegedly sought to eliminate. In her article, Lawrence describes the various ways that IHS sterilization practices impacted tribal communities. She details a loss of political power from reduced population numbers, breakdowns of marriages due to infertility, reduced census numbers and corresponding declines in federal services, and

increases in rates of alcoholism, drug abuse, and mental health disorders resulting from the stress and depression caused by sterilization.

In addition to the social and economic factors guiding the sterilization program, Lawrence also explains that many physicians doubted the intelligence of Native women. The physicians believed that these women were not capable of effectively using other methods of contraception, including hormonal birth control. Lawrence goes on to explain the tense relationship that existed between Native communities and contraception. As the number of American Indians living in the United States continued to dwindle, many Native women felt a responsibility to help repopulate their communities, "driven by a feeling that [they], personally, had to make up for the genocide" of their people (Lawrence 2000:412). In addition, many Native women had their own methods of family planning that were not dependent on hormonal birth control, according to Lawrence.

The IHS sterilization programs were effectively eradicated with the passage of the Indian Health Care Improvement Act of 1976, which allowed tribes to take over managerial control of IHS facilities within their tribal jurisdictions. Although the specific violence of coerced sterilization is now over, I was interested in how the colonial project of health care interfaced with and was received by Native women today. While the clinic I was visiting was not specifically an IHS clinic, it did receive funding and support from the agency. With the sterilization program more than forty years in the past, how had Indian Health Service and its associated organizations

evolved to anticipate and respond to the reproductive health concerns of contemporary Native women? And how might these organizations implicitly perpetuate specific categories of Nativeness through the continued validation of only certain reproductive futures?

AS I SAT waiting for my contact to retrieve me from the small lobby, I took note of the various ways in which Nativeness was marked in this space. At first glance, the nondescript nature of this waiting room made it feel as though it could belong to any doctor's office or bureaucratic agency. Overstuffed furniture lined the walls while plants with flowing synthetic branches sat in the corners. The colors were neutral to the point of being forgettable and the carpet was a standard industrial pattern – subtle but with just enough detail to make it seem like the choice was intentional.

However, on closer inspection, I realized there were small clues that pointed to the fact that this office was tasked with serving a particular legally and socially defined category of people. The only piece of artwork on the wall was a watercolor painting of an elderly woman riding horseback, her hair depicted as wisps of wind. There was also signage for a number of public health campaigns targeted specifically to Native populations. These images were especially remarkable, as there seemed to be no connection between the health policies they were promoting and the stereotypical "Native" images accompanying them. One brochure advertised the Oklahoma Helpline, a hotline set up to support people attempting to quit tobacco. On the front of this brochure was a picture of a green field with several large buffalo grazing and the words

"Honor what is SACRED". Another poster urged people to get their annual flu shot to "Protect the Circle of Life" while a picture below this text displayed a circle of shoes, many of which were traditional moccasins. I wondered how exactly buffalo and moccasins were related to quitting tobacco and getting flu shots.

Although neither of these campaigns, nor any of the others I observed in the waiting room, were related to pregnancy or reproductive health, I was nonetheless struck by the ways in which these images depicted Native peoples in a particular way. This iconography provided visual cues to the ways that certain biomedical regimes categorize Native bodies. By drawing on images that I would characterize as tradition-oriented, these campaigns seemed to be implicitly validating one form of embodied Nativeness over others. What were the stakes of this tacit legitimatization of the reproductive futures of the women who used this clinic? I recognized the fact that I had begun this entire process with similar ideas in mind regarding a set of idealized conceptions of Nativeness and thought back to my conversations with Mallory and Courtney, both of whom would have been eligible for services in this clinic. I wondered how they would respond to these depictions of Nativeness.

LIKE TRIBAL HEALTH systems, IHS-funded clinics like this one offer care, typically, to anyone with a CDIB card at no cost to the consumer. In instances where the services needed are outside the scope of the facility, patients are referred out to contracted providers and the cost of their care can be subsidized 100%. This system of population-

specific subsidized care represents a disruption of what is otherwise a predominantly privatized health care system in this country. The fact that the care provided by these sources is limited to a particular population creates a situation in which the bounded group receiving care is characterized as an exception to the norm while also in need of an exceptional, othered, form of care. Since the services of these facilities are limited to a specific group, there must, therefore, be something different about the needs of that group. While subsidized care is offered to a variety of groups in this country, American Indians are the only group that receives such care based on race. In this double-bind situation, simply by qualifying for these systems of care, and, importantly, being reliant upon them, American Indians are automatically categorized as medically "at risk" (Gurr 2014).

The official language of Indian Health Services is laden with examples that point to the perceived unique needs of American Indians as a population. Terms such as "culturally acceptable" and "spiritual health" permeate the IHS website, highlighting a racial exceptionalism while obscuring the ongoing settler colonialism that has created the more pressing economic challenges that both lead to common Native health issues and force many American Indians to rely upon these subsidized systems of care. In addition, there are numerous ways in which IHS states the need for improved care for American Indians – words such as raise, elevate, uplift – both alluding to the currently unacceptable state of Native health and reinforcing the need for its own neocolonial project.

When American Indians rely upon and accept these forms of racially-regulated public health care, a secondary double-bind occurs that further constrains and disempowers Native populations. In a neoliberal system where the onus of responsibility is removed from the state and transferred to the individual, IHS and tribal health systems unsettle this dynamic by shifting the responsibility of care back towards government-facilitated structures. In so doing, Native patients, by working outside of the dominant neoliberal system, expose themselves to morally weighted labels within the context of health care delivery. By bucking the primacy of individual responsibility, American Indian patients, particularly women, are then deemed unruly and at-risk (Gurr 2014:29, Bridges 2011:16-17). The combination of these weighted labels with the public responsibility for Native health realized through IHS classifies American Indian health care consumers as in need of biomedical management through these specialized health structures. This apparatus of subsidized care is such that many Natives are forced to make themselves available to the exceptional demands and interrogations of these health care delivery systems in order to receive care. Khiara Bridges (2011) describes how subsidized care both mandates intrusions into the lives of patients and medicalizes their bodies in ways that exceed what is necessary or received by those who are privately insured. This opens up the opportunity for the inscription of class and, by extension, race onto the physical bodies of American Indians (or others who may be receiving subsidized care).[9] Through the processes of state-mediated medical bureaucracy that demand entrance to the private lives of patients in exchange for access to health care, racial and economic markers become embodied.

[9] See Abu El-Haj (2007) for a more thorough discussion of the re-emergence of racialized medicine in the postgenomic era.

The colonial history and structural design of this IHS-funded clinic made the site inherently different from the tribal hospital and presented an additional layer of questions about Nativeness and reproduction. What were the implications of receiving reproductive healthcare from a settler colonial government that had historically sought to cut off the reproductive futures of the population it serves? Exactly what categories of Nativeness could such an agency attempt to reproduce and legitimate?

Additionally, I found the ways that this clinic incentivized their care opened up another site of interrogation. The goals of the prenatal education and home-visit programs are to reduce preterm births, improve the health outcomes of women and their babies, and to generally provide support and encouragement to Native mothers, all of which are worthwhile and important aims.[10] However, I wondered about the role of incentives in these programs. Were the incentives the main drivers of participation or were women actually invested in the programs themselves? What role did these programs, their incentives, and the type of information contained in them play in the construction or maintenance of a particularly Native reproductive subjectivity?

EVENTUALLY A DOOR in the waiting room opened and the department director stuck her head through the opening, calling out my name. I stood up and smiled, excited to be meeting with this woman whom I hoped would welcome my research project. As we walked through the door and into the main office area of the department,

[10] For more detail see the Strong Start website, http://www.okcic.com/programs/strong-start-group-prenatal-care/

another woman joined us and followed us to the back corner office. I took a seat across from a large wooden desk. The director sat behind the desk and the other woman, who was introduced to me as one of the nurses, slid into a chair next to me. As we began chatting I told the two women about my research interests, explained the basics of the standard methodology of participant observation, and asked them how I might be able to serve the clinic and its patients through my work.

Entry into this clinic marked a different kind of engagement with my research interests, both ethnographically and conceptually. After my experience with trying to do research with the tribal hospital, I decided to approach this clinic in a different manner. When I began communications for the tribal health iteration of the project, I had first consulted a more external layer of collaboration in the form of tribal IRB and research navigation. I knew that eventually IRB approval would be necessary and had developed the belief that ultimately their approval was the hinge upon which the project hung. However, during that experience I learned that I had failed to convey the value of my research to the hospital clinicians, and thus had failed to garner their support for the project. Therefore, as I began to consider this urban clinic as another possible field site, I reasoned that perhaps by talking first with the providers themselves I would have better luck gaining access to this space as a researcher. As I sat talking with these two women who were a part of the daily operations of the department, I was hopeful that this strategy would be more effective. During our meeting they told me more about the programs they offered and expressed excitement over having someone in the office who

could possibly help with a client-based evaluation of their programs. After months of setbacks and limited progress, I was encouraged to hear this.

Our conversation continued for another half hour or so as we talked more about the specific needs of the clinic, the questions they had regarding their operations and programs, and the ways in which I could help them address these issues while also integrating my own research interests. We wrapped up the meeting and I left with a plan to return the following week. I would start by sitting in on the prenatal education classes. Doing so would allow me to gain a deeper understanding of the program and to begin developing relationships with the patients. Although I knew that I would eventually need to gain further administrative and IRB approval, I moved forward anyway. I was confident that approval would be forthcoming and was excited that I finally had a defined ethnographic site from which to explore my interests.

Over the following weeks I spent numerous days at the clinic. Integrating myself into the fairly regimented structure of the clinic was difficult and slow-going at first. I ran into the exact problem put forth by Wind (2008) – how exactly was I to participate in these day-to-day clinic events and processes? I was not a nurse or a patient. Although I was invested in the experiences of the patients themselves, I was not in a position to offer any kind of specific advice or opinions pertaining to their pregnancies, particularly if it would contradict the official line of the clinic itself. And so, I found small ways to move beyond the role of simply observer – helping to set up the conference room before

classes, offering small anecdotes of my own experience during patient appointments, offering to give women and their families rides back to the main clinic across the street.

Eventually patients began to recognize me and feel comfortable striking up conversations, while the nurses seemed to adjust to my presence. After about seven weeks I was finally beginning to feel at ease in the clinic, with the patients, and with the nurses. I had managed to attend my first home visit with a nurse and was about to complete my second cycle of the prenatal course. I was learning how this health system interfaced with Native women's reproductive experiences while also serving as a site for the social and cultural reproduction of Nativeness. Although it took some time, I was at the point where I was beginning to understand how the women who utilized these programs created a specific reproductive subjectivity built around their Nativeness and their experiences with this particular system of care. More than a year after I had begun this ethnographic journey, I felt I was finally getting closer to the questions I had originally set out to answer. This clinic provided the clearly defined ethnographic population I had been seeking – namely a group of women whose individual biographies allowed them to interact with this particular biomedical regime. The women themselves were culturally, racially, and economically diverse. Nonetheless, they each qualified for clinic services because of their status as federally recognized tribal members. As I spent more time at the clinic and got to know more of these women, I found that the diversity of patient backgrounds actually provided a more nuanced view of how this system of care influenced women's reproductive experiences, granting me a level of understanding I had been seeking for a year.

ONE MORNING AS I was driving to the clinic I received a call from the nurse I had been working with most closely. She asked about a specific document and whether or not I knew if it had been set up between the clinic and my university. When I told her I was not familiar with the form, she told me to wait to visit for a couple of days until she could get this particular piece of paperwork in order. She reassured me that it was an easy fix but something that needed to be in place before I could continue working with her. Slightly confused but not discouraged, I turned around and headed back towards home. Over the next several days my communications bounced between a number of different parties as I tried to figure out exactly what needed to be done about this paperwork. Eventually I was told that I would hear back in a matter of days regarding what was needed from me and I carried on, assuming the matter would be handled soon.

At 4:30 on a Friday afternoon I received a phone call from the clinic. Expecting things to be resolved, I answered the phone and the man on the other end of the line gave me a friendly greeting. I was surprised then when he then told me that I would not be able to continue my research at the clinic. This not only halted my current progress just as I felt I was gaining footing in the clinic but effectively meant that all of the work I had done over the previous two months was unusable. Without the explicit approval of the clinic, I could not morally or legally write about the interactions and events I had witnessed over this time.

I spent the following week doing what I could to determine exactly why I had received this response. There were a number of factors involved and ultimately I had to take responsibility for the outcome. I had allowed my enthusiasm for the project to overshadow my awareness that I was essentially conducting research without the all of the necessary approvals in place. This enthusiasm had also precluded me from learning more about the larger operational details of the clinic itself. In reaching out to various contacts there, I learned that the clinic had a number of requirements for supporting any kind of student opportunities, none of which I met. Students had to be American Indian and have a legal contract in place between their educational institution and the clinic. Additionally, and perhaps more importantly, the clinic was not authorized as a research institution and therefore could not facilitate student research. Since it was a teaching clinic, various departments were able to host students needing to complete internships or practicums for health-related degrees but this did not extend to any kind of study beyond observation for training purposes. None of this was communicated to me when I began spending time at the clinic, yet I had to acknowledge that I had failed to develop a deeper understanding of the various structural mechanisms at play.

This second denial left me to once again consider more deeply the nature of my ethnographic inquiry. Why was I being denied access to these sites of Native reproduction? How were my research questions pushing against these various biomedical structures? And what did this illustrate about the nature of the Native reproductive subjectivities I was attempting to understand?

CONCLUSION

THE SEEDS OF this project were borne out of my own experiences and questions - a birth experience that was as different from my expectations as possible; a young son who possessed both white privilege and the benefits of tribal enrollment; what I viewed as a complicity in the often extractive nature of contemporary categories of Nativeness as my family received the benefits of tribal enrollment without enduring any of the historical or contemporary hardships faced by many American Indians. All of these discomforts coalesced to push me towards an ethnographic inquiry into the nature of reproductive subjectivities and Nativeness.

Building on the work of Emily Martin, Robbie Davis-Floyd, Rayna Rapp and Faye Ginsburg, and others, I sought to explore how the anthropology of reproduction may differ when taking into account the complicated subject position of Native women. Rapp and Ginsburg discuss the fact that reproduction is the site where many social and cultural forces are shaped and negotiated. I wondered what this process would look like when the reproduction was historically and legally regulated and the cultural forms in question were frequently under attack. Emily Martin explores the various ways that American society responds to and impinges on the reproductive potentials of women's bodies. How might this be different, or not, when the bodies in question were Native? I was further interested in the ways that Native women are continually reconstituted as

particular categories of being through the reproductive process. Following Biehl and Moran-Thomas' argument that particular subjectivities are increasing created through biomedical regimes, I sought to investigate how the exceptional category of Nativeness was maintained and regulated through specific systems of reproductive care.

This ethnographic journey provided unique insights into these questions. While I attempted through various methods to locate the sites of the tensions between individual lives and biomedical institutions, I repeatedly found that they were inaccessible to me in one way or another. In the case of the tribal hospital, my ethnographic inquiries were ultimately deemed unnecessary or unproductive to the larger goal of the maternal health ward. While I was thankful to have the opportunity to hear the stories of Mallory, LiErin, and Courtney, I was eventually unable to find other women to share their experiences and was left with only a few interviews from a population I struggled to define. And finally, despite my enthusiasm and effort, in the end the urban Indian clinic was never a viable research site.

I was therefore left to consider what to make of "fieldwork that failed" (Kent 2000). In her piece by the same title, Kent discusses some of the reasons that ethnographic projects can fail to come to fruition. I realized many of these applied to my own process. I approached each of these investigations as respectfully and collaboratively as I knew how, a result of the understandings and doubts I had about my research topic and population. Although I continue to believe that collaborative ethnography is not only preferred but often necessary, my attempts to be respectful of those with whom I

wanted to work may have actually impeded my ability to move forward. With both clinical encounters and my efforts to recruit women for interviews, I always erred on the side of caution and quiet deference regarding the research process. In hindsight, a more active recognition and admission of my own goals for these projects may have allowed me to see a more clear way forward.

Kent also explains that she failed to fully grasp some of the historical and social contingencies of the populations she was interested in. While I was aware of the potential hurdles I would face trying to conduct research with Native populations, I nonetheless may have underestimated the extent to which the historical relationship between tribal communities and researchers would affect my own work. I was, after all, attempting to work with a population that has historically been subject to exploitative, harmful, and genocidal research practices (Hodge 2012). This history contributes to not only a specific political climate surrounding Native medical research but also to explicit regulatory structures and parameters. For example, the urban Indian clinic expressly prohibits research while also relying on an IHS Institutional Review Board to help regulate these practices. An additional impetus for the research refusal I experienced could be attributed to the compounding component of doing medically-themed research focused on reproduction, an arena that, as Lawrence illustrated, has historically been the site of medical overreach and the cause of community trauma.

My attempts to locate and understand Native reproductive subjectivities were denied or truncated with each new encounter. However, as Kent also explains, the failures of

fieldwork are themselves instructive. I began this project hoping to understand more fully the relationship between Nativeness and reproduction. As I continued to encounter obstacles to this investigation, I began to realize that perhaps the problem was in the kind of answers I was seeking. I was expecting to find evidence of a specific connection between childbirth and Nativeness. However, such a connection proved to be less explicit than I expected. Within the realm of reproduction-oriented clinical spaces, the focus was on providing necessary medical care to patients. Although the patients interacted with these spaces because of specific categories of being, these categorizations and the types of subjectivities they created were external to the main functions of the biomedical regimes within which they were perpetuated. This was also true in regards to the women who shared their birth narratives with me. When asked how their experience related to their Nativeness, they often responded with confused stares and meandering responses. Despite the fact that these women were actively engaged in both the biological and legal reproduction of Nativeness, this was rarely a concern at the front of their minds. In the trenches of motherhood, these women worried less about how biomedical regimes contributed to Nativeness, however they understood it, and more about simply surviving the disorienting and exhausting challenge immediately ahead of them.

I began this project with the goal of understanding how Native women articulated their conceptualization of and relationship to Nativeness and how they saw that notion as being reproduced alongside their experiences of biological reproduction. I also sought to examine how biomedical systems dedicated to reproduction facilitated, managed, or

pushed against the reproduction or perpetuation of Nativeness. By taking this process as the basis of my research, I expected to uncover how biomedical structures interfaced with Native women's interior lives during pregnancy and childbirth to create a reproductive subjectivity that was particular to American Indian communities. However, during the course of this ethnographic process, I realized that attempting to understand what Nativeness means and how it is experienced through the social, legal, and biological processes of reproduction was actually precluding me from fully appreciating Native women's reproductive experiences. In order to engage with the more nuanced details of reproduction and how subjectivities are created through that process, I had to accept that reproductive subjectivities are not homogenous and are instead shaped by the relationship between individual biographies and external apparatuses of influence.

By taking subjectivity as my dominant theoretical framework, I was also better able to understand my own experiences with the fieldwork process itself. In this thesis I treat my fieldwork experience as a field site in and of itself. I present myself as a character in the narrative and attempt to make all of the intricacies of my experiences evident. In so doing, I demonstrate how my own subjectivity was constructed in relation to the various political and medical systems I came in contact with. As I engaged with the fieldwork process, and the "failures" and challenges involved with it, my own subjectivity shifted as my ability to respond to different events was impacted by these systems. By making all of this obvious, my goal was to leave my understandings and conclusions open for interpretation by my audience. I hope that this treatment will

allow others to engage with my process in a deeper way while also making plain the reality that all fieldwork fails to some degree. However, those failures can nonetheless be insightful and productive.

Throughout this thesis I have attempted to demonstrate how the reproductive subjectivities of Native women exceeded my own predetermined notions of Native exceptionalism. I examined the challenges and the benefits of an ethnographic methodology by treating my ethnographic journey itself as a field site, which helped to illuminate a set of answers to my questions that I was not anticipating. In pursuing questions regarding contemporary biomedical contexts, the inherent limitations of conducting ethnography in these spaces forced me to develop alternative strategies of locating the information I sought. Despite the disorienting experience of fieldwork denials, I was able to engage patient-centered biomedical narratives to gain an understanding of the ways in which Native women's reproductive subjectivities interface with the institutions that regulate them. Through a combination of these narratives and a deeper understanding of specific biomedical regimes developed through the research navigation process, this work illuminates the complexity of Native subjectivity surrounding reproduction and highlights the need for an engagement with Native reproduction that moves beyond the often essentialist or reductionist accounts that have been produced to date.

BIBLIOGRAPHY

Abu El-Haj, Nadia. 2007. "The Genetic Reinscription of Race." *Annual Review of Anthropology* 36: 283-300.

Abu Lughod, Lila. 1995. "A Tale of Two Pregnancies." In *Women Writing Culture* edited by Ruth Behar and Deborah A. Gordon, 339-349. Berkeley: Univeristy of California Press.

American College of Nurse Midwives. "Certified Nurse-Midwives and the Indian Health Service…a Perfect Match." *American College of Nurse-Midwives* website. Accessed March 24, 2017. http://www.midwife.org/acnm/files/cclibraryfiles/filename/000000002226/ihs_packet_june_08.pdf

Biehl, Joao, Byron Good, and Arthur Kleinman. 2007. "Introduction: Rethinking Subjectivity." In *Subjectivity: Ethnographic Investigations,* 1-23. Berkeley: University of California Press.

Biehl, Joao and Amy Moran-Thomas. 2009. "Symptoms: Subjectivities, Social Ills, and Technologies" *Annual Review of Anthropology* 38: 267-88.

Biehl, Joao. 2013. "Ethnography in the Way of Theory." *Cultural Anthropology* 28 (4): 573-597.

Bridges, Khiara M. 2011. *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization.* Berkeley: University of California Press.

Burton, Nadya and Rachel Ariss. 2014. "Diversity in Midwifery Care: Working towards social justice." *Canadian Review of Sociology* 51 (3): 262-287.

Comptroller of the United States. 1976. "Investigations of Allegations Concerning Indian Health Services." Washington D.C.: Government Printing Office.

Cruz-Begay, R. 2004. "Navajo Birth: A Bridge between the Past and the Future." In *Childbirth Across Cultures: Ideas and Practices of Pregnancy, Childbirth, and Postpartum* edited by Helaine Selin and Pamela Kendall Stone, 245-253.

Davis-Floyd, Robbie. 1992. *Birth as an American Rite of Passage.* Berkeley: University of California Press.

Davis-Floyd, Robbie and Elizabeth Davis. 1996. "Intuition as Authoritative Knowledge in Midwifery and Homebirth." *Medical Anthropology Quarterly* 10 (2): 237-269.

Davis-Floyd, Robbie and Carolyn Sargent. 1997. "Introduction: The Anthropology of Birth." In *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives,* edited by Robbie Davis-Floyd and Carolyn Sargent, 1-51. Berkeley: University of California Press.

Dixon, Mim and Yvette Roubideaux. 2001. *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century.* Washington D.C.: American Public Health Association.

Fleuriet, K. Jill. 2009. "La Tecnologia y Las Monjitas: Constellations of Authoritative Knowledge at a Religious Birthing Center." *Medical Anthropology Quarterly* 23 (3): 212-234.

Fraser, Gertrude. 1995. "Modern Bodies, Modern Minds: Midwifery and Reproductive Chance in an African American Community." In *Conceiving the New World Order,* edited by Faye D. Ginsburg and Rayna Rapp, 42-58. Berkeley: University of California Press.

Ginsburg, Faye D. and Rayna Rapp. 1995. "Introduction: Conceiving the New World Order." In *Conceiving the New World Order: The Global Politics of Reproduction* edited by Faye D. Ginsburg and Rayna Rapp, 1-17. Berkeley: University of California Press 1995.

Gonzales, Patrisia. 2012. *Red Medicine: Traditional rites of birthing and healing.* Tucson: University of Arizona Press.

Good, Byron J., Mary-Jo DelVecchio Good, Sandra Teresa Hyde, and Sarah Pinto. 2006. "Postcolonial Disorders: Reflections on Subjectivity in the Contemporary World." In *Postcolonial Disorders,* 1-42. Berkeley: University of California Press.

Gurr, Barbara. 2015. *Reproductive Justice: The politics of health care for Native American women.* New Brunswick: Rutgers University Press.

Hodge, Felicia Schanache. 2012. "No Meaningful Apology for American Indian Unethical Research Practices." *Ethics and Behavior* 22 (6): 431-444.

Inhorn, Marcia C. 2009. "Defining Women's Health: A Dozen Messages from More than 150 Ethnographies." In *Reproductive Disruptions: Gender, Technology, and Biopolitics in the New Millennium* edited by Marcia C. Inhorn, 1-35. New York: Berghahn Books.

Jordan, Brigitte. 1993. *Birth in Four Cultures.* Illinois: Waveland Press.

Jordan, Brigitte. 1997. "Authoritative Knowledge and Its Construction." In *Childbirth and Authoritative Knowledge* edited by Robbie Davis-Floyd and Carolyn Sargent, 55-79. Berkeley: University of California Press.

Kent, Linda L. 2000. "Fieldwork that Failed." In *Stumbling Towards Truth: Anthropologists at Work,* 17-25. Long Grove, IL: Waveland Press.

Lawrence, Jane. 2000. "The Indian Health Service and the Sterilization of Native American Women." *The American Indian Quarterly* 24 (3): 400-419.

Long, Debbi, Cynthia L. Hunter, and Sjaak van der Geest. 2008. "When the field is a ward or clinic: Hospital Ethnography." *Anthropology and Medicine* 15 (2): 71-78.

Macdonald, Margaret. 2006. "Gender Expectations: Natural bodies and natural births in the new midwifery in Canada." *Medical Anthropology Quarterly* 20 (2): 235-256.

Marcus, George. 2010. "Experts, reporters, witnesses: the making of anthropologists in States of Emergency." In *Contemporary States of Emergency. The Politics of Military and Humanitarian Intervention* edited by Didier Fassin and Mariella Pandolfi. New York: Zone Books.

Martin, Emily. 2001. *The Woman in the Body: A Cultural Analysis of Reproduction.* Boston: Beacon Press.

Ortner, Sherry. 2006. "Subjectivity and Cultural Critique." In *Anthropology and Social Theory: Culture, Power, and the Acting Subject.* Durham: Duke University Press.

Scheper-Hughes, Nancy and Margaret M. Lock. 1987. "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology." *Medical Anthropology Quarterly* 1 (1): 6-41.

Schrag, Zachary M. 2010. *Ethical Imperialism: Institutional Review Boards and the Social Sciences, 1965-2009.* Baltimore: John Hopkins University Press.

Simpson, Audra. 2014. *Mohawk Interruptus: Political Life Across the Borders of Settler States.* Durham: Duke University Press.

Smith, Linda Tuhiwai. 1999. *Decolonizing Methodologies: Research and Indigenous Peoples.* London: University of Otago Press.

Sturm, Circe. 2002. *Blood Politics: Race, Culture, and Identity in the Cherokee Nation of Oklahoma.* Berkeley: University of California Press.

Turner, Victor. 1969. *The Ritual Process.* New Jersey: University of New Jersey Press.

van der Geest, Sjaak and Kaja Finkler. 2004. "Hospital Ethnography: Introduction." *Social Science and Medicine* 59: 1995-2001.

Wind, Gitte. 2008. "Negotiated Interactive Observation: Doing Fieldwork in Hospital Settings." *Anthropology and Medicine* 15 (2): 79-89.