THE “INCOMPETENT” CERVIX AND THE “GOOD” MOTHER

by

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ABSTRACT

MADELEINE R. MICHALIK. The "Incompetent" Cervix and the "Good" Mother.
(Under the direction of DR. CHRISTINE S. DAVIS)

While many communication studies and feminist scholars study gendered discourse and the medicalization of the female body, no work has been done to understand the term "Incompetent Cervix" and its implications for those with this diagnosis. Using Poststructuralist Feminist Theory and Narrative Theory as guiding frameworks, this paper utilizes Critical Discourse Analysis, Contrapuntal Analysis, and Sociological Introspection to examine medical discourse surrounding the term "Incompetent Cervix." This study also includes my lived experience with this diagnosis and adds patient perspective where it is previously missing. Key findings of this work include the tropes of Doctors as Heroes, The Silenced Woman, and The "Good," "Competent" Mother wherein the analyzed medical discourse positions women as failures in need of a medical savior; women are silenced by medical providers, and women are made to (re)negotiate their identities in light of so-called their "incompetent" cervix.

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CHAPTER 1: INTRODUCTION

> *"We can prevent this next time." I was not thinking about "next time," I was focused on keeping the 25-week fetus inside my uterus for as long as possible; focused on doing the thing my body was supposedly designed to do. The doctor removed the ultrasound wand and walked out of the birthing suite without explaining how or what he could prevent "next time," and I was left feeling bitter, ashamed, and guilty.*

My story in the opening narrative describes the lived experience of an "Incompetent Cervix" diagnosis. While feminist and communication scholars have marked the importance of gendered discourse, they have ignored the "incompetent" cervix and its social and medicalized construction. I suggest two possible reasons for this cervical silence, the first being the low incidence of an "Incompetent Cervix" diagnosis. An "Incompetent Cervix" is thought to occur in only 1 out of 100 pregnancies ("Incompetent cervix: Weakened cervix," 2015), and perhaps this low prevalence rate has kept this gendered medical term off scholars' radar. Second, I contend that the cervix is not an inherently "sexy" body part, and although breast cancer narratives are frequently studied (Haines et al., 2010; Langellier & Sullivan, 1998) and popularized by the media, cervical cancer narratives are harder to find. This sexualizing of body parts is just another example of socio-cultural gender assumptions making their way into medical discourse (Germon, 2014). Larger cultural assumptions and norms inform medical science and dictate how women are treated by medical professionals (Beit-Hallahmi, 1985; Bell, 1995; Blum, 2004). In part, this project seeks to understand what the surrounding medical discourse constructs, and second, how we can better understand the lived experiences of

those with an “incompetent” cervix. In this thesis, I first define and situate the term “Incompetent Cervix” in its surrounding gendered medical discourse. Next, I place the terminology surrounding an “Incompetent Cervix” diagnosis in a poststructuralist feminist framework to understand how the term is socially constructed through gendered discourse, ultimately influencing medical care. Following, I overview Critical Discourse Analysis, Sociological Introspection and Contrapuntal Analysis, the guiding procedures of this study. Following, I discuss overarching discursive tropes put forth by medical discourse: Doctors as Heroes, The Silenced Woman, the “Good,” “Competent” Mother, Then vs. Now: Discourse Across Time; The “Incompetency” Continuum; Medical Coding and Billing; and Sampling. Lastly, I discuss the implications for this study and provide suggestions for future research.

CHAPTER 2: LITERATURE REVIEW

To fill in this critical gap in communication and women's studies scholarship, I aim to understand what ideologies, practices, and beliefs found in medical journals, informational websites, and brochures and pamphlets about the "Incompetent Cervix" diagnosis construct. In this project, I also intend to reveal how we can understand the lived experiences of an "incompetent" cervix diagnosis. Throughout this paper, I purposefully refer to this diagnosis in two ways: The "Incompetent Cervix" (upper case and in quotation marks) refers to the medical diagnosis and how it is discussed in medical discourse, and the "incompetent" cervix, (lower case and in quotation marks) is used at any point where I discuss the cervix outside of its surrounding medical discourse. This differentiation is necessary as I do not wish to refer to the cervix as incompetent in my own writing.

2.1 The "Incompetent Cervix

"Incompetent Cervix" – also interchangeably referred to by medical professionals as "Cervical Insufficiency" (Owen, 2012, p. 47), "Cervical Incompetence" (Williams, 1978, p. 703), or "Weak Cervix" (Jones, Clark, & Bewley, 1998, p. 1215) – is defined as follows: "A cervix (the structure at the bottom of the uterus) that is incompetent is abnormally weak, and [its opening] can gradually widen during pregnancy. Left untreated, this can result in repeated pregnancy losses or premature delivery" (Davidson, 2015, p. 1). Typically, the cervix closes in early pregnancy and does not open until labor begins. An "Incompetent Cervix" opens prior to the point in pregnancy where a fetus is viable due to pressure from its increasing weight. This dilation often occurs without contractions or other signs of labor and will result in fetal loss, premature labor, or

premature birth (Davidson, 2015; Neveu et al., 2017). These repeated pregnancy losses are also referred to as "habitual abortion" (Ayers, 1982, p. 177) or multiple fetal losses before a viable age (Ayers, 1982; Mason & de Chabert, 1963). This phenomenon has fascinated medical professionals for years as causes, symptoms, treatments, risks and outcomes were – and are – debated (Ayers, 1982; Davidson, 2015; Mason & de Chabert, 1963; Neveu et al., 2017; Owen, 2012; Quigley, 1964; Ritter, 1978). Many women are not diagnosed until they have had one or more spontaneous pregnancy losses in the second trimester as only 20-25% of spontaneous losses are attributed to "Incompetent Cervix" (Davidson, 2015).

Early detection of "Incompetent Cervix" is critical in preventing preterm birth, which is the leading cause of perinatal death (Maymon et al., 1996; Neveu et al., 2017). Early detection also helps women avoid the high cost of medical care associated with preterm labor and associated Neonatal Intensive Care Unit (NICU) costs (Chandiramani & Shennan, 2008; Romero, Yeo, Chaemsaithong, Chaiworapongsa, & Hassan, 2014; Wright, 1965). Treatments for "Incompetent Cervix" include bed rest, hormones, pessary, and cerclage (Davidson, 2015; Mason & de Chabert, 1963). A cerclage is a stitch that "encircl[es] the cervix at the level of the internal os" (Mason & de Chabert, 1963, p. 543) and closes the cervix and adds support (Davidson, 2015). Later in the third trimester, the cerclage is removed simply by cutting the stitch, and labor is allowed to progress spontaneously (Davidson, 2015; Owen, 2012). The cerclage has been used in this way for 50 years (Neveu et al., 2017), but it is not appropriate for all cases as there are varying degrees of "cervical failure" (Maymon et al., 1965, p. 151), and each patient must be assessed on an individual basis (Maymon et al., 1965). As a result, physicians

often monitor patients with history of spontaneous preterm births via transvaginal ultrasound to watch for cervical shortening (Guzman et al., 1997; Kelly et al., 2001).

The following sections review socially constructed gender discourse and situate the "incompetent" cervix within this realm. Next, medicalization of the female body is discussed as both harmful and helpful as exemplified by those with an "incompetent" cervix. An overview of gendered medical terminology research is presented followed by the theoretical frameworks that will guide this study.

2.2 Gendered Discourse and Medicalization

Before the "Incompetent Cervix" can be discussed as a gendered term, the relationship between socially constructed gender and medicalization must be understood. Some feminist scholars argue that sexist language is a symptom, and only *actions* that address equal pay and discrimination will yield change (Yieke, 2001). Although action is important, sexist language is not merely a symptom as we socially construct these models of unequal pay and systems of discrimination in part through our words; if we alter our language, we can reshape our social world (Blum, 2004; Brickman, 2004; Cody, 2010; Hedegaard et al., 2014; Yieke, 2001; Weedon, 1996). Moreover, words are not passive symptoms, but rather powerful actors (Oliver, 1990). The following sections explain the link between gender construction and medicalization and situate the "Incompetent Cervix" diagnosis within this intersection.

2.2a Socially Constructed Gendered Discourse

Human identity and social positions are linguistically constructed through discourse (Hedegaard et al., 2014; Motschenbacher, 2009), and these identities and positions are not neutral but fraught with sexism (Malkowski, 2014; Oliver, 1990). For

example, male and female sex cells are often described using gendered language in medical literature where the egg is positioned as passive as it is carried along the fallopian tube and the sperm active as it "propels" and "penetrates" the egg (Martin, 1991, p. 489). This is reflective of larger cultural norms which frame women as docile and males as aggressive. In some cultural myths, the vagina is referred to as diseased, disabled, and dangerous, which reflects society's construction of women (Beit-Hallahmi, 1985).

In an effort to take control of how female bodies are defined and move away from problematic essentialist ideas, feminist scholars distinguished between sex and gender, which separates biological sex from social gender (Yieke, 2001). Language is needed for humans to organize, and most power struggles are played out through discourse; whoever 'wins' gets to put forth their version of reality (Yieke, 2001). For women, this means a world where they are viewed and treated as lesser as they find themselves in a world constructed by male-dominated discourse. Language is the site of cultural production of gender identity, and gender identity is always socially, economically, and politically situated (Yieke, 2001); there is no natural language (Oliver, 1990). In westernized contexts, women are constituted as giving, nurturing (Ehrenreich & English, 2005; Malkowski, 2014) and as "naturally" inferior (Oliver, 1990), and since is impossible to separate science from its broader cultural context (Blum, 2004), these scripted traits are carried into the healthcare arena. Specifically, in body-part vocabulary, women are are not seen as a whole, independent individual but merely the sum of discursively gendered parts. These labels are carried over from dominant gender discourse, and the body is not viewed subjectively but as an object to be analyzed (Motschenbacher, 2009).

In general, the differences between males and females are assumed and emphasized in healthcare (Dusenbery, 2018; Hedegaard et al., 2014). Although acknowledging differences between males and females in healthcare can be positive, such as identifying differences in female's heart attack and stroke symptoms ("Heart Attack and Stroke," 2014), highlighting differences can also lead to gendered medical discourse that objectifies females and reaffirms already established social and economic distinctions where females are the housekeepers and males providers, roles which society has prescribed for them (Duerden Comeau, 2004; Ehrenreich & English, 2005; Hedegaard, Ahl, Rovio-Johansson, & Siouta, 2014; Malkowski, 2014). Medical discourse mirrors these gendered constructions and creates power inequities that enable or constrain the medicalized body (Brickman, 2004) and reflect socio-cultural constructions of gender (Duerden Comeau, 2004). This is exemplified by in the framing of femininity as disease (Brickman, 2004; Dusenbery, 2018), such as the "hysterical" woman, "a disorder linked to the essence of femininity itself" wherein the woman is "idle, self-indulgent and deceitful" (Usher, 2013, p. 63). Further, women are more likely to have their health complaints written off as psychosomatic and are more likely to be given more simplistic, unscientific explanations of their conditions (Brubaker, 2007; Dusenbery, 2018). For example, "women are more likely to seek treatment for chronic pain, but are also more likely to be inadequately treated by health-care providers" as their pain is often written-off as psychogenic (Hoffmann & Tarzian, 2001, p. 13). In sum, the misogynous nature of gender construction in westernized culture impacts how women are discussed by the medical community.

2.2b Medicalization of the Female Pregnant Body

Socially constructed gender and medicalization are inextricably linked. Gender is a social construct in that it is "a system of meanings that organizes interactions and governs access to power and resources" (Yieke, 2001, p. 336). In other words, gender is not inherent or natural but something that humans define, and in doing so, certain individuals are privileged over others. One cannot talk about gendered discourse without also talking about medicalization. Feminist scholarship asserts that medical discourse frames women's bodies as pathological (Brickman, 2004), and human identities and social positions are constructed socially and linguistically (Hedegaard et al., 2014); women are expected to act in the best interest of the fetus's well-being (Malkowski, 2014). For instance, the construction of a "good" pregnant woman or "good" mother gives moral guidelines and dictates how a woman must act in order to ensure her fetus and/or child develops "normally" (Brauer, 2016).

In dictionaries and medical texts, female genitalia are defined in terms of location and male genitalia are defined in terms of function (e.g., the penis is defined in terms of function, and the vagina and clitoris are defined in terms of location), which is reflective of socio-cultural constructions of gender (Braun & Kitzinger, 2001). Although feminist and critical communication scholars have examined how discourse around genital parts such as the vagina, clitoris, and penis maintain heteronormative beliefs about sex, sexuality, and gender (Braun & Kitzinger, 2001), they have not yet looked at language used in discussing the cervix – the "incompetent" cervix, in particular. Feminist scholars have, however, examined the discourse of the medicalized breast and found that it is imagined as detachable and dispensable and conceptualized based on cultural ideas of

femininity, beauty, and sexual desirability as opposed to its function (Langellier & Sullivan, 1998). Other scholars have studied the medical language discussing male sexual dysfunction and purport that dysfunction is normalized for men and not women (Marshall, 2002; Tiefer, 2003). In medicalized childbirth, medical professionals discuss women in passive terms: she "delivers" rather than "gives birth," and women often reflect on their birth experience and reminisce on being "allowed" to take certain actions (Silverton, 2017). Our ideas of what is "normal" are intricately tied to language (Yieke, 2001), and all language is persuasive (Oliver, 1990). Since gender is socially constructed through communicative acts (Hedegaard et al., 2014; Yieke, 2001), we must be conscious of how we name, label, and medicalize women and recognize that there are real consequences to these practices.

Medicalization works by identifying a behavior or condition as an illness or abnormality and – particularly for females – controlling its deviance (Brickman, 2004), and by implication, controlling female bodies and choice. This interest in managing the female body is especially evident in the use of medical technologies. Biomedicalization links the self and the body to technology and science (Vardeman, 2012), and medical technologies such as contraception, pain medicine, or the cervical cerclage can either enable or constrain women depending on how they are used and the laws that surround them (Pizzini, 1991). These practices are not value-free, and these values and legal regulations that are constructed through gendered discourse and medicalization determine who has access to what obstetric and gynecological medical technologies such as in vitro fertilization, abortion, contraception, ultrasounds, or cerclage (Brauer, 2016). Access to ultrasounds is critical in diagnosing an "Incompetent Cervix" (Guzman et al., 1997; Kelly

et al., 2002; Mason & de Chabert, 1963; Maymon et al., 1996), so it is imperative that we understand how access is granted or withheld through medicalization and gendered constitutions of women.

Medicalization is not inherently good or bad; rather, it is both harmful and beneficial simultaneously. For example, the medicalization of pregnancy disempowers women by framing them as an object in need of constant monitoring. In this context, sonograms can be viewed as a form of surveillance (Brauer, 2016). Sonograms reinforce a woman's lack of control in that "she can neither influence the genetic endowment of the fetus, nor control most of the physiological aspects of her pregnancy" (Brauer, 2016, p. 48). If a fetal abnormality is discovered, a woman is likely to place blame on herself because women are often framed as responsible for the well-being of their family (Aizpuru, 2015). So where does this leave women with a known "Incompetent Cervix" diagnosis? How do these women frame their responsibility and what role does the sonogram play in this construction? The medicalization of women's bodies is a sort of catch-22 – there can be no diagnosis and treatment without naming and defining. Medicalization of women's bodies is beneficial in that it allows women to seek treatment as well as validates their problems in the eyes of medical professionals (Dubriwny, 2010). At the same time, these problems are now part of an institutional practice where they are viewed as a problem in need of "expert" attention (Brubaker, 2007).

The medicalization of the pregnant female body and the shift from home births to hospital births and technological advancement is a focal point of much feminist scholarship. Women have come to rely on medical "experts" to define their experiences for them rather than using their own voice (Brubaker, 2007; Dusenbery, 2018; Ehrenreich

& English, 2005). Medical experts use language that positions women as passive and puts them at risk for obstetric violence – "violence directed at women because they are women" (Shabot, 2016, p. 231) – as they defer to the authority figure, which reflects larger socio-cultural and political beliefs where women are passive and men active and in control. As Shabot (2016) argues, a laboring body is the epitome of a strong, powerful body, one that does not need curing and is certainly not the disabled body our society constructs. Women should have the freedom to live "as fully embodied subjectivities free from objectifying violence or coercive practices" (Shabot, 2016, p. 245), but in the same moment, there are women – such as those with an "Incompetent Cervix" diagnosis – that *need* medical intervention in order to give birth to a viable fetus. Women are placed in the impossible position of wanting autonomy from harmful medicalization while needing benefits of technology, so how do women with an "incompetent" cervix negotiate this tension and construct their identity? In my part, my study intends to address this question.

2.3 The "Good" Mother

In order to fully understand the impact of an "Incompetent Cervix" diagnosis, social constructions of motherhood must also be taken into account as this diagnosis is tied to a woman's – and society's – conception of what it means to be a "good" mother. The ideal mother is socially constructed as one that is attached and intensive, dedicating all her time to child-rearing (Brooks, 2015; Estes, 2011; Kirby, Riforgiate, Anderson, Lahman, & Lietzenmayer, 2016); she is constantly reaching for perfection (Buzzanell et al., 2005). Additionally, low income and socially disadvantaged mothers are not considered to be compatible with "good" parenting (Narciso et al., 2018), and mothers who use drugs or break the law are deviant (Couvrette, Brochu, & Plourde, 2016); the

"good" mother is one without learning disabilities (Kaspar & Kroeses, 2017) and breastfeeds her child for a minimum of six months (ideally, until the child reaches age two) (Marshall, Godfrey, & Renfrew, 2007). If "the impetus to sensemaking is a challenge to one's identity or way in which one believes life events should unfold" (Buzzanell et al., 2005, p. 264), the use of narrative here can unpack the lived experience of an "incompetent" cervix and diagnosis breeches one's constructions of motherhood and womanhood.

CHAPTER 3: THEORETICAL FRAMEWORK

The questions raised in this study are best examined through two frameworks: Poststructuralist Feminist Theory and Narrative Theory. In part, this study aims to understand the medical discourse surrounding an "Incompetent Cervix" diagnosis and what reality it constructs for women with this diagnosis, and I contend that Poststructuralist Feminist Theory is well-positioned as a sensitizing concept for this critical analysis. Of course, it is important to note that "there is no such thing as a complete and definitive analysis of a text" (Fairclough, 2003, p. 14), so it is useful to understand this phenomenon from multiple viewpoints. Narrative Theory, then, allows for the addition of a woman's voice where it is missing from the studied discourse and aids in answering the second question: How might we examine and understand the lived experience of an "Incompetent Cervix" diagnosis? Ellis (1991) argues that "intrinsic to the constitution of emotions are contextual considerations, local moral orders, moral imperatives of display, linguistic practices, shared cognitions, and social roles" (p. 24), and personal narratives born from self-introspection allow us to divulge these points from our experiences. Although these two questions and their respective frameworks could stand alone, I argue that they are more impactful together and that we risk minimizing the emotive experience of the individual (who is embedded in this socially constructed reality) by only examining the surrounding medical discourse. In other words, it is not enough to understand *what* is constructed by this term but also what the diagnosed individual lives through as a result. In the following sections, I will first detail Poststructuralist Feminist Theory and its central tenets, followed by a review of Narrative Theory and its important role in this project.

3.1 Poststructuralist Feminist Theory

Poststructuralist feminist thought is especially useful in understanding how an "Incompetent Cervix" diagnosis is socially constructed. This theoretical framework draws on Foucault's notion that power is created through discourse (Blum, 2004; Weedon, 1996) and focuses on how social constructions of gender inform scientific thought, a historically male-dominated arena (Duerden Comeau, 2004). This is indicated by the simultaneous presence and absence in scientific literature where women are often the object of study and a problem to be solved (Cody, 2010; Hanson, 2001) and exemplified through the medicalization of the childbirth experience which has taken bodily autonomy away from women in the hospital setting (Brubaker, 2007; Johnson & Quinlan, 2015; Shabot, 2016). A culture's gender ideologies shape research (Blum, 2004; Duerden Comeau, 2004), and this gendered science abolishes a woman's autonomy and understanding of her body (Cody, 2010).

Feminist theory guides much of the research focused on socially constructed gender and medicalization of the female body, and it serves as one guiding theoretical framework for this study. Feminist works "seek to expose mechanisms of social control, surveillance, medicalization that attempt to constrict, redefine, and manage" (Brickman, 2004, p. 89) female bodies, especially in reproductive contexts (Brubaker, 2007). Feminist theory is also useful for understanding how we might reimagine and redefine what it means to be a woman (Weedon, 1996). Scholars from many disciplines have examined important topics such as the gendered and medicalized breast (Haines et al., 2010; Langellier & Sullivan, 1998), cancer as a woman's disease (Duerden Comeau, 2004), gendered constructions of sexual dysfunction (Marshall, 2002), the gendered

Gardasil vaccine (Malkowski, 2014; Thompson, 2010; Vardeman, 2012), gendered psychiatric illness (Blum, 2004; Godderis, 2010), gendered Tuberculosis research (Vissandjee, Mourid, Greenaway, Short, & Proctor, 2016) and gendered biomedical writing (Hanson, 2001); however, no one has explored how the term "Incompetent Cervix" is culturally constructed through gendered discourse or how this diagnosis impacts a woman's identity.

Feminist scholars recognize the sexism inherent to many labels in the English language in which men often have the power to determine meanings and terms; these constructions are reflective of the male's perception of reality rather than the female's (Yieke, 2001), and humans use these scripts to inform their actions (Hanson, 2001). Feminist scholars are interested in studying questions of identity and self-definition (Yieke, 2001), concepts key to understanding how a woman with an "Incompetent Cervix" diagnosis constructs her own conceptualization of "womanhood" or "motherhood." In part, this study seeks to understand *what* medical discourse constructs:

RQ_1: What reality does medical discourse surrounding an "Incompetent Cervix" diagnosis construct for women with this diagnosis?

3.2 Narrative Theory

One way to demystify the often-silenced lives of women and tell their lived experiences is through narratives. Narrative theory allows individuals to examine how they (re)create their identity (Dutta, 2008) and purports that humans are innate storytellers that use narrative to construct their social world (Miller, 2005). In an attempt to re-story health narratives and eliminate feelings of isolation, women can share their experiences through storytelling and consciousness-raising. In this way, women can come

to understand that their patient identity is reflective of the larger cultural gender construction (Malkowski, 2014). Some scholars practice defamiliarization where they use narratives to reverse gendered language so it seems a woman is writing about men in hopes of neutralizing power dynamics (Oliver, 1990), and this enables readers to understand a concept from a new perspective. We communicate gender but also 'do' gender through our words (Yieke, 2001). In other words, we use language to construct our social world including how we define gender and the roles associated with each. Narratives allow for individuals to speak from their perspective (Langellier & Sullivan, 1998; Malkowski, 2014; Shabot, 2016), and it is these subjective experiences that challenge dominant discourse. Using narrative theory to analyze women's identity construction after an "Incompetent Cervix" diagnosis would allow for perspective-taking and a deep understanding of the lived experiences of this diagnosis and therefore is well-suited to this study. As a result, the following research question is posed:

RQ2: How do those with an "Incompetent Cervix" diagnosis story their experience as women and mothers?

CHAPTER 4: METHOD

4.1 Critical Discourse Analysis

The language used to discuss the "Incompetent Cervix" in medical discourse is fraught with issues of power, hierarchy, gender, and ideology, issues that, in this context, are best investigated using Critical Discourse Analysis (CDA). Critical Discourse Analysis is concerned with morality (van Leeuwen, 2018), how power is created and maintained through language (Weiss & Wodak, 2003), and how discourse (re)produces power relations (Fairclough & Wodak, 1997). This study sought to understand what the discourse surrounding the term "Incompetent Cervix" constructs as well as how we can come to understand the lived experience of this diagnosis.

Critical Discourse Analysis (CDA) accounts for the need of multiple perspectives by analyzing discourse at macro and micro levels, and an assortment of disciplines have utilized this method (van Dijk, 1993; Weiss & Wodak, 2003) such as feminist media studies (Lawson, 2018), journalism (Hujanen, 2018; Yacoumis, 2018), communication education (Bouvier & Machin, 2018), and nursing (McIntyre, Francis, & Chapman, 2012), among others. Specific Methodologies of CDA also vary; however, all center on a concern with power and competing discourses (Weiss & Wodak, 2003) while aiming to transform the status quo (Fairclough & Wodak, 1997). In order for CDA to be successful, it must address social cognition and link the macro with the micro – in this case, institutional power with text (van Dijk, 1993); in this study, I aim to use CDA to address the gendered discourse surrounding the "Incompetent Cervix" and related social structures.

A criticism of CDA is its emphasis on binaries and the tendency to give voice to the marginalized by silencing the privileged (Baxter, 2008). I agree that power inequalities cannot be addressed by overthrowing one hierarchy for another, but the purpose of this particular analysis is not to position one voice over the other but to understand how discourse reinforces power inequities. Critical Discourse Analysis is also critiqued as being biased in its interpretation (Wodak & Meyer, 2001), but a researcher may combat this by engaging in self-reflexivity and acknowledging one's own biases; further, as stated by Wodak and Meyer (2001), there will always be debate on whether value-free research exists, and I argue that it is better to face one's potential biases head on.

4.2 Contrapuntal Analysis

Similar to Critical Discourse Analysis, Contrapuntal Analysis (CA) examines issues of power within discourse, particularly in a text and is often used alongside relational dialectics theory. This method is also compatible with CDA as CA can reveal power struggles between dominant and non-dominant voices (Thomas, 2017). Contrapuntal Analysis differs from CDA in that it "helps the researcher to understand meaning-making by focusing attention on the ways in which texts often hold two or more understandings…that are relevant to particular objects of meaning" (Thomas, 2017, p. 1). In other words, CA is useful in examining areas of tension that emerge from texts. After I examined articles and websites using CDA, I used CA to gain a deeper understanding of the counter-points that became apparent during analysis by revealing competing discourses within the tropes of Doctors as Heroes and The Silenced Woman.

4.3 Data Collection and Sampling

In this study, I reviewed medical literature, websites, and pamphlets and brochures about the following terms: "Incompetent Cervix," "Cervical Insufficiency," and "Cervical Incompetence." It was important to conduct searches surrounding these three terms as they are used interchangeably by medical professionals in medical literature and when speaking to their patients; the term "Weak Cervix," which is sometimes used, was not queried for data collection as it did not yield significant search results after initial query. To enhance multivocality (Buzzanell, 2017), I analyzed discourse from medical literature, websites, pamphlets and brochures, and importantly, included my own voice through use of personal narrative.

Data collection took place in several stages. First, I conducted cluster sampling accessible population of medical literature by searching the UNC-Charlotte library site using three different terms: "Incompetent Cervix," which yielded 1,633 peer-reviewed articles; "Cervical Insufficiency," which returned 17,889 peer-reviewed articles; and "Cervical Incompetence," which generated 3,245 peer-reviewed articles. I chose the three top journals with the most articles in each search – *the American Journal of Obstetrics and Gynecology, Obstetrics and Gynecology, and Ultrasound in Obstetrics and Gynecology* – due to their large sampling frame and wide date range. The first two journals originate from the United States, and I included the third journal, an international publication, after recognizing that even within the American publications, research on the "incompetent" cervix is taking place as an international conversation. I further refined results by accessibility – whether or not articles were available online or through Interlibrary Loan – and organized into date categories using cluster sampling from the

earliest available year to present: 1930-1960; 1961-1991; 1992-2019. Here, I examined article titles for relevance and accessibility and selected accordingly. I sampled articles sampled by date in order to account for depth – a deep understanding of the discourse – and breadth – to form a clear picture of how the target term evolved over time, if it all. The final analysis focused on articles from the third date category as the discourse has changed over time, and these changes are included in the discussion. In total, I analyzed 36 articles. Although the final sample size may seem small in comparison to the number of initial search results, Critical Discourse Analysis requires deep reading and multiple rounds of analysis, and it was important that I was mindful of the length of the articles as well as the time I would need to spend familiarizing myself with medical terminology. I gathered, read, and coded articles and websites until discourse from across the target range was uncovered and I was satisfied that no new data would provide new information pertinent to my questions.

Second, I used purposive sampling to conduct a Google search for both websites and pamphlets/brochures targeting patients with an "Incompetent Cervix;" purposive sampling is useful here as I assessed websites and pamphlets/brochures on their relevance, country of origin, and credibility; I also examined websites to ensure they are directed towards laypersons and backed by experts. I only included websites originating from within the United States so as to understand what American women are told by their healthcare providers. Therefore, I excluded personal blogs, websites originating outside of the United States, and websites without references or websites not supported by medical professionals. I conducted multiple rounds of searches using three key terms: "Incompetent Cervix," which gave 521,000 results; "Cervical Insufficiency," which

yielded 4,600,000 results, and "Cervical Incompetence," which provided 444,000 results. Of these, I selected the nine websites that met all the criteria for analysis. During these same searches, I reviewed images in hopes of locating pamphlets or brochures created by medical professionals directed towards laypersons. However, these images did not yield useable data. I conducted additional searches using the keywords, "Incompetent Cervix Pamphlet," "Incompetent Cervix Brochure," "Cervical Insufficiency Pamphlet," "Cervical Insufficiency Brochure," "Cervical Incompetence Pamphlet," and "Cervical Incompetence Brochure." Here, too, materials did not meet eligibility criteria.

I analyzed all journal articles and websites using Critical Discourse Analysis following the methods outlined by Fairclough's (1995) Three-Dimensional Framework: The Sociocultural Practice Level, which focuses on the social and institutional relations and practices; the Discourse Practice Level, which concentrates on ideology; and the Textual Analysis Level, which I examined from the thematic level using an adapted version of Janks's (2005) Linguistic Analysis Rubric. Janks (2005) designed this rubric to analyze at the textual level but also keeps the sociocultural and discourse practice levels in mind, and this rubric is unique in that it "offer[s] an approach to the analysis of linguistic texts without wanting to suggest that text analysis should be done in isolation or that other forms of semiosis are not as important as linguistic meaning" (p. 100). In my analysis, I paid careful attention to linguistic features of voice, nominalization, quoted or missing speech, turn-taking, mood, modality, and pronouns while keeping the other two dimensions in mind. Critical Discourse Analysis is "a critical, transformative practice that seeks to expose the ways in which discourse is able to constitute social, political, economic, gendered, racial, and sexual inequalities as normal and unremarkable"

(Roderick, 2018, p. 154), and each level of analysis enables the researcher to reveal the innerworkings of these concepts in a certain discourse. As a result, I reviewed each piece of data multiple times with various foci specific to each level of Fairclough's (1995) framework, and three separate code books were created. The first code book denotes the first level of analysis – The Sociocultural Practice Level. Here, the focus of analysis is explanation of the context and socio-cultural conditions in which the text was created as well as the larger meanings for social practice (Fairclough, 1992). As I read each website and journal article, I looked for discursive depictions of social and institutional practices such as discourse that framed women as a problem that must be controlled by the healthcare institution. The second code book represents the Discourse Practice Level, which is interested in interpretation and the process of text (re)production and consumption (Fairclough, 1992) and the ideologies that are changed or taught (Fairclough, 2003). Here, I paid attention to discursive renderings of attitudes, beliefs, and values embedded in the journals and websites such as the lack of women's voices. Lastly, the third code book corresponds to the Textual Analysis Level, which I analyzed at the textual level using Janks's (2005) Linguistic Analysis Rubric. This level focuses on description, and I paid attention to parts of the text such as voice, nominalization, and metaphor. For example, women were often talked about using passive voice which Janks' (2005) describes as a way of stripping agency from the subject.

In order to guide my analysis, I utilized Davis's (2017) analytical questions for CDA and asked myself questions such as: "Which systemic levels are participants referring to...?;" "How are participants creating meaning through symbols, constructs, and multiple contexts?;" "How do participants' organizational schemes reflect, create, or inhibit

meanings and actions? What meaning are they creating, and what are the ramifications for this research?;" "How does the discourse…construct meanings, and how does this social context influence the discourse?" (p. 86). Finally, I also used poststructuralist feminist theory as a sensitizing concept, which is "open-ended and suggestive in acknowledgment of the need to work with and through the empirical instances to recognize what the concepts refer to" (Hertzum, 2018, p. 179). In other words, poststructuralist feminist theory helped guide the questions I asked of the sampled texts wherein I looked for discursive practices that supported or challenged social constructions of gender and power relations. Specifically, I paid attention to instances where gender roles were either explicitly or implicitly implied, where one gender was positioned as more powerful than another, and where normative beliefs about sex and gender were either maintained or disrupted. Throughout this process, I also engaged in self-reflexivity by journaling. I recognize the potential biases I carry with me as a cis-gender, white, middle-class, female researcher with personal experience with an "incompetent" cervix as well as my personal values and beliefs. In taking a critical stance, it is inevitable that assumptions, perspectives, beliefs, and values will come about in analysis, and in practicing self-reflexivity, I was able to engage in a deeper level of knowledge production with the studied discourse. The final report addresses claim, explanation, and evidence (Davis, 2017) where findings are organized into the resulting tropes, and each trope is discussed and exemplified with direct quotes from journal articles and websites.

4.4 Sociological Introspection

Following Ellis's (1991) method of Sociological Introspection, I studied my own emotionally-laden self-dialogue related to my own experience with an "incompetent" cervix. To collect my narratives, I journaled throughout the research process on my personal experiences with an "Incompetent Cervix" diagnosis. In my writing, I paid careful attention to not only my thoughts and feelings at the time of my diagnosis and subsequent experiences, but also to my present thoughts and feelings as my research unfolded (Ellis, 1991). To start, I wrote narratives about my first pregnancy and my interactions with healthcare providers during that time. I then wrote narratives on my daughter Lidia's premature birth – which I later found out was due to my "incompetent" cervix – using her NICU bead journal as a prompt. Lidia's bead journal is a part of the Beads of Courage Program which provides arts-based medicine for critically ill children (Beads, 2017). Enrolled children or their parents receive a booklet in which they mark down specific events from the length of the child's hospital stay. For example, a child receives a yellow bead for each day they stay in the hospital, a red bead for a blood transfusion, a rainbow bead for a visit from the therapy team, etc. The beads serve as an artful narrative of the child's hospital stay, and they also help me to remember my pregnancy and daughter's premature birth, which took place in 2012. Sociological Introspection allows researchers to "examine emotion as a product of the individual processing of meaning as well as socially shared cognitions" (Ellis, 1991, p. 23). This method works well with CDA and CA as it allowed me to (re)imagine my lived experience in light of the discursive findings from my analysis. As I analyzed journal articles and websites, I wrote down my personal reactions to the data as well as places

where my personal experience either conflicted with or supported what I read. I used this insight into the emotional experience of an “incompetent” cervix in combination with the data collected from websites and medical literature to interject my voice in a conversation where patients are currently silenced.

CHAPTER 5: MY "INCOMPETENT" CERVIX

The two pink lines on the cheap pregnancy test were a surprise. My partner and I were not trying to get pregnant; in fact, as a newly-engaged, young couple, we were actively trying to do the opposite. Although the pregnancy was not planned, my partner and I were excited. I saw the doctor at regular intervals from the time I found out I was pregnant at just four-weeks gestation until the time I delivered at 25-weeks gestation. Upon ultrasound, the fetus looked to be developing "normally," and all of my test results came back "normal" as well. Neither my partner or I had an alarming family history, and my mother had four uneventful pregnancies that bore four healthy children. Except for extreme nausea and vomiting that lasted the duration of my pregnancy and some slight bleeding at the 9-week mark, my pregnancy seemed like it too would be uneventful.

At around 16-weeks, I began experiencing back pain for the first time. It was difficult to describe – not sharp but not dull, not crampy but more of an ache. At first, I thought it was due to the growing fetus and increased demand on my body, but I had a deep feeling of unease that I could not shake. I consulted a handout that the office gave me describing "normal" symptoms and symptoms that could potentially mean doom and gloom. I saw that lower back pain was listed as a symptom of a diagnosis called "Incompetent Cervix," something I had never heard of before. I recall reading about it further on the Internet, but the symptoms were quite vague and easily attributable to the normal stretching and growing that comes with pregnancy, so I tried my best to ignore the disquiet lurking at my core.

I first spoke of my symptoms to my practice through the nurse triage line – it was late, and I had been suffering from back pain all day to the point where I could not sit or

stand. This pain did not feel normal, although I had nothing to compare it to, so I phoned the triage line and explained the situation to the nurse. She was kind and suggested I take Tylenol and a bath and call back if the pain did not subside. I could not stand the thought of sitting upright in the tub, so I took a Tylenol and sat in the shower with the water hitting my back. I stayed there until the water turned cold and went to bed feeling a bit better, and when the pain began the next day anew, I repeated the process wondering why I had never heard any of the moms I knew describe a similar discomfort.

A few weeks later, I sat anxiously waiting for the physician on rotation that day to enter the room. As I sat, I tried to gather the nerve to explain the strange back pain and feeling that something just was not right. I had an anatomy scan at the 18-week mark which showed no abnormalities except for a few choroid plexus cysts in the fetus' brain, but I was assured these would most likely disappear on their own. The present appointment took place around the 22-week mark, so when I finally spoke up and told the physician about my concerns, he immediately responded saying what I was describing was "normal pregnancy pain," and that so long as I was not having other symptoms, I should not be worried. I was disappointed – I had hoped for an ultrasound to double-check or that he would at least check my cervix manually – but I began to feel paranoid. After all, if the physician is not concerned, why should I be? He is the expert, after all. At the 25-week mark, I awoke in the early hours of the morning with watery discharge and very small contractions. It took nearly two hours for me to finally call the nurse triage line. Even though I knew something was wrong, I felt unsure of myself and wanted to hear, "You need to come in." And so, I woke my partner saying, "I think I am having contractions, and the nurse says I need to go in to get checked out." I did not even bother

to pack a bag as I assumed everything would check out fine and I would be sent home with an increased sense of paranoia. Imagine my shock when the physician on rotation checked my cervix and said, “Well, you’re four to five centimeters dilated, fully-effaced. We are going to have to admit you and get you on medication to try to stop the labor from progressing.” Things started to blur together once the magnesium entered my veins, but I was transferred to a hospital with a level four NICU where I stayed on bed rest for five days, all the while continuing to dilate. It was during that time that the Maternal Fetal Medicine physician crassly told me that, “We can prevent this next time” without bothering to explain what it is we might prevent. On the fifth day, my water broke, and Lidia was born into a flurry of doctors and nurses at the ready to sweep her off to the NICU. I remember hearing her cry and seeing her purple body and asking, “Is it normal for her to be purple?” and receiving no response. As soon as she exited my body, the spotlight was on her; I performed my role, however poorly, and now it was time to concern myself with doing what I could to ease her NICU journey. My silencing began the moment I found out I was pregnant, although I was not aware. Pregnant women are made to submit to healthcare providers to receive treatment, and their bodies are no longer the priority (Dusenbery, 2018). In my circumstance, I was no longer an individual entity, but a vessel made to protect a fragile fetus; once she was born, I was still not recognized as my own entity but as a mother who most now place her sole focus on her infant.

I felt like a spy sitting and watching the nurses care for their assigned babies, tentatively reaching a finger into Lidia’s incubator so that she might squeeze it with her tiny hand. On multiple occasions, the nurses suggested I take time outside the NICU for

myself, but what they did not seem to understand was that I was made to leave her every night; the NICU was not set up for parental sleepovers. Every morning, I woke up, pumped, and set off on the 45-minute drive; if I left the house later than usual, I felt guilty for wasting time spent beside my struggling infant. Family and friends did not often ask how I was recovering – they asked after Lidia whose state was much more precarious than mine. My body, having hardly stretched to carry a two-pound fetus, did not look like a "typical" postpartum body, and I wore my hospital bracelet for the entirety of Lidia's NICU stay in hopes that the people I passed in public might notice and recognize that I was a mother. I envied pregnant women with rounded bellies and tired parents carting infant carriers. At night, my partner and I returned home to an empty nursery containing an unbuilt crib and unwashed clothes; we could not bear to prepare for a homecoming that was not guaranteed. In every aspect, we were silent parents waiting to be told we could hold our child or change her diaper; waiting to hear we could bring her home. Finally, after 91-days, we brought Lidia home.

I was not formally diagnosed until my second pregnancy when I was considered high-risk and had my cervical length measured every two weeks via transvaginal ultrasound (starting at 16-weeks gestation). At 22-weeks gestation, the ultrasound showed my cervical length had shortened past what the physician considered safe, and I was told I would need a cerclage placed the next day. As a result of this intervention, my son was born full-term. I still marvel at the fact that all it took to "fix" my "incompetent" cervix was a thick piece of thread. With that diagnosis came an influx of guilt I thought I surpassed when Lidia came home from the NICU healthy. With this new awareness of

my “incompetence,” I was made to reexamine Lidia’s birth with new evidence of my “failure.”

CHAPTER 6: FINDINGS

Critical Discourse Analysis is concerned with issues of power (Fairclough & Wodak, 1997) at both the micro and macro levels (Fairclough, 1995; van Dijk, 1993). I examined articles and websites at the Sociocultural Practice Level, the Discourse Practice Level, and the Textual Analysis Level (Fairclough, 1995). My analysis yielded overarching discursive tropes put forth by medical discourse: Doctors as Heroes, The Silenced Woman, the "Good Mother," Then vs. Now: Discourse Across Time; The "Incompetency" Continuum; Medical Coding and Billing; and Sampling. I then used CA to explore the competing tensions found within some discursive categories. In the following sections, I detail each of these tropes and provide supporting examples and evidence from each of the three levels of analysis as well as the contrapuntal level.

6.1 Doctors as Heroes

At all three levels of analysis, the discourse constructs the idea that women with the diagnosis of an "incompetent" cervix are failures, and because of this failure, they are a problem that can be solved only by a heroic doctor. This was also played out in the dialectical tension of medicalization of the female body as simultaneously harming and beneficial.

6.1a The Failure to be a Woman

Throughout analysis of both articles and websites, medical discourse often depicts the "incompetent" cervix as a failure of a woman's body. First, websites tell readers that "carrying your developing baby to full term is the objective of any pregnancy" ("Incompetent Cervix: Weakened Cervix," 2015), implying that women who delivered prematurely fail to meet this objective. This breakdown casts women with an

"incompetent" cervix in a negative light as she cannot meet this goal (or at least not without the help of medical technology), and it also means that because of her medical condition, the fetus or premature infant endures hardship or death. The medical journal articles imply this same failure: "The terms "cervical insufficiency" and "cervical incompetence" have been used to describe the *inability of the uterine cervix to retain a pregnancy* [emphasis added] in the absence of contractions or labor" (ACOG Committee, 2003, p. 1091). In this example, at the level of the text, the discourse personifies the uterus and assigns blame to women for failing herself and the fetus; the uterus fails women silently, neglecting to warn women of their body's disobedience. In this way, her body has failed her twice.

How does one develop an "incompetent" cervix in the first place? Potential causes are often found in articles. For example:

> Several investigators have postulated that most cases of cervical insufficiency occur as a result of surgical trauma to the cervix from conization, loop electrosurgical excision procedures, overdilation of the cervix during pregnancy termination, or obstetric lacerations, although data confirming this association are limited. Other proposed etiologies include congenital Mullerian anomalies, deficiencies in cervical collagen and elastin, and in utero exposure to diethylstilbestrol (DES). (ACOG Committee, 2003, p. 1092)

The first two potential causes, conization and loop procedures, are common treatments for high-grade cervical changes, which are often the result of high-risk Human Papilloma Virus (HPV) strains (Jiang & Chen, 2017). The third potential cause, pregnancy termination, suggests that women's "incompetent" cervix may be her own

fault for ending a previous pregnancy. At the discourse practice level, this implication may reflect anti-abortion ideologies where women's "selfishness" not only ends one pregnancy but has the potential to wreak havoc on potential future pregnancies. The subsequently proposed origins – abnormalities and a mother's exposure to DES – either suggest an inherent shortfall in women, imply that she created the condition herself as a result of risky sex, or that her mother caused her exposure to a harmful drug. Data from websites support this as well through their various lists of potential causes. For example, one website states, "Your mother took the drug DES (diethylstilbestrol) while she was pregnant with you" (Deshpande, 2016). Rather than using language that frames the mother as guilty, why not rephrase the sentence to reflect the fact that medical professionals prescribed the harmful drug to these women in the first place?

When considering the historical context in which medical literature is produced, the technology used to treat the "incompetent" cervix has remained mostly unchanged since the cerclage was first introduced in 1951 (Althuisius, Dekker, Hummel, Bekedam, & va Geijn, 2001, p. 1106). Although the cerclage remains the superhero technology "restor[ing] the cervix to its prediagnosis condition" (Guzman et al., 1996, p. 475), women with an "incompetent" cervix are so great a failure that even the hero physician has a difficult time making the diagnosis, and it is often only made "in the absence of other causes of preterm delivery" (Althuisius et al., 2001, p. 1107).

6.1b Women as a Problem to be Solved

At all three levels of analysis, women are presented as a problem to be managed because of their failure. First, the examined discourse repeatedly speaks of the problem women with "incompetent" cervixes pose to the medical community: "Women who have

cerclages for suspected incompetent cervices *continue to pose a challenge to obstetricians* [emphasis added]" (Funai et al., 1999, p. 117). The sociocultural practice level asks questions about how a text is produced, and this statement reflects traditional provider-patient relationships where the physician is dominant over the patient. At the textual level, medical providers engage in turn-taking only with other providers, speaking to each other through medical journal articles and (re)producing these power relations. Further, if the disruptive woman wishes to be fixed, she must relinquish control of her body to the healthcare provider as she endures various forms of treatment including surgical and non-surgical options (ACOG Practice, 2014). However, this fix is impermanent; if a cerclage is required, it is only there to support the "incompetent" cervix temporarily as in the majority of cases, the cerclage is removed towards the end of pregnancy, and in future pregnancies, the "incompetence" will reveal itself again.

Journal articles also note that the "incompetent" cervix has eluded doctors for many years without much change in diagnosis or treatment. For example, one 1959 article stated: "Within the past decade increasing attention has been directed toward a new syndrome, that of late abortion due to the incompetent cervix" (Dunn, Robinson, & Steer, 1959, p. 335), but even with this increased attention 60 years ago, most contemporary articles still lament the difficulty in establishing criteria for diagnosis and treatment. This is significant at both the sociocultural practice and discourse practice levels: Although the historical context in which the text is produced changes over time, the dominant ideological belief that women are mysterious creatures that men can never completely understand due to their innate differences (Ehrenreich & English, 2005) remains the same. This is also reflective of a historical lack of research on women's

health issues where women were (ironically) assumed to function the same as men, biologically speaking (Dusenbery, 2018). Moreover, as this discursive assertion illustrates, "the main problem of studies reporting on cervical cerclage is that cervical insufficiency is extremely difficult to establish objectively" (Daskalakis, Papantoniou, Mesogitis, & Antsaklis, 2006, p. 224), the diagnosis and treatment are widely debated. These disputes are covered in greater detail in later sections; however, it is worth mentioning here as even though women pose a challenge to medical professionals, medical professionals themselves cannot agree on just how to manage the delinquent cervix.

The most challenging patient with an "incompetent" cervix is "…the woman with prolapsed membranes at or beyond a dilated external cervical os…" (Althuisius, Dekker, Hummel, & van Geijn, 2003, p. 908). This patient poses unique challenges to providers as they debate what treatments are possible. I was one of these women as I was admitted to the hospital four centimeters dilated, cervix fully effaced, and waters bulging. My medical team placed me on bed rest, administered medications to slow contractions and magnesium to prevent brain bleeds in the fetus as well as steroids to develop the fetus's lungs faster. I was indeed treated as a problem to be solved and managed with no regard to my mental or emotional well-being. Although I believe my medical team provided excellent care in terms of preparing my daughter for her early arrival as best possible, my needs were neglected; I was merely a host for the fetus. As mentioned in my narrative, Lidia's well-being was the central concern while I was pregnant, and this was exacerbated once I gave birth.

6.1c The Harm-Benefit Tension of Medicalization of the Female Body

Contrapuntal Analysis helps to understand competing viewpoints within a text (Thomas, 2017). In the context of the medical discourse, in order to "solve the problem" of an "incompetent" cervix, women must submit to the medicalization of their bodies. For instance, "…serial evaluations may be performed (particularly in patients with pelvic pressure, backache, or increased mucoid discharge) every few days to avoid missing rapid changes in cervical dilation…" (ACOG Committee, 2003, p. 1095). In medicalizing the female body, there exists a harm-benefit tension, and in the case of the "incompetent" cervix, the benefit is the medical technology that becomes available (i.e., hormone therapy, ultrasound, cerclage, NICU). Specifically, if a doctor finds the cervix is shortening past a point of safety, a cerclage can be placed to support the fetus and prevent premature delivery: "Management of these women usually involved the placement of a cervical suture to support the cervix, which is considered insufficient" (Daskalakis et al., 2006, p. 221), and in emergent cases, the cerclage is sometimes referred to as a "heroic cerclage" ("Causes of," 2012). At the textual level, women are discursively placed as inferior to the physician as their "insufficiencies" are "managed." In my narrative, I *needed* medical intervention in order to give birth to a viable fetus. I was placed in the impossible position of wanting bodily autonomy and choice while needing the benefits of technology such as ultrasound and cerclage; I could not be both a "competent" woman with decision-making abilities and a woman with an "incompetent" cervix in need of medical intervention. As soon as I was labeled, the treatment decisions were made on my behalf with the focus on what was best for the fetus, not what was best for my health.

6.2 The Silenced Woman

As part of Critical Discourse Analysis, is important to reflect on what is missing from the studied language. Both websites and medical journal articles bear evidence of the erasure of women, and this is seen in the following ways: Silencing women, positioning women as passive, and disbelieving women.

6.2a Silencing Women

Understanding what is absent is just as imperative as analyzing what is present. In this case, not one journal article gives a personal account or testimony from a patient with an "incompetent" cervix.

Journal articles talk about women in the third-person: "The patient was kept at bed rest and on antibiotics (Frank & Rubovits, 1959, p. 334);" "The selection included asymptomatic pregnant women screened by transvaginal ultrasonography…" (Berghella, Odibo, To, Rust, & Althuisius, 2005, p. 182). The use of third-person language distances both the author and reader (presumably, both are medical professionals) from the patient and simultaneously disregards to women's personal experience. This use of third-person language is contrasted with discourse on websites. Here, websites differ from the medical journals in that all but one use second-person language: "If your cervix begins to open early…your doctor might recommend preventative medication during pregnancy" ("Incompetent Cervix," 2018). The use of second-person language acknowledges that the cervix is a part of her, not all of her by placing women as the subject. Websites targeting patients change their discourse to account for their audience – individuals searching for information regarding the "Incompetent Cervix" diagnosis – and employ a more

humanizing form of discourse, sometimes including direct quotes from individuals diagnosed with an "incompetent" cervix (Kolp, n.d.).

The exclusion of women's voices is also evident at the textual level in who is silenced. In articles, medical providers take turns speaking with each other about patients – "Cervical incompetence is treated generally by transvaginal cervical cerclage or bed rest…" (Althuisius et al., 2003, p. 907) – but never to them. In the following quote, women are also eliminated from the discourse: "Four twin and 25 singleton gestations underwent transvaginal ultrasonographic evaluation of the cervix because of poor obstetric history" (Guzman et al., 1996, p. 471). In this way, a woman is constructed as nothing more than her pregnancy.

The use of second-person language in websites is sometimes used when providing information to readers: "Incompetent cervix is when your cervix becomes weak enough that it opens before it's supposed to" (Kolp, n.d.). This quotation differs from articles in that it states, "your cervix," which may help keep the reader central to the conversation. However, second-person language does not necessarily equate to more equitable language. For example, one site posed the question, "What can I do to prevent incompetent cervix?" (Kolp, n.d.), and while the author acknowledges that women typically cannot control this diagnosis, readers are encouraged to tell their provider if they have risk factors and their provider will "monitor you closely throughout your pregnancy" (Kolp, n.d.). During my first pregnancy, I was given a sheet of paper outlining troublesome symptoms and was instructed to contact my physician if I experienced any of them. After experiencing unusual lower back pain for several weeks, I told my provider at my then monthly visit and was immediately brushed off as he

informed me that back pain was a normal pregnancy symptom. So, although this medical provider is communicating an ideal, it would be beneficial if sites meant for laypersons gave education on how to properly advocate for oneself when speaking with healthcare providers, especially in instances where they disregard patient experience. Other sites mirror medical journals in their use of third-person language: "Patients who have received prophylactic cerclage usually assume modified physical activities" ("Incompetent Cervix," 2011). Here, a woman is passive as she "receives" a cerclage and might "assume" physical activities under the discretions of her provider.

The medical discourse often further removes women from the conversation by framing the problem of the "incompetent" cervix in terms of prematurity as opposed to a problem of female fertility. Both journal articles and websites justify the need for solving the problem in order to reduce the high rate of preterm birth as demonstrated in the following quote: "Cervical incompetence is a well-recognized cause of preterm birth in the second or early third trimester of pregnancy" (Althuisius et al., 2003, p. 907). Certainly, a mother wants her pregnancy to last until full-term, so why not place the mother's needs, wants, and desires as the focal point? Websites also situate the problem of the "incompetent" cervix within the context of preventing premature birth: "An incompetent cervix, also called cervical insufficiency, occurs when weak cervical tissue causes or contributes to premature birth or the loss of an otherwise health pregnancy" ("Incompetent Cervix," 2018) and stress that the condition may lead to miscarriage or loss of the fetus ("Cervical Insufficiency," n.d.; Deshpande, 2016; "Incompetent Cervix: Weakened Cervix," 2015; Kolp, n.d.; March of Dimes, 2015; Weiss, 2017).

The "incompetent" black woman. At the sociological, discourse practice, and textual level, race is ignored. In critical work, it is important to consider representation (or lack thereof), and very few articles and websites address race. Existing examples are vague in their discussion of race and how it might impact a woman with an "incompetent" cervix: "Black women seem to have a higher risk of developing cervical insufficiency. It isn't clear why" ("Incompetent Cervix," 2018). This absence of information represents an ideological belief that black women are valued less than white women. Even though the discourse recognizes that "…the majority of these subjects were at high risk for preterm birth because of their ethnicity (African-American)" (Farinelli et al., 2012, p. 672), there is no attempt to situate this risk in a larger socioeconomic framework. Also, in this example, women are nominalized in that they are referred to as "subjects" insinuating that they are not human. Further, "High-risk African-American women experience cervical length shortening at twice the rate of women of other race/ethnicity, consistent with their recognized disproportionally higher preterm birth rates" (Szychowski et al., 2009, p. 74). Although the medical discourse recognizes a large disparity along racial lines, this critical health problem is stated like an afterthought with no sense of urgency. Women are silenced in our phallocratic society, but just as these findings demonstrate, minority women face the greatest challenge in being heard and accessing care.

Absent vs. central. In Contrapuntal Analysis it is important to consider whose voice is positioned over others. Although most discourses from articles and websites silenced women, the language in some articles brought women back to the forefront by discussing pregnancy outcomes: "Ultrasonographic evaluation of the cervix has been

used to predict pregnancy outcome in women with poor obstetric histories and those with threatened preterm labor…Studies on postelective cerclage ultrasonography of the cervix have shown some correlation with eventual pregnancy outcome" (Guzman et al., 1996, p. 471). In this example, the researchers are concerned with achieving positive outcomes for their patients, placing women as the central concern. Some medical discourse included concern surrounding the overtreatment of women in regard to cerclage placement: "Unnecessary history-indicated cerclage procedures can be avoided in more than one half of the patients" (ACOG Practice, 2014, p. 374). Although the phrase focuses on the procedure, this concern for over-treating women was new and challenged the devaluing of women at the institutional level. This was also demonstrated in the following quote: "Because several studies showed that approximately one half of these women do not need a prophylactic cerclage, the first choice of treatment has become transvaginal ultrasonographic follow-up of the cervix" (Althuisius et al., 2003, p. 907). Here, the discourse suggests a shift towards treating women on a case-by-case basis rather than assuming that women and their "incompetent" cervixes are all the same and can be treated as such.

6.2b The Ambiguous "Incompetent" Cervix

The understudied and ambiguous nature of the diagnosis also reifies how little women are valued in the medical realm at both the sociocultural and discourse practice levels. Consider the following quotation:

> Since the cervical cerclage was introduced to clinical practice 50 years ago, the efficacy of the operation has not been established by evidence-based standards for many indications. Serious flaws in the methods employed to study the safety and

> efficacy of cerclage have led to confusion and misuse of the operation, although some investigators maintain that current standards make randomized clinical trials of this traditional surgery unethical. (Harger, 2002, p. 1313)

Although the cerclage is a part of standard treatment for an "incompetent" cervix and has been for a long time, there is a lack of ethical and rigorous research indicating that women are not considered worthy of high-quality medical care. Previous studies randomly select which treatment options patients receive (Althuisius et al., 2001), potentially over-treating some patients and under-treating others. Randomly assigning a woman to a bed rest group, for example, could lead to the loss of a fetus where a cerclage may have prolonged the pregnancy. Additionally, research is lacking in important areas such as "the efficacy or safety of emergency cerclages performed for advanced cervical dilation" (Harger, 2002, p. 1313). Researchers maintain that randomized trials are difficult and require large and varying sample sizes, and without such evidence, "the decision regarding which treatment options to choose should take into account women's and clinicians' preferences" (Alfirevic et al., 2013, p. 150). This emphasis on women's choice is not common in the medical articles or websites, and in my personal experience, there was no choice involved – my healthcare providers made treatment decisions on my behalf and presented cerclage as the only option during my second pregnancy. The new healthcare ideological ideal advocates for patient-centered care, but with this diagnosis, treatment plans are fetus-centered and position the healthcare provider as omnipotent.

The difficulty in diagnosing and treating an "incompetent" cervix is demonstrated time and time again: "The role of cerclage in the treatment of patients with cervical insufficiency after fetal viability has not been adequately assessed" (Daskalakis et al.,

2006, p. 224); “Cervical incompetence has always been a difficult and subjective diagnosis” (MacDonald, Smith, & Yvas, 2001, p. 214); “This wide disparity reflects confusion about the diagnostic criteria for – as well as uncertainty about the proper treatment of – cervical insufficiency. The success rate of cerclage is equally difficult to estimate” (ACOG Committee, 2003, p. 1092). This ambiguity and deficient research are concerning considering the number of published articles on the topic spanning many decades and imitates a troubling lack of women’s health research more broadly as well as a general erasure of women in larger sociocultural discourse.

Websites also maintain that the “incompetent” cervix is not routinely checked for during pregnancies that are considered low-risk (“Incompetent Cervix: Weakened Cervix,” 2015). Further, once a patient has a cerclage, “standardized monitoring plans are lacking” but “close prenatal visits and serial sonographic cervical monitoring may be beneficial” (“Incompetent Cervix,” 2011). Transvaginal ultrasounds are typically used to monitor patients for cervical shortening, and medical discourse totes this as “an objective and non-invasive method for evaluating cervical status” (Rozenberg, Gillet, & Ville, 2002, p. 309). Discourse framed transvaginal ultrasounds as a more comfortable alternative for patients as opposed to prophylactic cerclage:

> The treatment usually proposed (cervical cerclage) is invasive, inconvenient for the patient, and carries with it a significant risk of morbidity and the possibility of mortality. There is a need for a method of cervical assessment which identifies which patients might benefit from a suture, and equally importantly, those in whom it would be ineffective and hence unnecessary. (MacDonald et al., 2001, p. 214)

Within the discourse practice realm, the context in which this discourse is (re)produced upholds provider-patient hierarchy as medical professionals decide what is more comfortable for women. At the ideological level, it is assumed that medical professionals know what is best and need not to take patient experience into consideration. Transvaginal ultrasounds may be a beneficial technology, but some women may find this procedure very invasive, awkward and uncomfortable; medical providers cannot define the experience for women. Overall, the lack of women's voices and patient perspective sends a strong message, one that rings true in many other subject areas: Women do not know their bodies better than medical experts and must submit to invasive medical practices, and women's opinions will not be taken into consideration.

6.2c Women as Passive

The discourse found in medical journal articles consistently paints women as passive by using language where actions happened *to* or *for* patients: "After 32 weeks, women were allowed mobilization with plenty of rest" (Daskalakis et al., 2006, p. 223). This subtle choice of language use is not accidental but mirrors ideological frameworks where women are made to be passive and delicate and men active and aggressive, similar to language used to describe sex cells (Martin, 1991). Moreover, women are not the agents in the birth process: "Three of the first 12 patients studied showed dilation of the internal os after placement of the cerclage and all were delivered prematurely" (Guzman et al., 1996, p. 474). The use of nominalization here serves to reify women as passive beings as the act of giving birth is turned into a process without crediting the main performer.

Websites frame women as passive in fewer instances due to their frequent use of second-person language; however, there were examples similar to those found in articles: "During this time she *will be observed* [emphasis added] for preterm labor and screened for infection" (Weiss, 2017). Women are also constructed as passive by reducing their whole selves to body parts: "A pillow was placed under the pelvis for ease of movement of the transvaginal transducer" (MacDonald et al., 2001, p. 211). In this example, the pelvis replaces women as the subject and is positioned at the benefit of the ultrasound wand rather than the comfort of women. This use of passive language in both journal articles and websites reflects cultural ideologies that frame women as passive (Martin, 1991). Placing women as the subject of action is an entry point for disrupting these gendered constructions.

6.2d Disbelieving Women

With the healthcare provider positioned in the seat of power, a woman and her "incompetent" cervix is at the mercy of the physician to either take her complaints seriously or ignore them. The absence of patient narratives is telling, but medical discourse goes beyond this absence to actively negate patient experience. For instance, the following quote highlights how little credibility is given to a patient's personal experience: "In rare cases, the patient's verbal history would suffice, if records were unavailable" (Szychowski et al., 2009, p. 72). In other words, the author would prefer hearing from other medical providers about a patient even when the patient is capable of relaying her own medical history.

It is understood that with an "incompetent" cervix, dilation takes place with little warning: "This relatively 'silent' labor could be taken to imply that the cervix dilated

with minimal uterine contractions; as delivery occurred at term, the cervix could perhaps be considered partially incompetent" (MacDonald et al., 2001, p. 215). My personal experience does reflect this "silent" labor; however, I experienced abnormal back pain – a known symptom of "incompetent" cervix – for weeks before my small contractions started, and it bears repeating that even though I brought this to the attention of my physician, I was ignored. Despite the fact that "depending on the degree of risk, surveillance should be carried out weekly or fortnightly, bearing in mind that incompetence is most often revealed by ultrasound between 17 and 22 weeks" (Rozenberg et al., 2002, p. 309), my cervix was not checked by exam or ultrasound. If my provider had taken my unease seriously, perhaps the outcome of my first pregnancy would have been different.

For medical providers, the degree of risk seems to influence when and how women are diagnosed. For instance, women who have successfully delivered at full-term appear to be at low-risk for developing an "incompetent" cervix, but "there is a subset of women who previously have a term delivery and are diagnosed unexpectedly with cervical insufficiency in a subsequent pregnancy" (Vyas et al., 2006, p. 788). Most women are not diagnosed without a "history of one or more mid-trimester abortions, with early rupture of the membranes, usually before the onset of labor" (MacDonald et al., 2001, p. 211). In other words, a woman will typically miscarry or give birth prematurely – often multiple times – before a diagnosis is made. There is an "absence of reliable criteria for the selection of a high-risk population for preterm delivery" (Rozenberg et al., 2002, p. 302), and in ignoring patient symptoms, this lack of protocol is exacerbated. Healthcare providers rely on a risk assessment to successfully diagnosis patients rather

than listening to women and their embodiment, reminiscent of ideological beliefs that women are irrational, hysterical, and untrustworthy.

Websites also discuss risk assessment: "There is still no good way to screen for cervical insufficiency, but if you're at risk for this condition, your practitioner may order regular transvaginal ultrasounds…" ("Cervical Insufficiency," n.d.); "A woman may not be diagnosed with a short cervix until she has experienced one or multiple miscarriages or early preterm births. Such a risk can be detected if a transvaginal ultrasound procedure is performed regularly from the sixteenth week of gestation" (Deshpande, 2016). In the second example, the irony of the situation is featured in a which-came-first scenario – a woman's degree of risk may depend on a transvaginal ultrasound that she may not have unless she is deemed high-risk. Interestingly, "Risk scoring systems based on patient's history have a positive predictive value of only 15-30%, and serial digital examinations of the cervix are subjective, non-specific, poor evaluators…" (Berghella, Kuhlman, Weiner, Texeira, & Wapner, 1997, p. 161), hence why sonography is considered a more reliable and objective tool for diagnosis. Yet, as shown above, providers are unsure when to use transvaginal ultrasounds in this way. So, even though transvaginal ultrasounds may be the best method for determining whether or not a woman's cervix is "incompetent," they are rendered useless without clear protocols.

6.3 The "Good," "Competent" Mother

How does medical discourse contribute to, reflect, and/or differ from the lived experience of the "incompetent" cervix? Here, I can add my voice to the conversation and address the parallels between what I found during analysis of articles and websites with my intimate understanding of the diagnosis. First, as demonstrated above, the

discourse surrounding the "incompetent" cervix positions women as failures, effectively positioning them as "incompetent" mothers. Second, the mother is silenced as she is spoken about and to but never heard from. The following sections detail these findings.

6.3a The "Incompetent" Mother

Once diagnosed with an "incompetent" cervix, a woman must engage in identity work – consciously or unconsciously – to consider its implications. According to dominant ideologies, mothers are expected to act in the best interest of and protect their fetus (Malkowski, 2014). For instance, if a "good" mother is one that protects her child, then the mother with an "incompetent" cervix diagnosis is surely the opposite. Once diagnosed, I understood what the abrasive doctor had meant by, "We can prevent this next time." The relief I felt for the fetus saved by cerclage was tainted by fresh guilt as I realized the suffering Lidia endured in the NICU could have been prevented with a cerclage. Many women with an "incompetent" cervix will either experience fetal loss or premature birth. If the latter, the infant will most likely spend time in the NICU as it continues to grow and develop outside the womb. As a result of my personal experience with this diagnosis, I felt guilty and personally responsible for my daughter's 91-day NICU stay. After all, "the cervix is a structure that is supposed to protect the fetus while it's developing in the womb" (Deshpande, 2016), and my body was not strong enough to support and protect my daughter; I failed her, and because of this failure, she had to endure countless needle pokes, ultrasounds, x-rays, blood transfusions and other invasive procedures that interrupt fetal development. I was told my daughter would most likely have some lasting impact as a result of her extreme prematurity.

In all the discourse, only one article acknowledged the possible impact of this term: "…it is easy to see how a mother grieving over the death of her premature infant might be additionally upset be being told by her physician that the premature birth resulted from her "incompetent cervix" (Fox, 1983, p. 462). Fox (1983) ponders the term "incompetent" outside of the medical realm in order to come to this understanding and explains that he first considered its impact after speaking with parents of deceased premature infants. This is the only evidence within this study where the medical discourse surrounding the "incompetent" cervix addresses issues of guilt and inadequacy. At the textual level, this discourse is the only example where a physician shares the floor with patients, even though they are not directly quoted. This article was not cited by other medical professionals in regard to the "incompetent" cervix diagnosis, and at the discourse practice level, this suggests that this arena is not yet ready to explore this "inadvertent insensitivity" (Fox, 1983, p. 463).

6.3b The Silenced Mother

Just as the discourse surrounding the "incompetent" cervix diagnosis excludes women's voices, my lived experience is one of a silenced mother. In examining the time leading up to Lidia's premature birth, I was ignored by my healthcare providers on at least two occasions.

As I contemplated my "incompetent" cervix, I reflected on Lidia's birth, which at the time was considered "spontaneous" with no known cause, and the lack of support I received from my healthcare providers. Similar to the sampled medical discourse, I was silenced as physicians talked over me and for me and ignored my questions and concerns. I can only speculate that because I was a young 21-year-old with no past medical history,

my team of healthcare providers anticipated a smooth pregnancy. The medical discourse highlights the ambiguity around diagnosing and treating the "incompetent" cervix, particularly in the absence of risk factors, as was the case of my first pregnancy. During my second pregnancy, I was considered high-risk and monitored with transvaginal ultrasounds bi-weekly starting at 16-weeks gestation. This treatment plan is consistent with the present-day literature, but none of this literature was able to suggest protocols for the low-risk woman. Websites encouraged readers to contact their providers if they had any symptoms associated with "incompetent" cervix, but as was my case, there is no guarantee that providers will take these reports seriously. This silencing carried over into the realm of the NICU where I was unable to participate in Lidia's care unless the nurse gave permission. Just as the medical discourse surrounding the "incompetent" cervix diagnosis frames women as passive, I was made to be a passive mother in the NICU, forced to relinquish control to medical professionals that knew what was best for my more-fetus-than infant growing inside a plastic shell.

When medical providers discuss the "incompetent" cervix diagnosis and, whether knowingly or not, exclude the patient's voice, they mystify all the stigma, guilt, and pain that comes along with the diagnosis. My narrative serves to break this silence so that as best practices are and continue to be debated, other women in similar situations might not feel quite as alone. The effects of this diagnosis do not end when a viable birth takes place; there are lasting impacts for both mother and child that are not covered in these sampled articles and websites.

6.4 Then vs. Now: Discourse Across Time

In examining articles from 1930 to present-day, the evolution of the discourse of the "incompetent" cervix was revealed. First, there has been a shift away from using the term "abortion" – "Late abortion or premature labor occurring after the sixteenth week of gestation as a result of cervical incompetence has emerged in recent years a clinical entity" (Barter et al., 1958, p. 511) – to "miscarriage" – "High risk is defined by history of preterm delivery, late miscarriage…" (Rozenberg et al., 2002, p. 303) or "second-trimester loss" (Berghella et al., 2005, p. 182). Although this move is not exhaustive – "Univariate analysis identified curettage procedures (for the management of spontaneous abortion or voluntary termination of pregnancy)" (Vyas et al., 2006, p. 788) – it does suggest an ideological shift away from anti-abortion rhetoric.

The "problem" was ambiguous then just as it is now: "That so little emphasis has been accorded second-trimester abortions is undoubtedly due to the limited number of patients in whom this condition occurs" (Barter et al., 1958, p. 511). In a surprising find, the sampled literature from the first date bracket did more to frame the problem around women that medical literature does today: "What can be done for the pregnant patient with a history of one or more late abortions or premature loses…?" (Baden & Baden, 1957). Although prematurity is still mentioned in relation to the "incompetent" cervix in most sampled articles from this time bracket, at least some of the articles framed the justification around women's needs. Overall, at the sociocultural and discourse practice levels, the main constructs remain unchanged.

6.5 The "Incompetency" Continuum

The most recent sampled articles discussed the cervix as a continuum:

> In the past, cervical insufficiency was thought to be a dichotomous variable, meaning the cervix is either insufficient or it is not. More recent data, however…suggest that cervical insufficiency may function as a continuous variable, with cervical insufficiency occupying the extreme of this continuum. (Warren et al., 2007, p.623)

But does this new model help or hinder women? Viewing the cervix as a dynamic structure that varies from woman to woman is significant as medical professionals recognize that women and their cervixes are not all the same and that they may differ from pregnancy to pregnancy (ACOG Committee, 2003). At the same time, this spectrum may be interpreted as a ranking system "where cervical insufficiency may represent the lowermost end of the continuum" (ACOG Committee, 2003, p. 1092). I specifically recall my Maternal Fetal Medicine physician explaining this continuum to me after first proclaiming that I had an "incompetent" cervix; he relayed that the "weak" cervix exists on a spectrum, and that mine was somewhere on the lower end. I believe he had good intentions, but this explanation only increased my feelings of otherness and inadequacy. Perhaps if he said something like, "Every woman is different, and so her body parts will vary as well. Your cervix is a dynamic structure, and for unknown reasons, your cervix cannot support the weight of the fetus once it reaches a certain weight, but a cerclage can help." Placing women center stage rather than the body part itself may help move healthcare providers towards more equitable language.

6.6 Medical Coding and Billing

Within the medical discourse surrounding the "incompetent" cervix, medical coding and billing exist at the textual level. These codes are the minute sum of a

diagnosis and have financial and emotional ramifications for the patient. In medical coding and billing, the term “Cervical Insufficiency” appears to overtake “Incompetent Cervix:” “Preterm labor and delivery” (PTD) remain an important contribution to neonatal morbidity and death. One etiology of PTD is cervical insufficiency (CI), previously referred to as “incompetent cervix” (Carter, Soper, Goetzl, & Van Dorsten, 2009, p. 111.e1). In my personal experience, the term used was “Incompetent Cervix,” which after seeing the shocked look on my face, the physician transitioned to “Weak Cervix” and explained that this “weakness” exists on a spectrum with some cervixes being weaker than others. It is also useful to note that the code used for medical billing (ICD-10-CM Code N88.3) is listed as “Incompetence of Cervix Uteri,” followed by a description that uses both of the terms “Cervical Incompetence” and “Cervical Insufficiency” (“ICD-10-CM,” 2019). There are other body parts that are sometimes considered “incompetent” or “insufficient” when the ICD index is searched including the aortic, mitral and tricuspid valves, esophagogastric junction, pelvic fundus, pubocervical tissue, and rectovaginal tissue (“Incompetency,” 2019).

6.7 Sampling

The noticeable lack of image results for pamphlets and brochures when searching “Incompetent Cervix,” “Cervical Insufficiency,” and “Cervical Incompetence” is not insignificant. Some resulting images depicted visualizations of a “normal” cervix versus an “incompetent” cervix, but these images did not meet sampling criteria. Other results centered on cervical cancer or related topics such as HPV. Also of note during sampling, the term “Cervical Insufficiency” provided the most results in all searches, suggesting it is the most commonly used term by medical professionals; however, as noted above, the

code used for medical billing and coding is “Incompetent Cervix” with “Cervical Incompetence” and “Cervical Insufficiency” used in the definition.

There were important differences between articles and websites that are worth more in-depth discussion. Perhaps the most obvious difference is the targeted audience – articles were authored for other medical professionals, and websites were created for laypersons. However, when conducting research and writing articles, healthcare providers could benefit from taking this lay audience into account – simply because laypersons are not the target audience does not mean that using disempowering language is acceptable. Additionally, if providers use this type of language when speaking to each other, how are they speaking to their patients? By considering their patients and lay audience members even when writing to others in their field, providers might become more mindful of their language use as Fox (1983) suggests.

CHAPTER 7: DISCUSSION

In this study, I sought to analyze what medical discourse regarding the "Incompetent Cervix" diagnosis constructs. Second, in this project, I aimed to incorporate narratives and lived experiences of the "Incompetent" Cervix diagnosis. My personal narratives often reinforced and illustrated the resulting discursive tropes. An important implication of this study is the introduction of a patient's perspective into an arena where it has previously been erased, building on the use of narrative theory. Women are often silenced in the discourse surrounding the "incompetent" cervix, and in my experience, disbelieved and ignored. Women with an "incompetent" cervix must reimagine their identity in light of their diagnosis as they consider what it means for their construction of motherhood and womanhood. The surrounding discourse frames her as a failure which runs counter to the social construction of what it means to be a "good" mother, and she must navigate this space in light of her experiences with the diagnosis.

The discourse of the "incompetent" cervix is similarly to the discourse of the medicalized breast which is spoken of as detachable and dispensable and is referent to cultural ideas of femininity, beauty, and sexual desirability as opposed to its function (Langellier & Sullivan, 1998). The medical discourse surrounding the "incompetent" cervix exemplifies the misogynous nature of our sociocultural gender construction, and this is represented in the replication of medical discourse as providers speak to each other about patients but do not include them; as providers continue to subscribe to and (re)produce normative gender ideologies; and as discursive textual constructions are used to maintain power imbalances inside the text.

An “Incompetent Cervix” diagnosis puts the onus on the individual – if she fails to notice and communicate symptoms, she has failed herself and the fetus. I will now wonder for the rest of my life, “What if?” What if I had demanded my doctor checked my cervical length when he brushed off my symptoms? What if I had gone to the hospital sooner instead of convincing myself that I was not experiencing “real” contractions so early in my pregnancy? What if I had called the nurse triage line sooner rather than worrying that the hospital staff would think I was crazy for being concerned? And how guilty am I if I tell you that a small part of me was relieved when the machine showed I was, in fact, having “real” contractions? What kind of mother does that make me? When the body fails to perform its culturally prescribed role of birthing a healthy child, she fails to be a “good” mother or “good” woman.

The “good” preemie mom is arguably one that pumps to provide the “best” nutrition for her delicate infant. Because of Lidia’s extreme prematurity, she was fed expressed milk through a feeding tube for many weeks. During my five days of hospital bedrest, I was told by hospital staff that the best nutrition for the premature infant is breastmilk as the body produces special milk after an early birth and premature infants have especially sensitive stomachs. I had planned on breastfeeding (as much as one can plan for it), but it was made clear to me that my only option for some time would be to pump. At first, I was relieved to have some form of control over my body (or so I thought) and some sense of purpose; I was satisfied knowing I could at least use my body to benefit Lidia in some way. However, when it came time for Lidia to try nursing, my sense of control was replaced with overwhelming anxiety and guilt. The protocol in Lidia’s NICU was to teach the infants to bottle feed first and then begin nursing, but

nursing expends more energy than bottle feeding, and Lidia was too small and tired to do so successfully. Eventually, when Lidia came home, my milk supply dropped due to my high level of anxiety, and I had to supplement what was left of my stored milk with formula; once the stored milk was gone, Lidia was weaned to an all-formula diet, and at that time, she developed severe reflux and required medication to keep from projectile vomiting. My "incompetent" cervix was the catalyst to a series of mothering failures that I was unprepared for and no one seemed to talk about. The only advice I received was how to increase milk production, and I was shamed by many for "giving up."

I wonder at the fact that this phenomenon still requires researchers to call for more rigorous study, and I cannot help but posit that if this were a men's issue, it would have been studied much more thoroughly. I can only speculate that with the increased awareness of premature birth and health campaigns, researchers found it compelling to frame their need for researching the "incompetent" cervix this way. However, I encourage medical professionals to put women's concerns at the heart of their work.

CHAPTER 8: CONCLUSION

The “incompetent” cervix and the “good” mother rest in opposition to one another. The analysis demonstrates that, like in many other areas, women with an “incompetent” cervix are positioned as failures and silenced. Despite the limitations of medical care in this instance – the ambiguous nature of the diagnosis and lack of rigorous and ethical research – women must give away some of their autonomy in order to have access to the technology needed in order to give birth to a viable fetus. These constructions have a lasting impact on a woman’s construction of her identity as a woman and/or mother as she is made to (re)negotiate her identity in light of her “incompetent” cervix.

The “incompetent” cervix diagnosis lies at the intersection of medicalization and gendered discourse and is a value-laden term that implies the larger socio-cultural belief that women are incompetent. Previous feminist works examining gendered healthcare made important contributions in understanding how gendered constructions and medicalization impact women (Blum, 2004; Duerden Comeau, 2004; Godderis, 2010; Haines et al., 2010; Langellier & Sullivan, 1998; Malkowski, 2014; Thompson, 2010; Vardeman, 2012; Vissandjee et al., 2016), and this study furthers this scholarship by including the previously absent “incompetent” cervix. Importantly, this study revealed what the discourse surrounding this diagnosis constructs – language reflective of the phallocratic order that positions women as failures and as incompetent. As my body failed to perform its prescribed role, I was left without a framework for fully comprehending my diagnosis. Analyzing the term and its surrounding discourse using CDA and poststructuralist feminist theory allowed me to (re)examine my identity in a

new light with the guidance of narrative theory. This analysis offers a critical entry point for communication studies scholars into a previously untouched area. Although my experience cannot and should not speak for women, it is an important step in creating space for women in an area they are typically barred from.

8.1 Implications for Medical Professionals

These findings indicate a need for medical professionals to reevaluate how they talk to and about patients with an "incompetent" cervix; specifically, this study demonstrates the need for incorporating women's voices into healthcare research; One way to do this is to include patient narratives in medical journal articles. The purpose of this study was not to demonize medical professionals but to raise awareness of the importance of acknowledging gender bias in healthcare and sociocultural practices and to consider the lived experience of patients. Healthcare providers might work against these harmful discursive practices by engaging in practices such as defamiliarization where gendered language is reversed so it seems a woman is writing about men (Oliver, 1990). For example, "Incompetent Cervix" might become "Incompetent Penis," and for many, the very thought of this term gracing any medical literature is incomprehensible.

CHAPTER 9: LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

Every study has its limitations, and perhaps the most important limitation of this study is its inability to account for multiple perspectives of the "incompetent" cervix experience. As a young, white, cisgender, heterosexual, middle-class female with two thriving children and no experience with fetal or infant loss, my experiences and inherent biases can only account for one small part of the patient experience of what it means to be told you have an "incompetent" cervix. However, the medical discourse analyzed serves to address a wide range of sociocultural discursive practices. However rigorous my methodology, a possible limitation of this study is its sample size. I could not examine all articles and websites about this topic as CDA requires deep reading and multiple rounds of coding, so it is possible that there may be existing articles and websites that run counter to the themes found here, such as Fox's (1983) call for a revised term. Although I am satisfied with the level of saturation reached during analysis.

Future research might recruit participants with this diagnosis from varying backgrounds to paint a more inclusive picture of the lived experiences associated with an "incompetent" cervix. As demonstrated, the sampled articles and websites failed to adequately account for racial differences, and future research must actively seek to address disparities along racial, ethnic, sexual orientation, and socioeconomic lines. This study is also limited in the data selected for analysis: Scholars might also examine the discourse found on blogs or message boards dedicated to the "Incompetent Cervix" diagnosis. Further, researchers might further investigate how a diagnosis of "Incompetent Cervix" impacts different aspects of a woman's identity. For example, women with an "incompetent" cervix diagnosis are made to reconfigure their identity as they consider

what it means in terms of motherhood and womanhood; in doing so, women might find themselves in a (in)fertile limbo – able to get pregnant but not able to carry a fetus to full-term or even viability. Current research on (in)fertility examines phenomena such as the body politics of women going through Reproductive Endocrinology and Infertility treatment (Johnson & Quinlan, 2016), doctor-patient communication in fertility clinics (Johnson, Quinlan, & Myers, 2018), and the role of telenursing in fertility nurse-patient relationships (Johnson, Quinlan, & Marsh, 2018). Communication scholars can expand on this by uncovering where women with an "incompetent" cervix diagnosis conceptualize themselves on the (in)fertility continuum. Here, interviewing both healthcare providers and patients would be useful.

Scholars might also be interested in understanding how the term "Incompetent Cervix" came to be by tracing its ontology through a rhetorical analysis of medical literature and archival sources. Researchers might ask why this term has not evolved as feminist movements have and continue to seek to de-shame and de-mystify the female body or how the discovery of the link between an "incompetent" cervix and premature birth impacted the power of this label. Additionally, researchers might seek to find a more equitable term through patient and provider interviews. This is a question I am asked frequently when discussing this present study, but it remains outside the scope of this project. For medical practitioners, the need for rigorous and ethical research is already known. Healthcare researchers could take this a step further by challenging their colleagues to engage in practices such as narrative medicine to include patient voices in their work. The need for screening protocols might also be assessed for women who providers deem at "low-risk" for an "incompetent" cervix. These examples are just a few

of many ways the “incompetent” cervix might be studied further. Those with this diagnosis deserve to be heard and their stories shared in hopes of shifting how women’s bodies are talked about and acted upon.

REFERENCES

ACOG Committee on Practice Bulletins (2003). *ACOG practice bulletin No. 48, clinical management guidelines for obstetrician-gynecologists, 102,* 1091-1099.

ACOG Practice Bulletin (2014). *Practice bulletin: Clinical management guidelines for obstetrician-gynecologists, 142*, 372-379.

Aizpuru, K. M. (2015). Gardasil, gendered discourse, and public health. *The Georgetown Journal of Gender and the Law, 16*, 347-378. Retrieved from https://articleworks.cadmus.com/geolaw/zsw00215.html

Alfirevic, Z., Owen, J., Carreras Moratonas, E., Sharp, A. N., Szychowski, J. M., & Goya, M. (2013). Vaginal progesterone, cerclage or cervical pessary for preventing preterm birth in asymptomatic singleton pregnant women with a history of preterm birth and a sonographic short cervix. *Ultrasound in Obstetrics & Gynecology, 41,* 146-151. doi:10.1002/uog.12300

Althuisius, S. M., Dekker, G. A., Hummel, P., Bekedam, D. J., & van Geijn, H. P. (2001). Final results of the cervical incompetence prevention randomized cerclage trial (CIPRACT): Therapeutic cerclage with bed rest versus bed rest alone. *American Journal of Obstetrics and Gynecology*, *185*, 1106-1112. doi:10.1067/mob.2001.118655

Althuisius, S. M., Dekker, G. A., Hummel, P., & van Geijn, H. P. (2003). Cervical incompetence prevention randomized cerclage trial: Emergency cerclage with bed rest versus bed rest alone. *American Journal of Obstetrics and Gynecology, 189,* 907-910. doi:10.1067/S0002-9378(03)00718-X

Ayers, J. W. T., Peterson, E. P., & Ansbacher, R. (1982). Early therapy for the incompetent cervix in patients with habitual abortion. *Fertility and Sterility, 38*, 177-181. doi:10.1016/S0015-0282(16)46455-1

Baden, W. F., & Baden, E. E. (1957). Cervical incompetence: Repair during pregnancy. *American Journal of Obstetrics and Gynecology*, *74*, 241-245. Retrieved from https://pmj.bmj.com/content/postgradmedj/43/506/763.full.pdf

Barter, R. H., Dusbabek, J. A., Riva, H. L., Colonel, M. C., & Parks, J. (1958). Surgical closure of the incompetent cervix during pregnancy. *American Journal of Obstetrics and Gynecology, 75*, 511-524. https//doi.org/10.1016/0002-9378(58)90608-2

Baxter, J. A. (2008). Feminist post-structuralist discourse analysis: A new theoretical and methodological approach? In K. Harrington, L. Litosseliti, H. Sauntson, & J. Sunderland (Eds.), *Gender and language and research methodologies* (pp. 243-255). London, England: Palgrave Macmillan.

Beads of Courage (2017). Retrieved from http://www.beadsofcourage.org/

Beit-Hallahmi, B. (1985). Dangers of the vagina. *British Journal of Medical Psychology, 58*, 351-356. doi:10.1111/j.2044-8341.1985.tb02652.x

Bell, S. E. (2009). *DES daughters, embodied knowledge, and the transformation of women's health politics in the late twentieth century*. Philadelphia, PA: Temple University Press.

Bell, S. E. (1995). Gendered medical science: Producing a drug for women. *Feminist Studies, 21*, 469-500. doi:10.2307/3178195

Bell, S. E. (1989). The meaning of risk, choice, and responsibility for a DES daughter. In K. Strother Ratcliff (Eds.), *Healing technology: Feminist perspectives* (245-261). Ann Arbor, MI: The University of Michigan Press.

Berghella, V., Kuhlman, K., Weiner, S., Texeira, L., & Wapner, R. J. (1997). Cervical funneling: Sonographic criteria predictive of preterm delivery. *Ultrasound in Obstetrics & Gynecology, 10*, 161-166. doi:10.1046/j.1469-0705.1997.10030161.x

Berghella, V., Odibo, A. O., To, M. S., Rust, O. A., & Althuisius, S. M. (2005). Cerclage for short cervix on ultrasonography: Meta-analysis of trails using individual patient-level data. *Obstetrics & Gynecology, 106*, 181-189. doi:10.1097/01.AOG.0000168435.17200.53

Blum, L. M., & Stracuzzi, N. F. (2004). Gender in the Prozac nation: Popular discourse and productive femininity. *Gender & Society, 18*, 269-289. doi:10.1177/0891243204263108

Bouvier, G., & Machin, D. (2018). Critical discourse analysis and the challenges and opportunities of social media. *Review of Communication, 18*(3), 178-192. doi:10.1080/15358593.2018.1479881

Brauer, S. (2016). Moral implications of obstetric technologies for pregnancy and motherhood. *Medicine, Health Care and Philosophy, 19*, 45-54. doi:10.1007/s110019-015-9635-8

Braun, V., & Kitzinger, C. (2001). Telling it straight? Dictionary definitions of women's genitals. *Journal of Sociolinguistics, 5*(2), 214-232. doi:10.1111/1467-9481.00148

Brickman, B. J. (2004). 'Delicate' cutters: Gendered self-mutilation and attractive flesh in medical discourse. *Body & Society, 10*(4), 87-111. doi:10.1177/1357034X04047857

Brooks, R. (2015). International students with dependent children: The reproduction of gender norms. *British Journal of Sociology of Education, 36*(2), 195-214. Retrieved from https://doi.org/10.1080/01425692.2013.820128

Brubaker, S. J. (2007). Denied, embracing, and resisting medicalization: African American teen mothers' perceptions of formal pregnancy and childbirth care. *Gender and Society, 21*, 528-552. doi:10.1177/0891243207304972

Buzzanell, P. M. (2017). Voice/multivocality. In J. Matthews, C. S. Davis, & R. F. Potter (Eds.), *The international encyclopedia of communication research methods* (pp. 1-2). Hoboken, NJ: Wiley & Sons.

Buzzanell, P. M., Meisenbach, R., Remke, R., Liu, M., Bowers, V., & Conn, C. (2005). The good *working* mother: Managerial women's sensemaking and feelings about work-family issues. *Communication Studies, 56*(3), 261-285. doi:10.1080/10510970500181389

Causes of preterm labor: Treatment for incompetent cervix (2012). Retrieved from https://www.healthline.com/health/pregnancy/preterm-delivery-incompetent-cervix#7

Carter, J. F., Soper, D. E., Goetzl, L. M., & Van Dorsten, P. (2009). Abdominal cerclage for the treatment of recurrent cervical insufficiency: Laparoscopy or laparotomy? *American Journal of Obstetrics and Gynecology, 201*, 111.e1-111.e4. doi:10.1016/j.ajog.2009.05.033

Cervical insufficiency and short cervix (2015). March of Dimes. Retrieved from https://www.marchofdimes.org/complications/cervical-insufficiency-and-short-cervix.aspx

Cervical insufficiency (cervical incompetence) (n.d.). Retrieved from https://www.babycenter.com/0_cervical-insufficiency-incompetent-cervix_1425796.bc

Chandiramani, M., & Shennan, A. H. (2008). Cervical insufficiency: Prediction, diagnosis and prevention. *The Obstetrician & Gynaecologist, 10*, 99-106. doi:10.1576/toag.10.2.099.27398

Cody, L. F. (2010). Engendering science. *Journal of Women's History, 22*, 214-223. doi:10.1353/jowh.2010.0590

Couvrette, A., Brochu, S., & Plourde, C. The "deviant good mother": Motherhood experiences of substance-using and lawbreaking women. *Journal of Drug Issues, 46*(4), 292-307. doi:10.1177/0022042616649003

Daskalakis, G., Papantoniou, N., Mesogitis, S., & Antsaklis, A. (2006). Management of cervical insufficiency and bulging fetal membranes. *Obstetrics & Gynecology, 107*, 221-226. doi:10.1097/01.AOG.0000187896.04535.e6

Davidson, T. (2015). Incompetent cervix. In *The Gale encyclopedia of medicine*. Retrieved from http://link.galegroup.com/apps/doc/YLYWZI429163418/GPS?u=char69915&sid=GPS&xid=8f92cc21

Davis, C. S. (2017). *Focus groups: Applying communication theory through design, facilitation, and analysis*. New York, NY: Routledge.

Deshpande, S. (2016). Incompetent cervix: Everything you need to know. Retrieved from https://www.babygaga.com/incompetent-cervix-everything-you-need-to-know/

Dubriwny, T. N. (2010). The television news coverage of postpartum disorders and the politics of medicalization. *Feminist Media Studies, 10*, 285-303. doi:10.1080/14680777.2010.493647

Duerden Comeau, T. (2004). *The gendered sub-text of medical discourse of cancer in the nineteenth century* (Doctoral dissertation). Retrieved from ProQuest Digital Dissertations. (AAT NR00327)

Dunn, L. J., Courtland Robinson, J., & Steer, C. M. (1959). Maternal death following suture of an incompetent cervix during pregnancy. *American Journal of Obstetrics and Gynecology, 78*, 335-339. https://doi.org/10.1016/0002-9378(59)90184-X

Dusenbery, M. (2018). *Doing harm: The truth about how bad medicine and lazy science leave women dismissed, misdiagnosed, and sick*. Ashland, OR: Blackstone Publishing.

Dutta, M. (2008). *Communication health: A culture-centered approach.* London, UK: Polity Press.

Ellis, C. (1991). Sociological introspection and emotional experience. *Symbolic Interaction, 14*(1), 23-50. Retrieved from https://www.jstor.org/stable/10.1525/si.1991.14.1.23

Ehrenreich, B., & English, D. (2005). The sexual politics of sickness. In *For her own good: Two centuries of experts' advice to women* (pp. 111-154). New York, NY: Anchor Books.

Estes, D. K. (2018). Managing the student-parent dilemma: Mothers and fathers in higher education. *Symbolic Interaction, 34*(2), 198-219. Retrieved from: http://www.jstor.org/stable/10.1525/si.2011.34.2.198

Fairclough, N. (2003). *Analyzing discourse: Textual analysis for social research*. London, England: Routledge.

Fairclough, N. (1995). *Critical discourse analysis: The critical study of language*. London, UK: Longman Publishing Group.

Fairlough, N. (1992). Discourse and text: Linguistic and intertextual analysis within discourse analysis. *Discourse & Society*, *3*(2), 193-217. doi:10.1177/095792659003002004

Fairclough, N., & Wodak, R. (1997). Critical discourse analysis. In T. van Dijk (Ed.), *Discourse studies: A multidisciplinary introduction* (Vol. 2, pp. 258-284). London, UK: Sage.

Farinelli, C. K., Wing, D. A., Szychowski, J. M., Owen, J., Hankins, G., Iams, J. D.,…Guzman, R. (2012). Association between body mass index and pregnancy outcome in a randomized trial of cerclage for short cervix. *Ultrasound in Obstetrics & Gynecology, 40*, 669-773. doi:10.1002/uog.11170

Fox, H. A. (1983). The incompetent cervix: Words that can hurt. *American Journal of Obstetrics and Gynecology, 147*, 462-463. doi:10.1016/S002-9378(16)32247-5

Frank, R., & Rubovits, F. E. (1959). Repair of incompetent cervix in a case of twin pregnancy. *American Journal of Obstetrics and Gynecology, 78*, 333-334. https://doi.org/10.1016/0002-9378(59)90183-8

Funai, E. F., Paidas, M. J., Rebarber, A., O'Neill, L., Rosen, T., & Young, B. K. (1999). Change in cervical length after prophylactic cerclage. *Obstetrics & Gynecology, 94*, 117-119. doi:10.1016/S0029-7844(98)00568-7

Gartrell, N., & Mosbacher, D. (1984). Sex differences in the naming of children's genitalia. *Sex Roles, 10*, 869-976. Retrieved from https://link.springer.com/article/10.1007%2FBF00288510

Germon, J. (2014). Researching masculinities, narrating sexual difference. *Qualitative Research Journal, 14*, 50-63. doi:10.1108/QRJ-03-2014-0004

Godderis, R. (2010). Precarious beginnings: Gendered risk discourses in psychiatric research literature about postpartum depression. *Health, 14*, 451-466. doi:10.1177/1363459309358595

Guzman, E. R., Houlihan, C., Vintzileos, A., Ivan, J., Benito, C., & Kappy, K. (1996). The significance of transvaginal ultrasonographic evaluation of the cervix in women treated with emergency cerclage. *American Journal of Obstetrics and Gynecology, 175*, 471-476. doi:10.1016/S0002-9378(96)70164-3

Guzman, E. R., Pisatowski, D. M., Vintzileos, A. M., Benito, C. W., Hanley, M. L, & Ananth, C. V. (1997). A comparison of ultrasonographically detected cervical changes in response to transfundal pressure, coughing, and standing in predicting cervical incompetence. *American Journal of Obstetrics & Gynecology, 177*, 660-665. doi:10.1016/S0002-9378(97)70161-3

Haines, R. J., Bottorff, J. L., Barclay McKeown, S., Ptolemy, E., Carey, J., & Sullivan, K. (2010). Breast cancer messaging for younger women: Gender, femininity, and risk. *Qualitative Health Research, 20*, 731-742. doi:11.1177/1049732310367502

Hanson, B. (2001). Social constructions of femaleness in writing about cancer. *Qualitative Health Research, 11*, 464-476. doi: http:10.1177/104973201129119253

Harger, J. H. (2002). Cerclage and cervical insufficiency: An evidence-based analysis. *Obstetrics & Gynecology, 100*, 1313-1327. doi:10.1016/S0029-7844(02)02365-7

Heart attack and stroke: Men vs. women (2014). *Harvard Heart Letter, 5*, 1-7. Retrieved from https://www.health.harvard.edu/heart-health/heart-attack-and-stroke-men-vs-women

Hedegaard, J., Ahl, H., Rovio-Johansson, A, & Siouta, E. (2014). Gendered communicative construction of patients in consultation settings. *Women & Health, 54*, 513-529. doi:10.1080/03630242.2014.903551

Hertzum, M. (2018). Commentary: Usability – a sensitizing concept. *Human-Computer Interaction, 33*(2), 178-181. doi:10.1080/07370024.2017.1302800

Hoffman, D. E., & Tarzian, A. J. (2001). The girl who cried pain: A bias against women in the treatment of pain. *Journal of Law, Medicine, & Ethics, 29*(4), 13-27. doi:10.1111/j.1748-720X.2001.tb00037.x

Hujanen, J. (2018). Rengotiating the journalism profession in the era of social media: Journalism students from the global north and south. *Journalism & Mass Communication Educator, 73*, 282-292. doi:10.1177/1077695817719353

ICD-10-CM code N88.3 (2019). Retrieved from https://icd.codes/icd10cm/N883

Incompetent cervix (2011). Retrieved from http://www.obgyn.net/fetal-monitoring/incompetent-cervix

Incompetent cervix (2018). Retrieved from https://www.mayoclinic.org/diseases-conditions/incompetent-cervix/symptoms-causes/syc-20373836

Incompetency ICD-10-CM alphabetical index. (2019). Retrieved from https://icd.codes/icd10cm/alphabetical-index/incompetency

Incompetent cervix: Weakened cervix. (2015). Retrieved from http://americanpregnancy.org/pregnancy-complications/incompetent-cervix/

Janks, H. (2005). Language and the design of texts. *English Teaching: Practice and Critique, 4*(3), 97-110. http://education.waikato.ac.nz/research/files/etpc/2005v4n3art6.pdf

Jiang, Y., Chen, C., & Li, L. (2017). Comparison of cold-knife conization versus loop electrosurgical excision for cervical adenocarcinoma in situ (ACIS): A systematic review and meta-analysis. *PLoS ONE, 12*(1), e0170587. doi:10.1371/journal.pone.0170587

Johnson, B., & Quinlan, M. M. (2016). For her own good: The expert-woman dynamic and the body politics of REI treatment. *Women and Language, 39*, 127-131.

Johnson, B., & Quinlan, M. M. (2015). Technical vs. public spheres of knowledge: A feminist analysis of women's rhetoric in the Twilight Sleep debates of 1914-1916. *Health Communication, 30*, 1076-1088. doi:10.1080/10410236.2014.921269

Johnson, B., Quinlan, M. M., & Marsh, J. S. (2018). Telenursing and nurse-patient communication within fertility, Inc. *Journal of Holistic Nursing, 1*, 38-53. doi:10.1177/0898010116685468

Johnson, B., Quinlan, M. M., & Myers, J. (2018). Commerce, industry, and security: Biomedicalization theory and the use of metaphor to describe practitioner-patient communication within fertility, Inc. *Women's Reproductive Health, 4*(2), 89-105. doi:10.1080/23293691.2017.1326250

Jones, C., Clark, T., & Bewley, S. (1998). The weak cervix: failing to keep the baby in or infection out?. *An International Journal of Obstetrics and Gynaecology, 105*, 1214-1215. doi:10.1111/j.1471-0528.1998.tb09979.x

Kaspar, P., & Stenfert Kroese, B. (2017). What makes a good mother? An interpretive phenomenological analysis of the views of women with learning disabilities. *Women's Studies International Forum, 62*, 107-115. doi:10.1016/j.wsif.2017.04.005

Kelly, S., Pollock, M., Maas, B., LeFebvre, C., Manley, J., & Sciscione, A. (2001). Early transvaginal ultrasonography versus early cerclage in women with an unclear history of incompetent cervix. *American Journal of Obstetrics & Gynecology, 184*, 1097-1099. doi:10.1067/mob.2001.114916

Kirby, E. L., Riforgiate, S. E., Anderson, I. K., Lahman, M. P., Lietzenmayer, A. M. (2016). Good working mothers as jugglers: A critical look at two work-family balance films. *Journal of Family Communication, 16*, 76-93. doi:10.1080/15267431.2015.1111216

Kolp, R. (n.d.) Incompetent cervix. Retrieved from https://www.thebump.com/a/incompetent-cervix

Langellier, K. M. & Sullivan, C. F. (1998). Breast talk in breast cancer narratives. *Qualitative Health Research, 8*, 76-94. doi:10.1177/104973239800800106

Lawson, C. (2018). Innocent victims, creepy boys: Discursive framings of sexuality in online news coverage of the celebrity nude photo. *Feminist Media Studies, 18,* 285-841. doi:10.1080/14680777.2017.1350197

Long, D. E. (1997). Hidden persuaders: Medical indexing and the gendered professionalism of American medicine. *Women, Gender, and Science, 12*, 100-120. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/11619776

MacDonald, R., Smith, P., & Vyas, S. (2001). Cervical incompetence: The use of transvaginal sonography to provide an objective diagnosis. *Ultrasound in Obstetrics & Gynecology, 18,* 211-216. doi:10.1046/j.1469-0705.2001.00459.x

Malkowski, J. (2014). Confessions of a pharmaceutical company: Voice, narrative, and gendered dialectics in the case of Gardasil. *Health Communication, 29*, 81-92. doi:10.1080/10410236.2012.719178

Marshall, B. L. (2002). 'Hard science': Gendered constructions of sexual dysfunction in the 'Viagra Age'. *Sexualities, 5*(2), 131-158. doi:10.1177/1363460702002001

Marshall, J. L., Godfrey, M., & Renfrew, M. J. (2007). Being a 'good mother': Managing breastfeeding and merging identities. *Social Science & Medicine, 65*(10), 2147-2159. doi:10.1016/j.socscimed.2007.06.015

Martin, E. (1991). The egg and the sperm: How science has constructed a romance based on stereotypical male-female roles. *Signs, 16*(3), 485-501. Retrieved from https://www.jstor.org/stable/3174586

Mason, V. C. & de Chabert, R. A. (1963). Incompetent cervix. *Journal of the National Medical Association, 55,* 542-561. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2642414/

Maymon, R., Shulman, A., Ariely, S., Halperin, R., Caspi, E., & Weinraub, Z. (1996). Sonographic assessment of cervical changes during pregnancy and delivery: Current concepts. *European Journal of Obstetrics & Gynecology and Reproductive Biology, 67,* 149-155. doi:10.1016/0301-2115(96)02458-X

McIntyre, M., Francis, K., & Chapman, Y. (2012). Critical discourse analysis: Understanding change in maternity services. *International Journal of Nursing Practice, 18*(1), 36-43. doi:10.1111/j.1440-172X.2011.01991.x

Miller, K. (2005). *Communication theories: Perspectives, processes, and contexts* (2nd ed.). Boston, MA: McGraw-Hill.

Motschenbacher, H. (2009). Speaking the gendered body: The performative construction of commercial femininities and masculinities via body-part vocabulary. *Language in Society, 38,* 1-22. doi:10.1017/S0047404508090015

Narciso, I., Relvas, A. P., Ferreira, L. C., Vieira-Santos, S., Fernandes, M., de Santa-Barbara, S., & Machado, I. (2018). Mapping the "good mother" – Meanings and experiences in economically and socially disadvantaged contexts. *Children and Youth Services, 93,* 418-427. Retrieved from: https://doi.org/10.1016/j.childyouth.2018.08.029

Neveu, M., Fernandez, H., Deffieux, X., Senat, M., Houllier, M., & Capmas, P. (2017). Fertility and pregnancy outcomes after transvaginal cervico-isthmic cerclage. *European Journal of Obstetrics & Gynecology and Reproductive Biology, 218,* 21-26. doi:10.1016/j.ejogrb.2017.09.0070301-2115/

Oliver, E. (1990). *A rhetorical analysis of selected misogynous discourses and their gender reverse*. Retrieved from ProQuest Digital Dissertations. (AAT 1342345)

Owen, J. (2012). Cervical insufficiency protocol. *Contemporary OB/GYN, 57*(7), 47-48. doi:10.1002/9781119001256.ch35

Pizzini, F. (1991). Communication hierarchies in humour: Gender differences in the obstetrical/gynaecological setting. *Discourse & Society, 2,* 477-488. doi:10.1177/0957926591002004008

Quigley, G. J. (1964). The incompetent cervix. *Canadian Journal of Surgery, 7,* 161-167. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/14142586

Ritter, H. A. (1978). Surgical closure of the incompetent cervix: 15 years' experience. *Department of Obstetrics and Gynecology, 16,* 194-196. Retrieved from https://www.ncbi.nlm.nih.gov/m/pubmed/33078/

Robby, S. J. (1983). *An atlas of findings in the human female after intrauterine exposure to diethylstilbestrol*. Bethseda, MD: U.S. Dept. of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute.

Roderick, I. (2018). Multimodal critical discourse analysis as ethical praxis. *Critical Discourse Studies, 15*(2), 154-168. doi:10.1080/17405904.2017.1418401

Romero, R., Yeo, L., Chaemsaithong, P., Chaiworapongsa, T., & Hassan, S. S. (2014). Progesterone to prevent spontaneous preterm birth. *Seminars in Fetal & Neonatal Medicine, 19*(1), 15-26. doi:10.1016/j.siny.2013.10.004

Rozenberg, P., Gillet, A., & Ville, Y. (2002). Transvaginal sonographic examination of the cervix in asymptomatic pregnant women: Review of the literature. *Ultrasound in Obstetrics & Gynecology, 19*, 302-311. doi:10.1046/j.1469-0705.2002.00645.x

Shabot, S. C. (2016). Making loud bodies "feminine": A feminist-phenomenological analysis of obstetric violence. *Human Studies, 39*, 231-247. Retrieved from https://philpapers.org/rec/SHAMLB

Silverton, L. (2017). Mind your language. *British Journal of Midwifery*, *25*(10), 618. doi:10.12968/bjom.2017.25.10.618

Szychowski, J. M., Owen, J., Hankins, G., Iams, J. Sheffield, J., Perez-Delboy, A.,…Guzman, R. (2009). Timing of mid-trimester cervical length shortening in high-risk women. *Ultrasound in Obstetrics & Gynecology*, *33*, 70-75. doi:10.1002/uog.6283

Thomas, L. J. (2017). Contrapuntal analysis. In J. Matthews, C. S. Davis, & R. F. Potter (Eds.), *The international encyclopedia of communication research methods* (pp. 1-3). Hoboken, NJ: Wiley & Sons.

Thompson, M. (2010). Who's guarding what?: A poststructural feminist analysis of Gardasil discourses. *Health Communication, 25*, 119-130. doi:10.1080/10410230903544910

Tiefer, L. (2003). Female sexual dysfunction (FSD): Witnessing social construction in action. *Sexualities, Evolution & Gender, 5*(1), 33-36. doi:10.1080/14616660310001594962

Usher, J. M. (2013). Diagnosing difficult women and pathologizing femininity: Gender bias in psychiatric nosology. *Feminism & Psychology, 23*(1), 63-69. doi:10.1177/0959353512467968

van Dijk, T. A. (1993). Principles of critical discourse analysis. *Discourse & Society, 4*, 249-283. doi:10.1177/0957926593004002006

van Leeuwen, T. (2018). Moral evaluation in critical discourse analysis. *Critical Discourse Studies*, 15(2), 140-153. doi:10.1080/17405904.2018.1427120

Vissandjee, B., Mourid, A., Greenaway, C. A., Short, W. E., & Proctor, J. A. (2016). Searching for sex- and gender-sensitive tuberculosis research in public health: Finding a needle in a haystack. *International Journal of Women's Health, 8*, 731-742. doi:10.2147/IJWH.S119757

Vyas, N. A., Vink, J. S., Ghidini, A., Pezzullo, J. C., Korker, V., Landy, H. J., & Poggi, S. H. (2006). Risk factors for cervical insufficiency after term delivery. *American Journal of Obstetrics and Gynecology, 195*, 787-791. doi:10.1016/j.ajog.2006.06.069

Warren, J. E., Silver, R. M., Dalton, J., Nelson, L. T., Ware Branch, D., & Flint Porter, T. (2007). Collagen 1A1 and transforming growth factor-β polymorphisms in women with cervical insufficiency. *Obstetrics & Gynecology, 110*, 619-624. http://dx.doi.org/10/1097/01.AOG.0000277261.92756.1a

Weedon, C. (1996). *Feminist practice and poststructuralist theory*. Malden, MA: Blackwell Publishing.

Weiss, G., & Wodak, R. (2003). *Critical discourse analysis: Theory and interdisciplinarity*. New York, NY: Palgrave Macmillan.

Weiss, R. E. (2017). The incompetent cervix: Cerclage, bedrest, and other treatments. Retrieved from https://www.verywellfamily.com/the-incompetent-cervix-2752927

Williams, W. H. (1978). Cervical incompetence. *American Journal of Obstetrics and Gynecology, 131*(6), 703. doi:10.1016/0002-9378(78)90840-2

Wodak, R., & Meyer, M. (Eds.). (2001). *Methods of critical discourse analysis*. London, England: Sage Publications Ltd.

Wright, C. H. (1965). The economic factor in incompetent cervix. *Journal of the National Medical Association, 57*(4), 309-310. Retrieved from https://www-ncbi-nlm-nih-gov.pmc/journals/655/

Yacoumis, P. (2018). Making progress? Reproducing hegemony through discourses of "sustainable development" in the Australian news media. *Environmental Communication, 6*, 840-853. doi:10.1080/17524032.2017.1308405

Yieke, F. (2001). Gender as a sociocultural construct: A sociocultural construct: A sociolinguistic perspective. *Journal of Cultural Studies, 3*, 333-347. Retrieved from https://www.ajol.info/index.php/jcs/article/view/6196

APPENDIX A: CODE BOOKS

A.1 Level 1: The Discourse Practice Level

Code	**Definition**	**Examples**	**Notes**
Women as problematic	Discourse the suggests women are a problem to be solved; takes the power out of the women's hands -- the physician (presumably male) will fix you	"...the cerclage procedures resulted in significant improvement in the state of the cervix" "Cervical cerclage restored the cervix" "After treatment, cervical length increased significantly"	Can be framed as solving the problem or positioning women as the problem The IC is in flux; it can be controlled, manipulated; subject yourself to our treatment, and we will make you *temporarily* competent; cerclage is tool
Women as passive	Discourse that frames women as passive	"Three of the first 12 patients studied showed dilation of the internal os after placement of the cerclage and all were delivered prematurely"	Sounds like the author is talking about the baby, not the woman; the woman did the delivering!
Women as failures	Discourse that positions women as a failure	"She had two previous abortions"	Abortion here meaning loss of fetus (miscarriage)

Disbelieving women	Discourse that suggests that the experiences or words of women cannot always be trusted	"The need to rely on past history to determine whether patients are at risk places the primigravid patient with congenital incompetency in a more vulnerable position"	
Women as incompetent	Discourse that polarizes women as either competent or incompetent	"Group 4 consisted of patients who were judged to be competent by ultrasound criteria…"	
Silencing women	Women's voices are missing; sampled articles do not include personal narratives from the women discussed	N/A	
Lack of research on women's health issues		"The role of cerclage in the treatment of patients with cervical insufficiency after fetal viability has not been adequately assessed"	
Women as suspicious/untrustworthy	Discourse that suggests women are suspect; not to be trusted	"...cerclage in patients with a suspicious clinical history"	

A.2 Level 2: The Sociocultural Practice Level

Code	**Definition**	**Examples**	**Notes**
Failure of woman	Discourse that frames women as failures; implies failure of woman	"...it might be possible to show benefit in a larger proportion of women because of a failing cervix"	Implies failure of woman

		"Cervical failure"	
Managing women	Language that frames women as something to be managed or controlled	"Management of these women usually involves the placement of a cervical suture to support the cervix, which is considered insufficient."	Controlling; Fixing
Women as problematic	IC discussed as an ongoing problem that has perplexed medical professionals for years; difficult to diagnose and treat	"Women who have cerclages for suspected incompetent cervices continue to pose a challenge to obstetricians."	Woman as problematic
Ambiguous nature	Discourse that categorizes certain women as high-risk for either preterm delivery or for having an IC	"...which while somewhat arbitrary, has been utilized by many other investigators to define a very high-risk population"	Women are categorized as "high-risk" based on ambiguous lines
Body parts	Women not discussed as whole individual but described by body part	"A pillow was placed under the pelvis for ease of movement"	The cervix is examined, not the woman The body part, not the woman
Exclusion of woman's voice	Sampled articles did not include personal narratives from patients or mention how the woman described her experience	N/A	
Solving preterm birth	Language that justifies treating IC to lower preterm birth rates rather than treating IC for the sake of the woman	"Preterm birth continues to be a common problem in the United States...Women with prior spontaneous preterm birth(s) have one of the strongest risk factors for subsequent preterm birth.	

Racial essentializing	Article discussing how different races are impacted by IC	"Furthermore, high-risk African-American women experience cervical length shortening at twice the rate of women of other race/ethnicity, consistent with their recognized disproportionally higher preterm birth rates"	Not mentioned frequently, but appears in some present-day literature
Speaking on behalf of women	Language that makes assumptions about patient experience without directly consulting patient	"Transvaginal sonography of the cervix provides an object and non-invasive method for evaluating cervical status."	
Women as Passive	Language that positions the woman as passive	"These 25 women previously experienced 33 preterm deliveries"	The women *delivered*

A.3 Level 3: Textual Analysis (Adapted from Janks (2005) Linguistic Analysis Rubric)

Linguistic feature	**Explanation**	**Data**	**Example/Explanation**
Voice	Active and passive voice construct participants as doers or as done-to's. Passive voice allows for the deletion of the agent.	Passive voice	Language that frames author (medical professional) as active and patient as passive
Nominalization	A process is turned into a thing or an event without participants or tense or modality. Central mechanism for reification.	"Greenhill's valuable bit of information influenced us to do something constructive toward obtaining living babies for these women"	Process of giving birth is removed; babies are "obtained" for women rather than birthed by the women

Quoted Speech Direct Speech (DS) Indirect Speech (IS) Free Indirect Speech (FIS). This is a mixture of direct and indirect speech features. Scare quotes or "so-called"	Who is quoted in DS/IS/FIS? Who is quoted first/last/most? Who is not quoted? Has someone been misquoted or quoted out of context? What reporting verb was chose? What is the effect of scare quotes?	Women are only directly quoted in one website. Women are never quoted in the sampled articles. Medical providers spoke on behalf of their patients, describing the patients' experiences in their own terms.	Lack of patient voice or discussion of the woman as a whole
Turn-Taking	Who gets the floor? How many turns do different participants get? Who is silent/silenced? Who interrupts? Who gets heard? Whose points are followed through? Who controls the topic?	In journal articles, the healthcare provider gets the floor. Patients are silenced in all data except for the one website that quotes patients directly. Medical providers control the topic.	Healthcare providers control the conversation; it is one-sided
Mood	Is the clause a statement, question, offer or command?	Distrust; disbelief	Discourse used by author (medical professional) that creates sense of distrust of the patient

Modality Degrees of Uncertainty	Logical possibility/probability Social Authority Modality created by modals (may, might, could, will) adverbs (possibly, certainly, hopefully) intonation, tag questions	Medical professionals positioned over patients	Discourse that positioned author (medical professional) as having control over patient
Pronouns	Inclusive we/exclusive we/you Us and them: Othering pronouns Sexist/Non sexist pronouns The choice of first/second/third person	Third-person; articles consistently refer to women in third-person Websites: used second-person	"This woman previously experienced one preterm delivery…" "Before pregnancy, your cervix -- the lower part of the uterus…"

APPENDIX B: WEBSITES

Websites offering information on the "Incompetent Cervix" diagnosis were used as data; these websites are geared toward patients and are popular health and/or pregnancy sites supported by medical experts. Websites that were excluded included personal blogs, discussion boards, and websites originating outside the U.S. The following U.S. websites were analyzed:

1. https://www.mayoclinic.org/diseases-conditions/incompetent-cervix/symptoms-causes/syc-20373836
2. http://americanpregnancy.org/pregnancy-complications/incompetent-cervix/
3. https://www.thebump.com/a/incompetent-cervix
4. https://www.marchofdimes.org/complications/cervical-insufficiency-and-short-cervix.aspx
5. https://www.babycenter.com/0_cervical-insufficiency-incompetent-cervix_1425796.bc
6. https://www.verywellfamily.com/the-incompetent-cervix-2752927
7. https://www.babygaga.com/incompetent-cervix-everything-you-need-to-know/
8. https://www.healthline.com/health/pregnancy/preterm-delivery-incompetent-cervix#7
9. http://www.obgyn.net/fetal-monitoring/incompetent-cervix
10. https://www.whattoexpect.com/pregnancy/ask-heidi/incompetent-cervix.aspx