HEALTHCARE AT THE INTERSECTIONS OF RACE AND GENDER: CRITIQUING EUGENICS IN ROSARIO CASTELLANOS'S *CIUDAD REAL* AND RENEE TAJIMA-PEÑA'S *NO MÁS BEBÉS/NO MORE BABIES*

by

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ABSTRACT

PERLA CECILIA PINALES FRUTOS. Healthcare at the Intersections of Race and Gender: Critiquing Eugenics in Rosario Castellanos's *Ciudad Real* and Renee Tajima-Peña's *No Más Bebés/No More Babies*.
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The purpose of this thesis is to discuss the use of medicine as a technology of power used to uplift white hegemonic actors: whites in the United States and mixed-race Ladinos in Mexico. Through this lens I discuss and analyze two mid-twentieth century cultural productions: Rosario Castellanos's literary works, "La rueda del hambriento" and "El don Rechazado," and Renee Tajima-Peña's documentary film, *No más bebés*. Before analyzing the two cultural productions, this thesis provides historical contexts of race construction, gender as a construct, and eugenic practices in both the United States and Mexico. Analyzing cultural productions from both the United States and Mexico allows for a comparison of that highlights the role of medicine in racial formation. While the United States and Mexico are two very different countries, the analysis of both cultural productions stresses the fact that racialized women and their place in societal hierarchies ultimately impacts their access to medical care, as well as the quality of care.

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Introduction

In both the United States and Mexico, access to healthcare is a powerfully political issue. The healthcare systems in both countries are very different from one another, but healthcare workers in both contexts face certain similar challenges: language barriers, questions about how to fund people's access to care, racial and ethnic inequities, and so forth. The first decade of the twenty-first century was an important time period in the history of healthcare in both countries, as they underwent significant policy changes to ensure greater access to healthcare. Following his election in 2008, Barack Obama and his allies in the House and Senate proposed and signed into law the Affordable Care Act with the hope that it would extend health coverage to all Americans. During these same years, the United Nations certified Mexico as having achieved universal health coverage for all of its citizens (Feldscher). Despite these successes, both countries face significant challenges in their respective national healthcare industries, with significant racial disparities emerging in both contexts. One prominent example took place in Mexico in 2013 when an Indigenous woman gave birth outside of a hospital after the hospital workers refused to admit her (Dalton, *Mestizo Modernity* 180). Cases such as this demonstrate the continued existence of healthcare disparities in the present day. In this thesis, I look at mid-twentieth-century literary and cultural productions that engage questions of the racialized and gendered nature of healthcare in both Mexico and the United States. My analysis casts access to medical care as a privilege that aims primarily to uplift hegemonic actors: whites in the U.S. context; mixed-race Ladinos in the work of Castellanos. The works that I discuss decry the racialized and gendered nature of health practices in both countries, asserting that poor access to care results directly from the eugenicist ideals that remained in force in both countries through the mid-twentieth century. This thesis argues that, through an analysis of Castellanos's literature

and Tajima-Peña's film, hegemonic actors use as a technology of power over racialized women to ensure a continued dominance over racialized bodies.

Furthermore, to provide some clarity in theories that are used throughout this thesis, I will briefly introduce Michel Foucault's theory technology of power, and Kimberlé Williams Crenshaw's theory of intersectionality. To discuss medicine and medical care as a privilege controlled by hegemonic actors, this thesis incorporates Michel Foucault's theory of technologies of power. Foucault argues that technologies of power "determine the conduct of individuals and submit them to certain ends or domination, an objectivizing of the subject" (Foucault 18). In both of the literary and cultural productions that discussed in later chapters, medicine serves as the technology of power that is used to objectivize and control racialized communities. Foucault emphasizes that his theory of technology of power is one of domination that leads to governmentality, the "contact between the technologies of domination of others and those of the self" (19). Moving forward, Kimberlé Williams Crenshaw's theory of intersectionality also requires a brief introduction. In analyzing the use of medicine as a technology of power, one reoccurring component has been the intersectionality of race and gender. First introduced in 1989, Crenshaw built on the work of Anna Carastathis to define intersectionality as "the manifold manifestations of oppression, discrimination, and violence that structure the conditions in which women of color live in the United States, Britain and other white settler imperial states" (Carastathis 16). Essentially, Crenshaw's theory of intersectionality acknowledges how race and gender intertwine to construct a person’s subjectivity; in many cases, the combination creates conditions and subjectivities that go beyond race or gender alone. What is more, as my thesis shows, the lens of intersectionality can also apply to cases like Mexico that are less explicitly settler-colonist nations because racialized women still experience the world through their unique

combination of race and gender. Crenshaw thus creates a space for a discussion and analysis that stresses the oppression of racialized women, as it provides the analytical tools necessary to gauge how these intersections create conditions that would not exist based on race and gender alone.

Aside from incorporating Foucault's and Crenshaw's theories, this thesis also utilizes a comparative approach discussing works from Mexico and the United States. The decision to apply a comparative approach to this thesis began as the analysis of Rosario Castellanos's and Renee Tajima-Peña's works demonstrated medicine as a technology of power as a common ground. However, in further analyzing their literary and cultural productions, the common themes of racial construction in the United States and discussion of ethnicity in Mexico, gender as a construct, and eugenicist movements in both countries highlighted the importance of a comparative approach. The flow and structure of this thesis is meant to assist the reader in highlighting said similarities and differences. This introduction begins with a discussion of racial construction in the United States and Mexico as both countries view race differently, in Mexico, there is a greater focus on ethnicity, rather than race which is not the case in the United States. Moving forward to gender as a construct, as the literary and cultural productions tell the stories of women and their experiences, it is important to understand the similarities that exist for women when seeking medical care. Lastly, this introduction discuses eugenicist movements in the United States and Mexico, more importantly, their differences. While both countries have a history of eugenicist movements their applications are significantly different given the countries racial constructions. A comparative approach allows for a in depth discussion of two literary and cultural productions that go on to critique a States use of medicine as a technology of power over racialized women’s bodies. Even more so, it leaves room for a discussion of each countries historical background that can help the reader understand the similarities and differences that

allow for States to have similar oppressive practices while operating through differing societal structures.

Racial Construction: the United States and Mexico

The understanding of race as a social construct leads us to understand that race itself has lingering implications on the societal structure both in Mexico and the United States. Michael Omi and Howard Winant define race as “a concept that signifies and symbolizes social conflicts and interests by referring to different types of human bodies” (110). Their definition explicitly notes the power dynamics in racial categorization by arguing further that: "Race is strategic; race does ideological and political work" (111). The key to their discussion is that race is a social construct, an ideology whose definition and societal implications can be manipulated and altered in different national contexts (137). While they focus primarily on the United States, Omi and Winant’s basic argument about the constructed nature of race holds true in the Mexican context as well. One especially crucial component of Omi and Winant’s discussion is that race as a unit of analysis was ultimately developed after the discovery of the Americas with the goal of assigning people their role in society based on phenotype. Vijay Prashad also discusses this point as he argues that prior to the Atlantic slave trade, the idea of race differed from the modern notion of race (6). While there was an acknowledgement of different skin pigmentations, they were not used as a divisive measure as "African and Asian peoples constituted notions of distinction based not on skin color but on cultural exchange” (Prashad 6). Similarly, Prashad highlights that in the 17th century, the Atlantic slave trade began enslaving peoples base on skin pigmentation (15). In the United States, this resulted in a white supremacist society where whites had access to land and capital. In the Chiapanecan case, this meant that Ladinos—a type of mestizo—or caxlanes—a type of criollo—had greater access to land and capital than those coded

as Indigenous.[1] An analysis of racial formation in the United States and Mexico facilitates my discussion of the intersectional subjectivity of racialized women, be they Latinas, Chicanas, and/or Indigenous. As I show throughout, women from these communities' face health disparities precisely due to the combination of their different race, ethnicity, and gender.

For Omi and Winant, "race is not something rooted in nature, something that reflects clear and discrete variations in human identity. But race is also not an illusion. While it may not be 'real' in a biological sense, race is indeed real as a social category with definite social consequences" (Omi and Winant 277). Viewed in this light, race must always be in formation, and this happens through a series of racial projects. Both of the chapters in this thesis theorize medicine as a technology that the state uses in its projects of race formation.[2] Medical workers naturalize the superiority of whites and/or Ladinos by consciously providing people from these groups with superior healthcare vis a vis their ethnically Othered counterparts. Viewed in this light, acts of medical violence—either through providing poor medical care or by mutilating the bodies of racial Others—play a key role in forcing marginalized actors to accept their role in society. The fact that medicine plays such a central role in racial formation in texts from such different countries and populations speaks to the value of this thesis. Clearly, one's access to medicine reflects myriad factors, but the intersections of race, ethnicity, and gender play a key role in their relative medical privilege. Both of my chapters explore the intersectionality between race, ethnicity, and gender as medical professionals' intentionally target racialized women. Both

[1] In his article, " Treating Indigeneity: Medicine and Racial Privilege in Rosario Castellanos's "La Rueda del hambriento" and "El don rechazado," David Dalton differentiates between the terms Ladino (mixed-race people from Chiapas) and mestizo (a more general type of mixed-race identity that, in the works of Castellanos, refers specifically to official mestizaje) (see 959-982).

[2] For studies that discuss the role of medicine and eugenics in racial formation in the United States see *Controlling Human Heredity* (43-49; 50-71). For a discussion of medicine and eugenics in racial formation in Latin America, see Nancy Leys Stepan (35-62; 63-101**)**. For a discussion of medicine and racial formation among Latinx populations in the United States see Benny Andrés (91-116). For a discussion of medicine and eugenics and healthcare within Mexico, see Dalton (1-31; 100-07).

works explicitly note the role that race, and ethnicity plays in the experience of these women as they receive inferior care when compared to women from more privileged races.

Many of the most significant obstacles faced by Indigenous women in Castellanos's works and by the Mexican and Chicana women interviewed in Tajima-Peña's documentary are linguistic in nature. Writing on the Latinx population in the United States, Christopher D. Mellinger notes that "approximately 25 million people (8.6. percent of the total population) speak English 'less than very well'" (120). Acknowledging linguistic differences, Title VI of the Civil Rights Act of 1964 decreed that medical facilities are legally obligated to provide language services to any non-English speaking patients (Mellinger 121). The title states: "no person in the United States shall, on the ground of race, color, or national origin, can be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving federal funding assistance (Civil Rights Act of 1964, Title VI). Similar to their Chicana and Latina counterparts in the United States, millions of Indigenous women in Mexico do not speak the principal language (Spanish in this case) of the country that they inhabit.[3] This fact has historically led to subpar healthcare being administered to these populations. Indigenous communities in Mexico ostensibly have access to clinics that provide services in the target language; nevertheless, logistical challenges often mean that these institutions go understaffed for long periods of time or that specific language specialists are not always present and may be unreachable during unexpected emergencies.

To understand racial hierarchies in Mexico—and especially in Chiapas, the site of my second chapter—we must first understand the colonial backdrop, which differs from that of the

[3] Similarly, millions of Indigenous women in Mexico speak Spanish less than very well. See The CIA World Factbook 2020 data on languages spoken in Mexico (https://www.cia.gov/the-world-factbook/countries/mexico/#people-and-society). Approximately seven million people in Mexico speak only indigenous languages.

United States in keyways. Aníbal Quijano's notion of coloniality of power provides a valuable framework. Similar to Omi and Winant, he asserts that the development of racial and social hierarchies resulted from the development of capitalist economies that assigned people their roles in the economy based on their phenotype (Quijano 216). It is through the development of said hierarchies and racial categorization that the elite could impose their power onto marginalized peoples for profit and generational wealth. A system had to be developed that would justify the dominance of the Spanish Crown and its European subjects who governed and enjoyed the greatest economic privilege. As a result, a racialized system of labor and accumulation was created. There was also a need to develop various identities "in order to better articulate each of these new identities to specific forms of control of work. Each of them was articulated with each 'race.' And so, the control of some specific work could be at the same time, the control of some specific, dominated people" (Quijano 219-220). As the dominance of European elites persisted, so too did the practice and use of racial hierarchies that permitted the development of feudal societies that ultimately became the blueprint for capitalism. That said, feudal economies remained in place well into the twentieth century in Chiapas; indeed, my discussion of Castellanos's literature engages with a Ladino order that does not wish to relinquish the feudalist distinctions between Indigenous and Ladino.

A key point in Quijano's work on coloniality is his understanding of the permanence of colonialism, a fact that becomes clear in my analysis of medicinal discrimination both in Mexico and in the United States. As he makes clear, "even when formal colonial status would end, coloniality would not. It continues in form of a sociocultural hierarchy of European and non-European" (Quijano and Wallerstein). Coloniality, then, is a mentality imposed on marginalized actors regardless of whether or not their country remains under colonial rule. In applying his

theory of coloniality to post-independence countries, Quijano opens a space to approach healthcare inequities both in Mexico and in the United States. Indeed, the chapters of my thesis build on the work of Quijano and Wallerstein by showing how different people's access (or not) to healthcare functions as a "control" of work and political status. In maintaining differing types of healthcare depending on race, ethnicity, and gender, the societies in question maintain their rigid racial hierarchies. As such, they further validate—and propagate—the coloniality of power within their national borders.

The existence of a coloniality of power does not mean that racial ideals and identity have remained static over multiple centuries. Rather, modern societies constantly reimagine race, a process that leads to new cases of racial formation. A type of coloniality of power remains in force, but it is articulated in a new sphere. We see this clearly in twentieth-century Mexico, when the postrevolutionary state attempted to modernize through a form of official mestizaje that would leave behind Indigenous identities and formulate a Hispanicized image of the ideal national identity. Some of those most impactful pieces of literature regarding national identity in Mexico come from the anthropologists Manuel Gamio (*Forjando patria*) and the philosopher José Vasconcelos (*La raza cósmica*). *La raza cósmica* was vital to Mexican identity during the postrevolutionary period. Following the Revolution, the country had to determine what, and perhaps even who, Mexico was. Vasconcelos saw the opportunity for Mexico to develop its own identity without the need to imitate the culture of its North Atlantic colonizers. He identified a possibility within his country to forge a new, autochthonous identity that could avoid the pitfalls of segregation and reservation systems in the United States (Vasconcelos 19). For Vasconcelos, the solution was obvious given the extent to which Latin America had already taken part in racial mixing. In pursuing a project of official mestizaje, Mexico would set itself up for long-term

success. In stark contrast to the United States, hybridity would allow Mexico to develop a superior, aesthetically beautiful race. Although not explicitly stated, one can infer that, for Vasconcelos, Indigenous peoples are a premodern people from which a modern, mestizo nation will evolve. As such, despite its lofty rhetoric, Vasconcelos's fetishized cosmic race would intentionally leave the Indigenous cultures (and even peoples) of Mexico behind (see Dalton, *Mestizo Modernity* 32). For twentieth century Mexico it is matter of ethnicity, different from the United States racial construction. As Vasconcelos's theory of *La raza cósmica* emphasizes the importance of racial mixing, it is not a matter of alienating Indigenous peoples in Mexico, rather, it is an emphasizes on further racial mixing.

In the Mexican context, European and mestizo elites' persistence in maintaining their societal power and dominance has proven crucial to the development of a racialized society that grants them greater privilege. This notion continues to hold relevance throughout postrevolutionary Mexico, as was discussed through Vasconcelos political agendas of modernity, through which, indigeneity would be left behind through proposed mestizaje:

> On the one hand, mestizaje represented elimination of ethnicity because it resulted from interracial fusion. On the other hand, it became a distinct racial identity that stood in opposition to the Indigenous. State officials believed that a prerequisite to modernization was the transformation of Amerindian individuals into mestizos, and they aimed to achieve this end through a process of race formation that used technology to modernize the Indigenous body and transform it into a mestizo entity. (Dalton, *Mestizo Modernity,* 2)

Dalton emphasizes the direct correlation between racial identity and modernity as "Mexican society associates a person's racial identity with his or her ties to modernity" (*Mestizo Modernity* 1). For postrevolutionary Mexico the focus shifts towards assimilation of Indigenous peoples as "they championed the 'brown' mestizo (rather than the *criollo*/white mestizo of the nineteenth century) as the principal protagonist of the postrevolutionary order" (Dalton, *Mestizo Modernity* 5, emphasis in original). Vasconcellos's *La raza cósmica* and Dalton's discussion of official mestizaje allow one to understand how racial formation in Mexico is significantly different than that in the United States. Mexico's official mestizaje, however, "also entailed projects of 'internal colonialism' that depended on a pro-mestizo eugenics that scientifically justified racialized distinctions between rich and poor" (Dalton, *Mestizo Modernity* 7). While postrevolutionary Mexico may not have followed a racial hierarchy such as the that of the United States, Indigenous identities, languages, and cultures were controlled and erased through assimilation to the federal to the federal state. To further discuss the correlation between the state-imposed agenda of modernity through mestizaje and technology, it is crucial to keep in mind who controls the access to the technology of medicine.

Viewed together, Omi and Winant, Quijano, and Vasconcelos show how the development of racial formation in both the United States and Mexico have contributed directly to the racial hierarchies and societal hierarchies that exist in each country into the present. The development of racial hierarchies serves as a means of domination by colonizers who enjoy ties to Europe (whites in the United States; Ladinos/mestizos in Chiapas). This study focuses specifically on the medical care that women coded as racially Other receive, and how this treatment further cements their relegation to the periphery. While the United States and Mexico may rhetorically renounce

racist agendas and platforms in government, both countries have failed to root out racialized systems of privilege. It is for this reason that Omi and Winant state:

> We conceive of racial formation processes as occurring through a linkage between structure and signification. *Racial projects* do both the ideological and the practical "work" of making these links and articulating the connection between them. *A racial project is simultaneously an interpretation, representation, or explanation of racial identities and meaning, and an effort to organize and distribute resources (economic, political, cultural) among particular racial lines.* Racial projects connect what race *means* in a particular discursive or ideological practice and the ways in which both social structures and everyday experiences are racially *organized*, based upon that meaning. (Omi and Winant 279- emphasis in original)

This thesis treats access to healthcare as a type of "racial project" that interfaces directly with racial formation in both the U.S. and Mexican contexts. In providing inferior—and even deliberately violent—healthcare to racially Othered women, racial elites in both cases cement their institutional authority. While Omi and Winant provide an in-depth analysis of the implications that race has on the societal development and distribution of power in the United States, they provide a framework for understanding the case of Castellanos's fictional Chiapas as well.

Moving forward, the question remains as to why analyzing literary and cultural representations of midcentury, healthcare in both Mexico and the United States, is worthwhile.

Ultimately, I argue that this comparison is valuable because it highlights the role of medicine in racial formation in two very different countries where race operates in completely different ways. While in both cultural productions medicine is utilized as a technology of power, the identity of these racialized women, as well as their place in societal hierarchies, further demonstrate the influence of racial formation in healthcare. The repetitiveness in the technology of power and the identity of the individual demonstrates a transnational oppression of marginalized people, in this case, women.

Gender as a Construct: the United States and Mexico

Analyzing both race and gender as social constructs is crucial to understanding the societal implications and barriers that are placed upon marginalized people in both the United States and Mexico. Given this thesis's focus on women's health and the substantial barriers that are present for racialized women, the intersections of race and gender, that is, identifying as an Indigenous woman or a Mexican/Chicana woman in the United States, must be analyzed further. The cultural productions that I discuss in this thesis analyze the intersectionality in identifying as a woman and being a racialized woman; the needs of women of color have been continuously left out of the larger discussions in feminist circles, a fact that I discuss in depth in Chapter 1.

A central tenet of gender theory is to differentiate sex from gender. The former is a biological condition that one has at birth, while the latter is a social construct imposed upon individuals based on their biological sex. As Judith Lorber argues, "individuals are born sexed but not gendered, and they have to be taught to be masculine or feminine" (Lorber 349). Before birth, the fetus's sex is assigned, male or female, based on their genitalia. However, it is after birth that the child is taught gender, beginning with the colors and clothing with which they are

dressed and associated. Societal norms are further implemented upon children into adulthood. Lorber says that "for human beings there is no essential femaleness or maleness, femininity or masculinity, womanhood or manhood, but once gender is ascribed, the social order construct holds individuals to strongly gendered norms and expectations" (349). For women, this can quickly be transcribed into motherhood, the societal expectation to perform the role of the mother and domestic caretaker. Ultimately, notions of gender are formed and upheld by actions that both men and women internalize and perform throughout their lives. It is for this reason that Judith Butler developed the term performativity when discussing how a person's gendered body interfaces with their autonomy. In Butler's theory, "*gender* is not a noun, but neither is it a set of free-floating attributes, for we have seen that the substantive effect of gender is performatively produced and compelled by the regulatory practices of gender coherence" (*Gender Trouble* 24). Given its societal implications and practices, gender cannot simply be interchangeable with the term sex. Butler drives this point home when she says, "there is no gender identity behind the expressions of gender; that identity is performatively constituted by the very 'expressions' that are said to be its results" (*Gender Trouble* 25). One is not defined by their gender, rather, they are defined by the actions, personas, etc. that they take on as a result of gender.

It is important to understand the effect that the societal expectation of motherhood has on women. The literary and cultural production analyzed in this thesis discuss women from very different cultures; nevertheless, the call of motherhood functions as a glue of sorts that brings their experiences together. Not only are the expected societal expressions of these women derivative of their experiences, but so is the language surrounding their implications as women. Successful childbearing plays a key role in female subjectivity throughout these different works. Butler's theory of gender also encompasses language; as she explains, "language gains the power

to create 'the socially real' through the locutionary acts of speaking subjects" (*Gender Trouble* 115). Societal implications of gender are further perpetrated not only by the individuals' performativity, but also by the language surrounding the central idea. In both senses, through language and performativity, gender is binding on the individual to which it is imposed. Indeed, Butler explains that "'sex,' the category, compels 'sex,' the social configuration of bodies, through what Wittig calls a coerced contract. Hence, the category of 'sex' is a name that enslaves" (*Gender Trouble* 115). Here, Butler's argument becomes complicated: on the one hand, gender is performative and learned; on the other hand, the categorization of sex as a binding agent. As much as sex is attributed to an individual based on biology, as argued by Lorber, Butler takes it a step further. Sex may be biological, but, given the social construction of gender, this biological condition quickly leads to societal expectations that form the basis of gender as a construct.

As Butler addresses the societal expectation that is attributed to gender, taking this a step further and speaking specifically on the societal expectation of women, the expectation and experiences of racialized women differ from those of white women. Furthermore, as this thesis focuses on healthcare, the experiences of racialized women seeking healthcare differ from the experiences of those women who belong to the racial majority. As mentioned previously, this point leads to an intersectionality between gender and racialized women that can be further accentuated through Butler's argument on gender and performativity. Gloria Anzaldúa, from the perspective of a Chicana, emphasizes the conflict that Indigenous women face through the societal pressure of transitioning into mestizaje, leaving behind their Indigenous identity, as well as the newer societal implications of machismo (104). Indigenous women are not only performing gender, but they are also expected to perform this new identity of a mestiza women if

they wish to be incorporated into "modern" society. The path of modernization leads to further struggles through gender and performativity:

> The struggle of the mestiza is above all a feminist one. As long as *los hombres* think they have to *chingar mujeres* and each other to be men, as long as men are taught that they are superior and therefore culturally favored over *la mujer*, as long as to be a *vieja* is a thing of derision, there can be no real healing of our psyches. (Anzaldúa 106, emphasis in original)

Indigenous women are marginalized further as they can either claim their Indigenous identity, however face scrutiny for being Indigenous, or they can modernize into a mestiza and be expected to uphold the societal role and norms that are expected of women in society.

Latinas in the United States face similar intersectionality to Indigenous women in Mexico. A trend in the United States emphasizes that the needs of white women continuously overshadowed the needs of Latinas in society (Blackwell 17). This notion is clear in healthcare as women of color fought against forced sterilizations, a plea that white feminists had repeatedly ignored (Blackwell 195). The lack of inclusion of women of color—specifically Latinas—in the movement further highlights not only the societal pressure to perform gender but also the additional barriers that racialized women face in accessing public goods like healthcare. Latinas in the United States must also demonstrate that their identity as a woman is just as valuable as that of a white woman in society. This notion became a pivotal factor in the fight to end the forced sterilization of Chicana women in California during the 1970s. As white women fought for bodily autonomy, "many white women did not understand why poor women of color saw sterilization as a dangerous medical option and why they mandated a thirty-day waiting period

before a doctor could carry out a sterilization" (Solinger 23). While women in the 1970s fought for rights over their bodies, the privilege of being a white woman did not allow white feminists to see past their own privilege over that of racialized women regarding healthcare.

Butlers' theory of performativity delves deeper than acting out the societal expectations of gender because of the implications and consequences it has on the individual. It also shows how systemic and structural beliefs contribute to building and policing constructs of gender and race. Each of the works that I discuss show cases where male physicians abuse their power to exercise dominion of women, and particularly women of color. As these works show, the experiences of women in healthcare is influenced by how their male doctors use medicine to impose "proper" performativity upon them. Before the professionalization of maternal care, in Mexico, women tended to other women through midwifery, however, the professionalization of the field quickly led to a male dominance (Hernández Sáenz 205). The displacement of midwives, women caring for women, into the dominance of male physicians not only leaves behind cultural significance, but it also leads to a hierarchical dynamic of a male physician with power and female patients seeking care. While I have previously argued the use of medicine as a technology of power through racial categorization, the intersectionality between race and gender plays a significant role in this analysis. In both works, male physicians police the reproduction of women from marginalized racial and ethnic communities to uphold an eugenic ideal.

The Practice of Eugenics in the United States and Mexico

According to Nancy Leys Stepan, the word 'eugenics' first appeared in "1883 (from the Greek *eugenēs,* meaning 'wellborn') by the British scientist Francis Galton to encompass the social uses to which knowledge of heredity could be put in order to achieve the goal of 'better

breeding'" (Stepan 1). While other definitions of the word appeared over time, the practice of eugenics represents the belief within society that a better, or improved, breed of the human race is possible through scientific and societal intervention (Stepan 1). Scholars like Stepan and Alexandra Stern have written extensively on the practice of eugenics in the so-called New World. As such, both thinkers provide valuable insight into my project. There are some similarities between the practice of eugenics in Mexico and the United States: state leaders in both contexts have used eugenics to justify the oppression of racialized women, for example. It is necessary to tease out the role of medicine and women's health in establishing eugenicist projects in both nations. Indeed, my focus on eugenics and intersectionality shows how these women's stories cast medicine as a technology of power.

Eugenic practices in the United States have been practiced on Black and brown women, as well as low-income women, for generations. A pivotal case in the history of the United States pertaining to forced sterilization is Buck v. Bell, the first eugenics case to reach the Supreme Court (Stern 1); the Supreme Court justices "overwhelmingly upheld the constitutionality of involuntary sterilization in the 1927 ruling of Buck v. Bell (Stern 1). The case of Carrie Buck is certainly not a stand-alone case in the history of the United States. As Stern goes on to discuss in her text: Oregon, Virginia, North Carolina, South Carolina, and California, five states who issued public apologies and some form of compensation to victims of forced sterilization only "represent a fraction of the thirty-two that had sterilization laws on the books at some point in the twentieth century" (Stern 2). The practice of eugenics in the United States was extremely common, and in some states legal through the 20th century. As such, state officials and physicians could target women they deemed as undesirable and sterilize them in order to keep them from reproducing future generations. Following the end of World War II, the practice of

eugenics was repackaged as "the abandonment of overt racial categories by many postwar eugenicists" leading many to view the practice as obsolete despite the fact that it still very much existed in practice (Stern 3). This becomes evident in the shift from eugenics to what Stern presents as the as personal choice of the individual, "thus efforts to encourage better breeding continued in the United States, primarily through family planning, population control, and genetic marital counseling" (Stern 4).

As eugenics was repackaged, Latinas in the state of California became key figures in the continued practice of forced sterilization, a phenomenon that I explore in Chapter 1. As I show in Chapter 1, racialized women are specifically targeted either through forced sterilization or implementation of further federal programs to curtail their reproduction. The federal funding provided to hospitals in California, and other states, to control population growth ultimately led to negligence and gross abuse of power by the physicians at the Los Angeles County Clinic and other sites throughout the country. Returning to Omi and Winant, the actions of the Los Angeles County Clinic can be classified as a racial—and racist—project. For Omi and Winant, a racial project becomes a racist project "if it *created or reproduces structures of domination based on racial significations and identities"* (Omi and Winant 128, emphasis in the original).

Moving forward to the practice of eugenics in Mexico, Stepan highlights the lack of attention that Latin America as a whole received in the discussion of eugenics when their book was initially published in 1991 (2). Perhaps stemming from the fact that Mexico, as Vasconcelos argues, did not present the same violent approach to racial hierarchies and racial segregation, the discussion of eugenics in Mexico differs greatly from that in the United States. The division between Indigenous and mestizo leads towards the path of eugenics in late 19th century Mexico:

> Mexico was not an immigrant society but an "Indian" and mestizo one; decades of debate about how the Indian population would become integrated into the national whole and how the health of the poor could be improved now converged on eugenics. (Stepan 55-56)

From this moment forward, Mexico would begin to blur the lines between modernization and eugenics as a means of strengthening the country. One key tool for the state was access to medicine. Mexico would go on to take eugenics and develop the idea into new spheres, such as hereditary science, with discussions revolving around alcoholism, contraction of diseases from the parent to the child (Stepan 78). Through hereditary science, Mexico began to discuss biological inheritance, ultimately leading them to the eugenists ideal that "a true nation had a common purpose, a shared language and culture, and a homogenous population" (Stepan 105). This would develop into the political and social movements highlighted in Vasconcelos work of creating one racialized Mexican identity: "thus the Mexicans praised racial hybridization as itself a form of eugenization that would help consolidate the nation around the mestizo" (Stepan 106).

Despite the differences that may exist in the development or application of eugenics in the United States and Mexico, both countries demonstrate the government's imposition of power over racialized communities to manipulate the progression of their nation. More so, in dictating which lives, or bodies, in society hold more value over others, the practice of eugenics can be analyzed alongside Giorgio Agamben's theory of *Homor Sacer.* Agamben's theory presented life in two terms, *zoe,* and *bios:* "*zoe* which expressed the simple fact of living common to all living beings (animals, men or gods), and *bios,* which indicated the form or way of living proper to an individual or a group (Agamben 9, emphasis in original). As *bios* embodies the good life, a

political life, *zoe* embodies "bare life, that is, the life of *homo sacer* (sacred man), who *may be killed and yet not scarified,* and whose essential function in modern politics we intend to assert" (Agamben 12, emphasis in original). Eugenics specifically targeted those women who belonged to a *zoe* class that existed outside of hegemonic society and thus lacked certain protections under the law.

Description of the Chapters

In order to track the role of medicine in assigning racialized women their marginalized role in society, I will look at several examples of literary and cultural production. Chapter 1 will discuss how Ladino actors in Rosario Castellanos's fictitious Chiapas use medicine as a means to further marginalize Indigenous actors and, as a result, to maintain the social and economic divisions that have remained in effect since colonial times. Chapter 2 will look at Chicanas forced sterilization in the state of California and the state's use of obstetric care as a technology of power over racialized women in Renee Tajima-Peña's documentary film.

Chapter 1 discusses the fictional accounts of Indigenous women who seek prenatal and maternal care in the fictitious Chiapas of Rosario Castellanos's collection of short stories, *Ciudad Real*. Through the analysis of two short stories, "El Don Rechazado," and "La rueda del hambriento," I analyze the persistence of racial hierarchies in twentieth-century Mexico. Castellanos depicts the federally funded programs aimed at assisting Indigenous communities that largely took place in early twentieth-century Mexico as a means of modernizing Indigenous communities. That said, these projects hit a snag when they come up against local power dynamics that wish to keep Indigenous people isolated from society at large. Both short stories demonstrate sub-par and unethical treatment of female patients due to their identities as

Indigenous women. In "El Don Rechazado," there is a clear distinction between the protagonist, Manuela, an Indigenous woman and the antagonist, Doña Prájeda, a Ladina. Castellanos utilizes Doña Prájeda's character and her racial identity as a vessel to portray the reality of anti-Indigenous racism that persisted in Chiapas even after the postrevolutionary government declared its commitment to uplifting Indigenous populations. Rather than allow her Indigenous servant to give birth in the home, she sends her to give birth in a stable, for example. "La rueda del hambriento," depicts the desultory way in which publicly funded operations were organized at the federal level—and undermined at the local level—through its portrayal of Alicia, a volunteer nurse who lacks formal training and certification to treat patients. Once arriving at the location of the mission, Alicia faces the reality of the low funded operation she has joined. Even more so, Castellanos depicts the tensions between the Ladinos and the state. Local Ladinos explicitly state their disgust with the mission's goal of providing medical and educational services to local Indigenous populations because this will undermine Ladino authority in the state.

Chapter 2 focuses on Renée Tajima Peña's documentary film *No más bebés*. The film tells the true story of numerous Chicana women who were sterilized immediately after giving birth at the Los Angeles County Clinic from 1971-1974. Hospital workers took advantage of their patients' lack of fluency in English to coerce them into consenting to undergo tubal ligation surgeries while under duress. The film emphasizes how hospital workers weaponized linguistic and cultural barriers to in order to force them to accept sterilization procedures. The doctors imposed their racist and stereotypical understandings on their patients, a fact that made it easier for them to justify their actions. While the film points out these conditions, Tajima-Peña ultimately focuses on the trauma that these Mexican and Chicana women underwent as a result

of their forced sterilization. An array of interviews details how these women were unable to live the lives that they had foreseen for themselves because they could no longer have as many children as they had hoped for.

Taken together, these chapters both discuss how medical care—particularly women's access to healthcare—contributes to projects of racial formation in both the United States and Mexico. This thesis highlights the power that those at the top of societal hierarchies impose onto marginalized communities. Medicine becomes but one of many tools that people from dominant social classes employ in order to perpetuate their hegemony. One of the most interesting findings of my thesis is that, despite obvious differences, Indigenous women in Chiapas and Mexican and Chicana women in Los Angeles share certain key similarities. Both are linguistic minorities whose inability to speak the dominant language makes it harder for them to access care while also making it easier for local healthcare providers to provide worse care without facing serious consequences. As such, in comparing access to healthcare to people from such different circumstances, I am able to better show how access to medical care functions as a technology of power that assigns marginalized women their role in society.

Chapter 1: Chiapanecan Ladinaje vs. Statist Official Mestizaje: Medicine and Competing Projects of Racial Formation in Rosario Castellanos's *Ciudad Real*

A pregnant Maya woman named Manuela finds employment as a housekeeper for Doña Prájeda, a local Ladina woman in Chiapas, Mexico. When she goes into labor, her new employer tries to take her to a local hospital; Doña Prájeda does not do this because she values her servant's life but because she does not want the woman to bleed all over her belongings. When an irrational fear leads Manuela to refuse care in the hospital, Doña Prájeda forces her to give birth in the horse stable, surrounded by filth and without a doctor. These conditions result in severe infection. In another scenario, Dr. Salazar—who represents the federally appointed medics of the time who worked with the Maya in Chiapas—saves the life of a Maya woman and child following a complicated birth. Shortly thereafter, the mother learns that she cannot breastfeed her child. She cannot afford formula, and the doctor refuses to provide it for free. Ultimately, the child dies, and the mother leaves the rural clinic in tears. Both events occur in *Ciudad Real*, a collection of short stories by Rosario Castellanos set in Mexico's southernmost state of Chiapas. In both works, local Ladino (mixed-race) populations use medicine as a technology of power to carry out projects of racial formation. The federal government tries to use medicine to promote official mestizaje and assimilate the Maya to the mestizo state. The local government, however, attempts to use medicine to further institutionalize the segregation of Maya and Ladino communities.

Maya women being blocked from receiving adequate healthcare because of societal hierarchies is not new. Ever since the colonial period, Indigenous peoples have occupied one of the lowest rungs of the social ladder (Lewis 177). Indigenous women face double marginalization because of the intersections of race and gender. The intersectional nature of

Maya female agency is a central pillar throughout Rosario Castellanos's oeuvre; that said, in this chapter, I will focus primarily on "La rueda del hambriento," and "El don rechazado," the two stories mentioned in the previous paragraph. Both fictions depict the experiences of Maya women's access to healthcare and situate it within a highly racist and patriarchal system that deliberately marginalizes women. The depiction of these fictional women's stories speaks to the various factors that hinder them from receiving adequate medical attention. This chapter tracks cases where race- and gender-based discrimination frustrates Maya women's ability to access healthcare. In both works, the female protagonists' stories center on an individual—typically one holding a higher place in the social hierarchy—who dictates whether these women require medical attention. In both stories, healthcare plays a central role in perpetuating distinctions between Mayas and Ladinos despite federal attempts to achieve the opposite.

"La rueda del hambriento" tells the story of Alicia, a naïve young woman with the desire to provide medical assistance to those in need. She decides to work for a mission—a veiled reference to the Instituto Nacional Indigenista (INI) (Dalton, "Treating Indigeneity" 965)—that will allow her to do this for the Maya population of Chiapas. She travels to Chiapas with a brief stay in Ciudad Real before moving to the rural town of Oxchuc, where she assists Dr. Salazar in tending to the Maya community. Both Alicia and Dr. Salazar tend to sick patients, provide, or attempt to provide, vaccinations, as well as assist women during labor, or with labor complications. It is through Alicia's employment and Dr. Salazar's actions in caring for the woman with complications during labor that Castellanos accentuates the use of medicine as a technology of power.

"El don rechazado" touches on this power dynamic while depicting the severe consequences that can result from the use of obstetric care as a technology of power. The

protagonist of the story, José Antonio Romero, arrives in Ciudad Real as an employee for the Misión de Ayuda a los Indios, a fictionalized program dedicated to aiding the Maya community in the area that, once again, alludes to the INI. It is through his responsibility as an employee that the audience arrives to the story of Manuela after José stumbles upon her daughter, Marta, who pleads with José to help her mother. Manuela suffers severe complications following the birth of her child in a horse stable. José, and the Misión de Ayuda a los Indios, nurse Manuela back to health, while also educating her older daughter, Marta, in an attempt to "redeem" both of these Maya women. Both short stories showcase the tension between Ladinos and Maya in Chiapas, but they also discuss machismo and inaccessibility of healthcare for Maya women. Before moving forward into the analysis of each story, this chapter will briefly outline the common and recurring themes of machismo and inaccessibility to healthcare that abound in both stories. From there, it will outline the tension between federal and local government and discuss the key role that Chiapas played in (post)Revolutionary Mexico.

The academic scholarship on Rosario Castellanos and her literature is rather diverse. Dissertations written on Castellanos's literature focus significantly on Castellanos as an Indigenista writer. Sachiko Fuji provides an in-depth and insightful argument and analysis of Castellanos's works and her depiction of the racial marginalization of the Indigenous community and Indigenous women in her texts (see Fuji 7-10). Margarita B. Orro analyses the contradictions in Castellanos's literature as Castellanos claims to focus on class differences, while her texts essentially discuss the complex relationship that exists between Maya and Ladinos in Chiapas (see Orro 7-8). Douglas J. Weatherford discusses Castellanos's depiction of female characters in her literature through a broader lens of initiation theory (see Weatherford 5, 12). These differing focuses on Castellanos's literature allows for an analysis of female characters throughout

Castellanos's work. Mary Gómez Parham adds to the argument of Castellanos as an Indigenista writer by centering her argument on the role and influence of alienation in *Ciudad Real* (22). Joanna O'Connell provides one of the deepest discussions of Castellanos's work, and she focuses at length on how the author understood oppression to come from an array of factors, of which both race and gender were especially key. In recent years, Emily Hind has questioned the extent to which Castellanos promoted a liberatory discourse for Amerindians or women (see Hind 57-58). Joshua Lund and David S. Dalton have built on that argument and situated her as a key voice in critiquing officialist lines of mestizaje (Lund 80; Dalton, "Treating Indigeneity" 964). This thesis seeks to build on the recent scholarship's focus on Castellanos as a female intellectual of twentieth-century Mexico. A more nuanced understanding of her own role in promoting officialist lines of mestizaje will assist in our discussion of medicine as a technology of power with a key role to play in racial formation.

This chapter situates itself within arguments presented in more recent publications on Castellanos's literature through an analysis of machismo, inaccessibility to healthcare for Maya women, and linguistic barriers. I will begin with a brief introduction to the machista themes in "La rueda del hambriento" and "El don rechazado." While Castellanos herself does not reward machista power dynamics, she includes machista characters who accentuate discussions of gender roles within Mexican society. Throughout these stories, Castellanos provides subtle remarks and details that allude to the gender dynamics and machista thought. Juan Ventura Sandoval identifies several crucial points on the role of women within machista Mexican society. One of his points highlights the societal view of women as objects to satisfy men's needs: "...la mujer es un instrumento de los deseos particulares o sociales del hombre, para los que no cuenta en absoluto la opinión de la mujer" (30). This point encompasses the societal view of both Maya

women and Ladinas in Castellanos's stories. At the same time, machista sentiments do not affect all men equally; rather, they constrict the agency of Maya women even more than Ladina women. Sachiko Fuji notes that Ladina women frequently carry out machista-like violence against Maya women throughout Castellanos's literature (101).

Not only is there a discussion on the gendered nature of Castellanos's works, but there is a discussion of gendered and racialized marginalization pertaining to healthcare in Castellanos's "La rueda del hambriento" and "El don rechazado." Dalton, for example, discusses how Castellanos depicts the lack of resources and medical staff for Mayan communities in her stories, a condition that makes it almost impossible for Mayan patients to receive the healthcare they need. Some hurdles keeping Maya women from receiving adequate care stem from language and cultural barriers. This notion of communicative breakdown appears with frequency in both stories: Ladinos do not wish to see the local Maya communities prosper because they want to continue to exploit cheap, Maya labor and land. Writing on the state of healthcare in Chiapas in 2010, Samuel Loewenberg states:

> Most clinics are occupied by medical students who are doing a year of service. But this does not suffice, according to both government officials and women's advocates, who say that students are often not sufficiently trained, do not speak the local Indigenous languages (of which there are dozens), and can be arrogant towards the women they are supposed to be helping. (1681)

Through both subtle and graphic scenes, Castellanos shows how efforts to create a bureaucratic fix will crumble immediately if those individuals who work on-site, either cannot or will not,

accommodate their knowledge and resources in a way that reflects the cultural and linguistic needs of their patients.

Each of these stories engages the political climate of twentieth-century Mexico. Toward the latter end of the nineteenth century, healthcare in Mexico was quickly modernizing and taking on new practices through the implementation of state-run medical schools (Hernández Berrones 26). The federal government endorsed and supported these processes of professional certification. Nevertheless, the professionalization of medicine often resulted in better care only for Mexico's elites and not the population at large. Given the fact that much of the anger that led to the Revolution had resulted from Indigenous people who lacked adequate access to healthcare (Knight, "Culture and State" 406), the post-revolutionary state made improved access to healthcare a top priority. Katherine Bliss characterizes post-revolutionary Mexico's focus on hygiene as a "more general developmentalist ideology throughout the years of the ‘reform phase’ of the Mexican Revolution between 1917-1940" (Bliss 197). Similarly, Hernández Berrones notes that "the Constitution of 1917 made health a right of all Mexicans, sanitation a responsibility of the executive, sanitary policies mandatory all over the country" (Hernández Berrones 29).

As a result of the 1917 Constitution, the Department of Public Health was created with a clear list of objectives and priorities. The department took on the responsibility of extending healthcare to the rural areas of Mexico that had been previously neglected. However, this redirected attention led to the stigmatization of racialized bodies:

> In this process, public health authorities increasingly associated health conditions with poor urbanization, low socioeconomic status, and Indigenous background. Consequently, public health

> programs such as vaccination campaigns, sanitation of public and private spaces, distribution of hygienic propaganda, inspection of drugs, and food, and special training of medical staff, among others, were frequently imbued with redemptive undertones that aligned with the values of national medical community and international funding agencies. (Hernández Berrones 30)

Castellanos delineates this precise shift in public health in her stories; the focus from the federal government in providing a redemptive, mestizophilic care to rural areas of Mexico. As Bliss notes, "in the aftermath of constitutional reform, other revolutionaries who styled themselves as 'progressives' dedicated themselves to redeeming the Mexican people from the vices they believed the dictatorship had allowed to flourish" (Bliss 197). Both short stories discussed below center on paternalistic "progressives" who view their intellect and way of life as self-evidently superior to those of Maya society. The workers at the misión unironically aim to free Mayas from their supposed vices (read: their cultures and way of life) to bring about a more advanced, mestizo order.

In Castellanos's pieces, there are explicit examples of medicine being utilized as a technology of power toward the Maya community. As Dalton has discussed, official mestizaje was a postrevolutionary project of racial mixing "whose principal aim was the incorporation of the nation's Amerindians to the modern state and economy" ("Treating Indigeneity" 960). Official mestizaje led to the development of state-based projects, through which the federal government continued to encourage racial mixing while also attempting to modernize Indigenous communities in rural areas. As Dalton argues, "medicine proved especially useful to projects of indigenous assimilation; it simultaneously modernized indigenous individuals, separated them

from the "bare" communities from which they came, and transformed them into members of the mestizo community through technological hybridity" (*Mestizo Modernity* 105). Castellanos's stories demonstrate the power struggle between local and federal governments. As the federal government pushes to modernize Indigenous peoples in Mexico through programs of official mestizaje, local and state governments in Chiapas attempt to maintain the racial hierarchies that have benefited those Ladinos and caxlanes since colonial times ("Treating Indigeneity" 962-963). In no place does Castellanos highlight the struggle between federal and local officials more explicitly than in the area of medicine. While the use of medicine as a technology of power is easier to identify when analyzing the action of local government, it is also crucial to note the type of care and medication that the federal government is offering. Essentially, post-revolutionary Mexico aimed to develop a homogenous heterogeneity through mestizaje (Gamio 14; Lund 15). Official mestizaje allowed the federal government an attempt at modernizing and educating Indigenous peoples throughout the country. Such a project would succeed in bringing Indigenous actors under the umbrella of official mestizaje, a fact that appealed to federal leaders but worried local, landed elites in faraway states like Chiapas.

Indeed, in Chiapas, the dichotomy between Ladinos and the Maya ultimately shaped the local healthcare system. Ladinos opposed official mestizaje because it aimed to create equality among Ladinos and Maya actors, a fact that would entail the expropriation of land to Maya communities (Lund 75). In utilizing medicine as a technology of power, Ladinos in Castellanos's short stories can frustrate modernization efforts by the federal government and deny the Maya people access to medical care. However, the question remains, why is the discussion of medicine as a technology of power relevant in the state of Chiapas? Stephen E. Lewis and Joshua Lund both speak to the geographical location of Chiapas and how this factor allowed for a disconnect

between the objectives of the federal government and the actions carried out by local Ladino government leaders. The state's isolation from the central government in Mexico City meant local leaders could remain insulated from certain policies that would put their economic interests in danger.

Writing from a historiographical perspective, Lewis states that the inability of the federal government to achieve success in Chiapas resulted from an array of "powerful local interest groups" (188). Local Ladinos opposed the federal government's actions as "lowland plantations relied on their [Indigenous] labor; *enganchadores* and state alcohol interest depended on their consumption of alcohol; and local governments subsisted on their labor and taxes they paid" (Lewis 188). Not only was there a structural reliance on the marginalization of Indigenous peoples, but the Indigenous communities themselves were distrustful of anyone outside of their community given the years of marginalization by the local government coupled with the historical indifference of the federal government (Lewis 188). Lund notes a similar dynamic from the perspective of literary criticism when he discusses the contribution that Chiapas's geographical location has to this imbalanced power dynamic. Lund describes Chiapas as "something like the 'deep south' of Mexico, with all the discursive weight implied by such a term intact, and it is a convention to speak of the dynamic of its basic race relations, between indigenous peoples of Maya descent (mainly Tzotzils and Tzeltals) and the nonindigenous 'ladinos,' as a kind of apartheid" (Lund 78). Not only is there a racial power dynamic, but there is also the question of land, a valuable resource that Ladinos refuse to return to the local Maya. However, Lund views the "racialization of space" as the logical result of Chiapas's history of segregation and systemic racism (Lund 75). We see this clearly in Castellanos's fiction, where the Maya live primarily in rural areas and in the poor parts of Ladino-run cities.

The racialized marginalization that unfolds in “La rueda” and “El don rechazado” encompass Lund's argument that the "privatization of the countryside becomes the contemporary language of an ongoing primitive accumulation, the race war wherein one civilization is forced to recede before the cultural logic of another" (Lund 76). Indeed, the Maya function as serfs who work land owned by Ladino hacendados. One interesting narrative point about both works is that the protagonists of both stories are not Indigenous themselves; instead, the protagonists are volunteers from Mexico City who have traveled to Chiapas to assist the Maya community in ways that will uphold the doctrines of official mestizaje. Castellanos capitalizes on the foreignness of her protagonists to show how Ladinos undermine attempts to uplift Maya actors. While they do this through various means, I will focus primarily on how they coopt medicine as a technology of power that validates Ladinos at the top of the local social hierarchies. Let us now turn to “La rueda del hambriento,” a story that shows how local actors frustrate the attempts of the federal state to assimilate the Maya population to the state by ensuring subpar healthcare initiatives among the local Maya populations.

Linguistic Barriers and Machismo in "La rueda del hambriento"

"La rueda" begins with a brief portrayal of the story’s protagonist, Alicia. As a single woman with no family, she decides to leave Mexico City and find employment—and, hopefully, love—elsewhere ("La rueda" 116-117; Weatherford 30-31). In instances of hardships or when faced with vulgarity—specifically in scenes where she is the only woman present—Alicia is offended or taken aback by the actions of the men around her. We see this when she meets Dr. Salazar, an educated man, for the first time. Instead of welcoming her, he immediately complains about what she has not brought: "Ni una vitamina, ni un antibiótico" (131). The coarseness of his

language shocks Alicia, but she does not dare to reproach him. This dialogue is a subtle critique by Castellanos that begins by highlighting Alicia's naivety as a hindrance to the misión. Her inexperience and her sheltered upbringing mean that she will struggle to contribute to the institution's goals. Indeed, while Alicia finds Dr. Salazar to be vulgar, his reaction to the medications that she has (not) provided is well-founded: the misión constantly receives medicines for the rich while ignoring the basics that people in this town need to survive. One can argue that the federal government provides medicines that give an appearance of hypermodernity, even if they are not as important as other medicines, because this will help to promote notions of mestizo modernity. However, there lies a gray area in the push for official mestizaje. As the federal government pushes towards this ideal, it shows off its most advanced medications; oftentimes, these medicines highlight advances in medical technology, but they fail to address the most basic medical challenges that rural communities face. Indeed, rather than supplementing medication and tools for vaccination, the doctor constantly receives 'leftovers' from the rich. Dalton emphasizes how the "modernization of the indigenous body is a societal good, but it also impedes Salazar from helping the locals with more urgent medical conditions and infections" (Dalton "Treating Indigeneity," 967). The indifference of the misión toward the actual needs of the Maya community in Chiapas underscores their desire to modernize Indigenous bodies and assimilate them to the state without consulting with the very populations that they wish to uplift. This, in turn, allows for Ladinos to manipulate local medical conditions, a fact that allows them to continue to use healthcare as a technology of power that favors them.[4]

Alicia serves as an excellent narrator precisely because her unfamiliarity with the Chiapanecan context allows her to denaturalize practices that others may take for granted. In this

[4] Dalton identifies a similar process that plays out regarding education in Castellanos's novel, *Balún Canán*. See ("Educating Social Hierarchies" 156-59).

way, she can challenge the practices of the misión and of the local, landed elite while at the same time observing tensions that exist between each of these communities. Of course, one of the overriding themes that appears throughout the story is her own, gender-based subservience. A scene that highlights this point occurs during Alicia's expedition from Ciudad Real to Oxchuc. The young woman begins to weep during the long, physically demanding journey because she is not accustomed to the weather or to traveling by horse. The men react mockingly, saying "¡No se me raje, patrona, que ya vamos a llegar!" (128). These words carry significant, gender-related overtones, especially if we view them alongside the writings of Octavio Paz, whose seminal work, *El laberinto de la soledad* came out only a few years prior to *Ciudad Real*. For Paz, the term "rajarse" means to open, particularly in a sexual—and feminine—way that facilitates the domination of one person over another (29-30). With this understanding, the men with whom Alicia is traveling utilize misogynistic expressions to mock her and to remind her that, her professional position notwithstanding, they maintain a superior position over her in the overall social hierarchies in Chiapas and even throughout Mexico. The ramifications of these deeply ingrained, misogynistic attitudes will ring even more clearly as she observes how men—particularly Ladino (Chiapanecan) and mestizo (Mexico City) men interact with Maya women who face marginalization both due to their race and gender.

As soon as Alicia arrives at the clinic, enthusiastic to tend to patients, Dr. Salazar imposes strict, gendered responsibilities that show that he does not view her as a fellow worker of the misión but as a domestic caretaker. Instead of asking Alicia about her qualifications in relation to their work (which she admittedly lacks), Dr. Salazar questions her on her domestic abilities: "Por lo menos sabrá cocinar. Estoy hasta el copete de estas inmundas latas de sardina" ("La rueda" 131). Mary Gómez Parham analyzes Dr. Salazar's sexist expectations as an issue of

alienation that Castellanos highlights through "severe codes of courtesy, *machismo* and other forms of sex-role stereotyping, greed and above all, language barriers" (Parham 22, emphasis in original). Although Parham does not go on to define alienation, she highlights the persistence with which Castellanos situates her female characters in paternalistic narratives. Dr. Salazar expects Alicia to continue to abide by the gender norms of mid-twentieth-century Mexico, and, as such, she faces similar expectations to those that she had prior to moving to Oxchuc (O'Connell 120). Indeed, given her weak credentials in healthcare, these expectations likely come as a relief; as O'Connell notes, Alicia remains hopeful that a romantic relationship could develop out of this situation (120). Clearly, Alicia's principal goal is not to provide healthcare, but to find a man to care for and protect her.

The text suggests that Alicia's incompetence may be, in part, by design. Ladino actors continue to do everything in their power to withhold the privileges of modern medicine from the local Maya communities. Furthermore, the misión lacks the funding to hire competent workers and instead employs corrupt tactics to hire inexpensive (and thus inexperienced) workers. Castellanos acknowledges early on Alicia's lack of accreditation to be a nurse:

> —Entonces han de ser muy exigentes. Y yo no tengo título.
>
> —Eso no es problema. Si hacemos valer algunas influencias... además tú tienes práctica, que es lo esencial. Y no te preocupes. La misión está empezando apenas. ("La rueda" 118)

While Alicia may not hold much power within Mexican society or come from extreme wealth, her friend appears to hold a certain sway with the misión. Dalton argues that "Alicia becomes qualified to be a nurse with the mission only after taking care of her godmother who is terminally ill with cancer" ("Treating Indigeneity" 966). While this certainly speaks to a degree of altruism

on her part, it does not mean that she has the medical skill to look after an entire community. The decision to hire Alicia thus reflects Loewenberg's observation that the medical programs that have been implemented throughout rural Mexico have historically ignored the needs of the actual communities inhabiting that land (1681). If a qualified nurse was sent to Oxchuc, one who understood and cared for the needs of the Maya community, perhaps they would have been able to care for patients that Dr. Salazar neglected. The passion behind Alicia's character cannot fully compensate for her lack of skills and knowledge necessary to competently care for patients. While Alicia is also to blame in that she actively treats patients without proper medical accreditation, the misión she is a part of demonstrates no hesitation in hiring individuals who are underqualified.

A different scenario in which Castellanos discusses the power dynamic between local Ladinos and the Maya community is through the use of language barriers. In one sequence, the misión finally receives vaccines and Dr. Salazar springs into action and goes into town with Alicia, and a Ladino interpreter ("La rueda" 136-137). With a shift in his character, Dr. Salazar is optimistic that, perhaps for once, he will be able to treat his patients as actual patients. Not only does he have the medication necessary to administer vaccinations, but he also has a nurse and an interpreter at his disposal to assist him in treating and garnering his patient's trust. Perhaps, influenced by Alicia's optimism (and naivety), Dr. Salazar provides the interpreter with a script that states that they wish to protect them from serious diseases and that they seek no remuneration ("La rueda" 138). Nevertheless, the interpreter does not agree with the misión's attempts to modernize the nation and promote officialist forms of mestizaje. As such, the interpreter works to undermine the vaccination project in an attempt to frustrate statist attempts to promote official mestizaje. The Maya in Oxchuc remain hesitant, largely due to the work of

the interpreter and because they remain ignorant about the healthcare guarantees enumerated in the Constitution of 1917 (see Dalton, “Borderlands, Race, and Gender” 240). The interpreter seems to be happy when they call off the campaign without having vaccinated anyone (138). His nonchalant demeanor portrays to the audience a sense of satisfaction as the Maya community is refusing medical care. Of course, this could be his doing: there is no evidence that this man is truly conveying the message that Dr. Salazar has asked him to spread. These agents of the mestizo state find themselves having to rely on and trust a man more closely aligned with the oppositional system of Chiapanecan Ladinaje. As such, their project is threatened from the start.

Through the interactions of the Ladino interpreter and the Maya patients one is able to identify an intersectionality that exist between a doctor and patient relationship and ethnicity in this story. As Dr. Salazar and Alicia place their trust in the Ladino interpreter, they are entrusting that this man also supports the misión and federal state's agenda of official mestizaje. Even more so, their trust demonstrates an ignorance towards the societal and ethnic hierarchy through which the people of Oxchuc abide by. Dr. Salazar and Alicia, in this moment, view the Ladino man as an equal to them– a mixed-race person who also believes in the assimilation of Indigenous peoples. The vaccinations that they attempt to administer serves as the gateway into garnering the Maya's trust that will ultimately allow them to assimilate them further towards the country’s national agenda. However, the Ladino interpreter, understanding the power he holds as Dr. Salazar and Alicia are unable to communicate directly with their patients, uses this linguistic barrier and unethical practice to further dominate the Maya in Oxchuc. The Ladino interpreter in this story demonstrates a clear understanding of the cultural significance of the patient, and therefore manipulates this factor. This scene brings language to the forefront of the story, a critique of the misión and their inability to fully understand the cultural and societal make-up of

their target region. While the interjection of the Ladino interpreter highlights the societal hierarchies of Oxchuc, a critique of Ladino's and their dominance over the Maya, it also critiques the misión and their one-sided projects and beliefs. Postrevolutionary Mexico's official mestizaje, in targeting Indigenous bodies, also targets their cultures and languages, therefore ignoring the need capable interpreters who can bridge the communication between doctors and their patients.

Furthermore, O'Connell argues that this scene depicts Dr. Salazar's resentment towards the Maya community, pondering on tensions between differing socioeconomic classes (121). However, what is being portrayed by Castellanos is a disconnect between the individuals of the misión and their ignorance of the tension that exists between Ladinos and Maya in Oxchuc. Neither Dr. Salazar nor Alicia at any point consider that their interpreter is hindering the Maya community from receiving medical assistance. Dalton emphasizes this in his discussion of the biopolitical order that exists between the Ladinos and Maya in Oxchuc. More importantly, if the Ladinos wish to continue to withhold power from the Maya, they must maintain their system of "rigid separation of *ladino* and indigenous privileges" (Dalton, "Treating Indigeneity" 969 emphasis in original). Suppressing Maya access to vaccinations is crucial to their oppressive structure as allowing them to receive vaccinations would lead to a domino effect: "If immunizations make their way into the population at large, the *ladino* will lose his comparative corporeal advantage in the town. Worse still, the population may start demanding other rights as well (Dalton, "Treating Indigeneity" 969 emphasis in original).[5] Ladino opposition to the misión results from their desire to maintain a societal hierarchy in which they are controlling the socioeconomic structure of Chiapas, resulting in medicine as a technology of power.

[5] An array of scholars have tied public health initiatives to hygiene to eugenics. See Susan Antebi (5, 103-04); Dalton (*Mestizo Modernity* 100-07); Nancy Leys Stepan (67-95).

Towards the end of this story, Castellanos shifts the focus from a discussion of medicine, to one that finalizes the discussion with a focus on women's health, specifically obstetric care. As Castellanos critiques the quality of care and medicine as a technology of power in this story, it is further culminated through Dr. Salazar's actions. While it was previously argued that the misión continuously provides Dr. Salazar and the clinic in Oxchuc with unnecessary medications, Castellanos depicts a shift in Dr. Salazar's character. In instances during which Dr. Salazar has the medicine and tools necessary to assist a patient, it is ultimately his decision whether he will provide care or not. Dr. Salazar's sentiments when deciding to treat patients are intentional, calculated measures, utilized to assert his status as a mestizo man. This becomes clear in the culmination of the story when a Maya woman is rushed to the clinic seeking obstetric care for complicated labor. Again, there is a shift in Dr. Salazar's character that immediately allows him to jump into action and care for the woman. While doing so, Dr. Salazar expresses his shock in the Maya's decision to seek medical care from him and not the brujo and comadronas that the Maya typically seek care from (142). His immediate action can be associated to the boost in his ego as the Maya woman prefers his care in such a high-risk moment, leading him to accept her as a patient and assist her in her delivery. However, as this character has continuously demonstrated, his actions are performative as he only chooses to act in moments in which he will be perceived as a savior or when he can assert his power. As Castellanos only provides her audience with a brief mention that the Maya woman seeking care is experiencing a complicated labor, there are not many details as to the type of care or procedures that Dr. Salazar administers. While he assists the Maya woman in labor, resulting in the birth of a healthy child and stable mother, he quickly disregards the mother as he feels that his act of service is done. There is a brief moment following the delivery in which Dr. Salazar follows up with the mother and child,

however, the description of this scene leads to interpretation that it is a rather short and limited check-up ("La Rueda" 143). Believing that his job is done, Dr. Salazar quickly retreats to the persona that he presents throughout the entirety of the story.

Upon his return, Dr. Salazar is informed that the mother is unable to produce breast milk for her child, the Maya woman requests help from Dr. Salazar and begs him to provide her child with formula. Instead of assisting the mother or demonstrating some form of interest in the Maya woman's postnatal care, or the child who not been feed, Dr. Salazar takes on a different approach. Dr. Salazar uses this as an opportunity demonstrates the power he has over medicine when patients cannot pay for care or medication. Without the money to pay for the formula, Dr. Salazar will not provide any medication to any patient. Even more so, Dr. Salazar's actions are further examples of medicine as a technology of power, as there is no sign in the text that his refusal to provide the Maya women with formula is based on any shortage or high demand for the formula. His actions show his power to act cruelly and nothing else, an imposition of his belief that is the Maya are forced to pay for medicine and medical care that they will take his practice and the misión seriously. At this moment, Dr. Salazar dictates if and when his patients will receive care; he holds control over whether a patient will live or die. The woman's child dies from starvation as they cannot pay for the formula that their child desperately needs.

While he views this as a teaching opportunity, to his patients, his actions make him seem no different from the local ladinos (Dalton, "Treating Indigeneity" 968). Even more so, his actions reflect twentieth century eugenicist ideology that is continuously imposed over racialized bodies. As Mexico's eugenic practices favored mestizaje, in allowing the Maya child to die, Dr. Salazar carried out a eugenic act based on his experience with the Maya in Oxchuc. While he claims a few small victories with some Maya, Dr. Salazar ultimately dictates that all Maya are

the same, unwilling to abandon their cultural beliefs, making his nonchalance towards the death of the child even more telling. As Castellanos narrates, "Los gritos habían cesado. Alicia hizo una mueca de alarma. Salazar sonrió" ("La rueda" 146). Dr. Salazar demonstrates a sense of satisfaction at the lesson he is teaching his Maya patients, indifferent to the fact that his use of medicine as a technology of power has cost a life. The continued disdain that Dr. Salazar expresses toward the Maya in Oxchuc allows for his actions to be interpreted as an eugenic act. His extreme actions demonstrate a statist approach that will push Indigenous peoples into taking postrevolutionary Mexico's attempts of official mestizaje seriously. The Maya resistance to the misión essentially leads Dr. Salazar to act through Mexico's eugenic goal, "not to give value to the variety of biological and cultural types that made up the Mexican nation but to eliminate heterogeneity in favor of a new homogeneity, the Europeanized mestizo" (Stepan 150). Through Dr. Salazar's actions, the Maya in Oxchuc are left to interpret official mestizaje as either a means of life or death. If the Maya are unwilling to assimilate to the federal state, through one mean or another, they will face life threatening consequences, which in this story, Dr. Salazar has identified as medicine and medical care.

Through "La rueda del hambriento," Castellanos situates the reader Chiapas, Mexico's southernmost state by discussing specifically the opposition of local Chiapanecan Ladinaje to federal constructs of official mestizaje. Through this lens, Castellanos highlights the societal hierarchies in Chiapas that allow for the continued control of the Maya in the region. In the fictional town of Oxchuc, Castellanos develops a statist agenda that is critical of twentieth century Chiapas and its ability to use medicine as a technology of power over racialized bodies in "La rueda del hambriento." The story itself builds up to the final eugenic act through the frustration of Dr. Salazar and his inability to treat Maya patients because of cultural and

linguistic differences. Castellanos continues this critique in "El don rechazado." Through a continued discussion of the misión and their involvement in Chiapas, Castellanos presents another story set in Chiapas where the narrator, a worker at the mission, attempts to save a Maya woman and her children both from disease and from their supposed cultural backwardness. Again, Castellanos critiques the opposition of local actors in Chiapas and their use of medicine as a technology of power to continue their claim over Maya bodies.

Treating Ignorance and Disease in "El don rechazado"

"El don rechazado" allows for further discussion and analysis both of medicine as a technology of power and of the political and social hierarchies that abound in Castellanos's Chiapas. The story is narrated from the perspective of a male protagonist named José Antonio Romero. He is not an objective narrator, but rather, one who speaks from his own personal experiences and beliefs as a worker of the misión. In having the narrator be a worker of the misión, Castellanos develops a very specific dialogue that depicts the Maya as helpless and incompetent when left to their own devices. Joshua Lund argues that this discussion of race is a common theme throughout Castellanos's work and that, in some instances, it reflects her own experiences working with the Instituto Nacional Indigenista (Lund 82). More importantly, Lund asserts that Castellanos's literature reflects the "ethical demand: for the necessity (but impossibility) of intercultural communication and the equal necessity of striving to transcend that impossibility" (Lund 104). Essentially, "Chiapas is a race war, impossible to overcome or effectively mediate, equally impossible to escape" (Lund 104). Essentially, Lund argues that Castellanos's depiction of the racial tensions is a valid representation of Chiapas (Lund 103). Castellanos's stories discussing the misión and their attempts towards modernization and official

mestizaje not only discuss the manipulation of racialized bodies, but they also center medicine as a technology of power through which Ladinos in Chiapas can further control the socioeconomic growth, or lack thereof, in Chiapas. These points are highlighted in "El don rechazado" through the use of a misión worker as the narrator, the depiction of Manuela, a Mayan woman, as supposedly obstinate, and Doña Prájeda's influence and control over Manuela as a Ladina in Chiapas.

José Antonio Romero, who will from here on be referred to as the narrator, is rather influential in his telling of the story because of his depiction of Ladino and Maya characters. In his introduction, the narrator informs the reader that he is a mestizo man that has relocated to Chiapas as a result of his employment through the Misión de Ayuda a los Indios. As he briefly outlines his responsibilities as a worker of the misión, he alludes to the lack of trust that exists between the misión and local Mayas. For example, he mentions in passing the importance of making his institution's presence known in the local community ("El don" 313). Essentially, the narrator "tends to view himself as a savior figure whose redemptive potential is intimately tied to his status as a mestizo" (Dalton, "Treating Indigeneity 974). Castellanos extends the narrator's superiority complex through machista inner dialogue that the narrator has with himself. The narrator's first encounter with Marta, a Maya child, is rather abrupt; Marta runs into the street, in front of his car, and begs for medical assistance for her mother. She takes his hand and leads him away from the road to what he believes to be an abandoned barn. Recognizing the optics of this situation—many may accuse him of trying to rape the girl (O'Connell 123)—he quickly explains why this could not possibly be the case. "Soy joven, estoy soltero y a veces la necesidad de hembra atosiga en estos pueblos infelices. Pero trabajo en una institución y hay algo que se llama ética profesional que yo respeto mucho. Y además ¿para qué nos andamos con cuentos? Mis

gustos son un poco más exigentes" (314). His defense, then, centers on the fact that he would not stoop to the level of engaging in sex with a Maya girl because he would not find her attractive.

As a mestizo, he claims to hold himself to a higher standard that would preclude a relationship with an Amerindian. Such assertions, of course, do not preclude the possibility of sexual abuse; what is more, given his unreliability as a narrator, the reader is left unconvinced about the mestizo man's stated intentions. O'Connell argues that the narrator "sets himself above the Ladinos but without necessarily differentiating himself from their contempt for Indians" (123). This, of course, is because local Ladinos frequently rape Maya women while mestizo men like the narrator at least claim that they do not. Castellanos's depiction of the narrator demonstrates how deeply ingrained the mestizo-normative, machista narrative is in twentieth-century Mexico. Regardless of the differences he asserts between himself and the Ladinos, Castellanos's characterization of the narrator shows the deep, colonialist beliefs that both groups espouse. Indeed, both the mestizos from Mexico City and the Ladinos view the Maya as a means to an end and as actors whom they must recruit to their respective economic models. Beckman argues that the Ladinos in Castellanos's literature reflect the historically racialized hierarchy of power in southern Mexico that existed during the twentieth century and has lasted into the present. More importantly, Ladinos were able to successfully "own church and indigenous lands, transforming them into vast haciendas, cattle ranches, and to the South, coffee plantations. But access to land meant nothing without access to labor," (140) resulting in the marginalization of Mayas in Chiapas. The narrator may disagree with the virtual enslavement of Amerindians, and he constantly compares himself favorably to Doña Prájeda, but he also views Manuela and her daughter not as autonomous individuals but as means to further his own goals with the mission.

Another component that Castellanos depicts, and Lund discusses, is the misunderstanding of Ladino and Maya relations. Gómez Parham relates this disconnect to her argument of alienation, in this story, one that demonstrates the narrator's lack of "comprehensive knowledge of Indian culture, as well as a knowledge of the Indian language," leaving him unable to "conquer the barrier of distrust between Indian and white" (Parham 26). This disconnect, or alienation, is accentuated through Castellanos's imposition of language barriers that hinder the quality of care that Maya patients receive. The narrator's first interaction with Manuela's daughter, depict his inability to verbally communicate with the child: "La muchachita me señalaba y me decía quien sabe cuantas cosas en su dialecto" ("El don" 315). This interaction demonstrates that Marta can only seek medical assistance for her mother through her own recognition of the misión, a victory in the eyes of the narrator. Furthermore, the narrator states that his inability to speak the language is not his wrongdoing as it is simply outside his area of expertise: "Por desgracia, yo no lo he aprendido aún porque, aparte de que mi especialidad no es la lingüística sino la antropología social, llevo poco tiempo todavía en Chiapas. Así es que me quedé en ayunas" ("El don" 315). Dalton states that this inability that the workers of the misión demonstrates throughout Castellanos stories are not unintentional:

> Part of the man's inability to speak Tzeltal and/or Tzotzil is institutional: Lewis notes that state officials believed that "Spanish meant progress; indigenous languages had no practical use in a school [or professional] setting." As they stigmatized indigenous languages, INI workers ironically ignored a great deal of input from local Mayan communities regarding their efforts. ("Treating Indigeneity" 974)

As Indigenous language held no standpoint in post-revolutionary Mexico's path to official mestizaje and modernity, it could be argued that the workers of the misión were not expected to learn an Indigenous language; if the Maya in Castellanos's short stories wish to receive help from the misión *they* must actively seek help and bridge the gap between cultural and linguistic barriers.

Furthermore, Castellanos uses her non-Indigenous characters' access to and power over medicine to juxtapose mestizo and Ladino approaches to Maya healthcare, a fact that we see especially clearly through the story of Manuela. Prior to giving birth, Manuela works in the home of Doña Prájeda, a middle-class Ladina woman. Castellanos describes Doña Prájeda as a woman with a strong and intimidating persona whose reputation as a ruthless employer demonstrates her racial privilege (316). Not only is she a woman of a higher economic background than her employees, but she is also of Ladina descent. Manuela's prenatal and maternal care falls on the hands of Doña Prájeda: "...cuando llegó la hora del parto, se hizo de nuevas, armó el gran borlote, dijo que su mesón no era un asilo y tomó las providencias para llevar a su sirvienta al Hospital Civil" ("El Don" 317). Doña Prájeda's decision to offer Manuela access to a hospital further demonstrates the power that she holds as a Ladina woman in this narrative. Dalton emphasizes that Doña Prájeda, as a Ladina, has demonstrated she has the power to provide Manuela with medical assistance, however, she is also able to manipulate when medical care will be provided, as well as the quality of care ("Treating Indigeneity" 973). The underlying reasons behind Doña Prájeda's intentions demonstrate that her control of medicine as a technology of power is implemented and taken away if and when they benefit her. Doña Prájeda worries about her employee giving birth in her home not because she cares about Manuela's health, but because Manuela will almost certainly ruin her home and furniture if she

gives birth in the house. It is because of this that she allows Manuela to refuse medical care at the facility and instead give birth in a horse stable.

Ultimately, Doña Prájeda's economic and racial privilege lead her to disregard the value of Manuela's (Indigenous) life. Understanding her power over Manuela, Doña Prájeda thus utilizes this opportunity to humiliate her servant by controlling whether and where Manuela will access medicine. The dehumanizing nature of this decision comes through in the following passage: "Para que Manuela no fuera a molestar a nadie con sus gritos, la zurdió en la caballeriza. Allí, entre el estiércol y las moscas, entre quién sabe cuántas porquerías más, la india tuvo su hijo y se consiguió la fiebre con que la recogí" ("El don" 317). To Doña Prájeda, this is an act of degradation. If Manuela wishes to deny the Ladina's 'goodwill,' she will provide Manuela with a 'facility' that is worthy of her societal status. Essentially, Manuela's life, and the life of her child, are disposable, a loss that Doña Prájeda can dictate with impunity.

Unlike "La rueda," "El don rechazado" depicts the interest of the misión after the narrator saves Manuela and entrusts her to its care. O'Connell argues that, in this story, the mission functions explicitly like a federal program rather than a private charity as they now have access to qualified workers and better resources (O'Connell 123). Perhaps one of the story's greatest critiques revolves around the fact that the narrator, while enthusiastic to serve, clearly expects Manuela to recognize her indebtedness to him and to the clinic; indeed, he expects her to become a spokeswoman for their projects after she recovers. In this sense, the misión also utilizes medicine as a technology of power to coerce Maya cooperation with their movement. Medicine becomes an entryway into the lives of the Maya in Ciudad Real as it opens the possibility of Maya assimilation ("El don" 317). While Doña Prájeda may have claimed control over Manuela's access to medicine, the misión has claimed it back and attempts to utilize it to forward

federal goals. Castellanos's portrayal of medicine in this story demonstrates not only the lack of autonomy that the local Maya has over their bodies, but it also depicts medicine as a technology of power that can be manipulated by those who control the sociopolitical hierarchies in Chiapas or Mexico.

As Manuela's departure from the clinic approaches, the narrator attempts to find different methods or causes to keep her and her children in the care of the misión. At this point, he wants to endow them with the skills they will need to 're-enter' society. The desire to claim Manuela as a victory of the misión demonstrates the lengths and manipulation that the misión is willing to go through. Dalton emphasizes that "rather than permit the mother to leave after her health improves, the anthropologists and his colleagues attempt to convince her to name Romero as the baby's godfather so that they will have a deeper familial bond" ("Treating Indigeneity" 975). While the narrator may not have the ill will of Dr. Salazar or Doña Prájeda, his actions demonstrate his expectation that any good action on his part merits praise and gratitude towards himself and the misión. When Manuela chooses not to name the narrator the godfather of her child, he feels slighted on a personal level. Castellanos provides the narrator in "El don" with the opportunity to demonstrate that he is unlike the Ladinos that have oppressed Manuela throughout her life. Of course, he fails. This scene occurs when he tries to get Manuela's daughter enrolled in a school through the misión. His attitude proves especially problematic when she refuses to send her daughter to the school. As he states, "yo me empeñé en demostrarle, por mí y por la Misión, que nuestros propósitos no eran, como los de cualquier ladino de Ciudad Real, ni envilecerlas ni explotarlas, sino que queríamos dar a su hija una oportunidad para educarse y mejorar su vida. Inútil" ("El don" 318). To the narrator, it is incredulous that Manuela would even consider denying his offer; he cannot accept she would act on her own accord. The narrator

depicts Manuela as an obstinate woman who, despite the endless resources provided to her, refuses to support his institution's mission. His disrespect for Manuela's decisions reinforces Dalton's argument that the narrator is not truly interested in Manuela and her children as people; rather, he sees in them the possibility to become mestizos ("Treating Indigeneity" 976). As such, they can only become truly valuable if they embark on a path toward modernity and officialist notions of mestizaje.

At the end of the story, Manuela decides to return with Doña Prájeda, the woman who almost killed her. This decision provides one of the story's greatest critiques of the mission and power relations in Chiapas. The decision to return with Doña Prájeda may not stem from any sense of gratitude that Manuela may have towards the Ladina, rather, it demonstrates Manuela's sentiment that this dynamic is her only means of survival. Prior to her employment with Doña Prájeda, Manuela sought refuge with her family, however, given her condition and the limited harvest from their crops, Manuela's family was unable to care for her and her children. As the narrator discusses the details he learns about of Manuela's life and her employment with Doña Prájeda—a woman who took her in while in the final stretch of her pregnancy and a with an older child—it becomes clear that to Manuela this seemed to be the only viable option.

One could also analyze the circumstances that led to her return to Doña Prájeda through Castellanos's subtle critique of the Ladino control of the Maya and their land. After the death of her husband, Manuela is forced out of her home because the landowner, who we can assume is a Ladino, claims that her husband owed him money: a debt for which she is now responsible (316). In seeking refuge with her family, Manuela faces further obstacles as their land is not plentiful enough to also feed her and her children. Due to their status as Maya, and given the societal hierarchies in Chiapas, one can assume that her family's land is rather small and lacking in

resources. As such, she departs for the city of Ciudad Real. Once there, Manuela is exploited for cheap labor by Doña Prájeda, a Ladina woman. Afterward, she is further exploited by the mission, who wishes to use her as a spokeswoman after providing her needed medical care. Of course, the misión wants her to validate statist notions of official mestizaje, a construct that devalues her own Indigenous heritage. Although she could have sought refuge with the misión, Manuela would have been forced to abandon her cultural beliefs as a result. Deciding to return to Doña Prájeda is thus not an impulsive decision by Manuela; rather, it demonstrates that, although exploited for cheap labor, Manuela would be able to maintain her cultural identity and ultimately have the decision as to how she wishes to raise her children. If Manuela were to accept the narrator's offer of staying with the misión, this would mean that Manuela would have to abandon her cultural and ethnic identity as a Maya woman and assimilate to the federal state. Official mestizaje strips away Manuela and her family of their identities; through the misión her children would be educated on the federal state's ideologies and raised in an environment that only utilizes Spanish. However, returning to her employment with Doña Prájeda, a Ladina woman who does not wish for local Maya to assimilate to the federal state, will allow Manuela and her family to maintain their identity as Maya, as well as their use of their native language and culture. The societal hierarchy in Ciudad Real is dominated by Ladinos, more importantly, they understand what the imposition of the federal state would signify in their lives and the lives of the Maya. As much as the Ladinos in Ciudad Real oppose the federal state's attempts of official mestizaje, they are aware that in order for this to occur the Maya must give up their identities as Maya. Doña Prájeda, as a Ladina woman, manipulates Manuela and dominates her life as she understands the significance that her identity as a Maya woman, her cultural value, and native

language. She is able to, under contradictory and hypocritical circumstances, provide Manuela with the thing she cares for the most– a claim over her ethnicity.

Conclusion

In the end, these very different stories come together to speak about the role of medicine as a technology of power in postrevolutionary Mexico, and particularly in the state of Chiapas, which enjoyed a degree of autonomy from Mexico City. In "El don rechazado," the use of a worker of the misión as the narrator of the story is a strategic choice by Castellanos that provides her readers with further understanding of who the misión is and what their overall goals entail. Whether or not this was an intentional move by Castellanos, this dynamic also provides further discussion of the power dynamic in Ciudad Real among mestizos, Ladinos, and Mayas. The former two engage in heated debate about the appropriate place of Amerindians in society, while the latter is not allowed to speak up in favor of their own interests and needs. This critique is further stressed through the use of medicine as a technology of power, one that is not only manageable by Ladinos, but by mestizos as well. Overall, while this story is significantly shorter than "La rueda del hambriento," the attention to detail by Castellanos allows for a larger discussion of the political order in the Chiapanecan cities where federal, *indigenista* programs tended to be headquartered.

Castellanos's development of Maya women throughout her two short stories serves as a beacon, bringing light to the issues that these women face regarding healthcare. The dangers that Castellanos's Maya mothers face as they are giving birth stem from complications that are easily treatable when the resources are made available. As such, the continued vulnerability of Indigenous mothers reflects the indifference of local, Ladino—and, one could argue, even

federal—governments that refuse to intervene on their behalf. What is more, Castellanos also alludes to the lack of follow-up care that is available to these women after giving birth. Castellanos depicts to her audiences the consequences of inadequate medical care for Maya women through scenes that underscore the effect of these medical policies on her protagonists' bodies. The scenes are raw and graphic, encompassing the reality of childbirth and the toll it takes on the mothers. This also brings to light the ridicule and humiliation they face because they are Maya within a state that does not wish to see them prosper. Ultimately, Castellanos emphasizes that the healthcare inequities in her fictitious Chiapas stem from a racialized social hierarchy that wishes to keep Indigenous people down. Not surprisingly, these depictions reflect the racist social order that existed in Chiapas during her lifetime. This underlying racial and economic hierarchy presents itself time and time again in both of these stories. While more subtle in some instances than others, Castellanos highlights the notion that any one person who is slightly above them in this contrast to Mexico's societal hierarchies, continuously turns them away or ridicules them. As important as it may be to understand where and what healthcare practices are lacking for mothers and soon to be Maya mothers, one must first delve into the issues that are restraining them from accessing the help.

Chapter 2: California's Eugenicists Movements: Forced Sterilizations of Chicanas and the Manipulation of Linguistic Differences in Renee Tajima-Peña's *No más bebés*

During the 1960s and 1970s, a pattern arose in the cases of women arriving in advanced labor at the USC-LA County Medical Center in Los Angeles, California. Shortly following their arrival, women would be informed by medical staff, that given the risk they faced of labor complications, they would require emergency cesarean deliveries. County clinic employees would give the women several forms to sign. The women thought they were consenting to c-sections, but they were actually granting doctors permission to perform tubal ligations following delivery. These women were thus tricked into undergoing this irreversible procedure under high-stress circumstances (see Manian 3-4). The recurring cases had a troubling common point: operatives at the medical center were specifically targeting Mexican and Chicana women, particularly those who struggled to communicate in English. In the majority of cases, the women were unaware of the procedure that had been carried out until months, or even years, after the fact. Many only learned after numerous failed attempts to conceive another child. Some women were ridiculed by their husbands and became victims of domestic violence (*No más bebés*). Others were forced to live in shame as they could no longer fulfill their dreams of having their ideal version of a family. Many of these women went on to be shaped by the trauma, and they lacked an adequate support system to confront it. Because they had undergone this procedure in their early twenties, these forced sterilizations radically changed the course of their lives. The stories of these women are discussed in Renee Tajima-Peña's documentary *No más bebés*, which analyzes the stories of the plaintiffs of the Supreme Court case Madrigal v. Quilligan. Tajima-Peña utilizes film to accentuate the underlying racist sentiments that informed the decisions of the doctors at the County Clinic to sterilize these patients. Viewed in this light, the film further

demonstrates how obstetric care can serve as a technology of power to elevate hegemonic actors—whites in this case—at the expense of people from marginalized communities.

Some context will help to explain the significance of the Madrigal case by showing how it related to other eugenicist events throughout the country. During the twentieth century, the United States carried out multiple federally and locally funded medical campaigns targeting specific demographics of the population (Lynch 284).[6] In 1907, Indiana became the first state to pass a sterilization law (Roth and Ainsworth 17), an act that marked the beginning of the eugenics movement in the United States. From 1922 to 1972 the state of Virginia sterilized thousands of individuals—mostly Black and Appalachian—as a means of ridding the state of so-called misfits.[7] Thirty additional states, including California, implemented practices of forced sterilization during these years (Stern, *Eugenic Nation* 2). The Supreme Court facilitated the expansion of these laws by "uph[olding] the constitutionality of involuntary sterilization" (Stern, *Eugenic Nation* 1). With this precedent in place, states throughout the nation were able to carry out an array of projects in the name of eugenics. Not surprisingly, these projects were generally aimed at maintaining white hegemony while at the same time curtailing the growth of minority populations.

Out of the thirty states that practiced eugenics, California accounted for approximately one third (Stern et al., "California's Sterilization Survivors" 51). The state's eugenicist actions in state homes, hospitals, and prisons is heavily documented (see Stern et al., "California's Sterilization Survivors" 50; Roth and Ainsworth 7-8). A 1909 law allowed the state of California

[6] Perhaps the most well-known of these studies was the Tuskegee Syphilis Study of Untreated Syphilis in the Negro Male—commonly referred to as the Tuskegee Experiment—which led to the deaths of over one hundred Black men in Macon County, Alabama. See Lynch (288-290).

[7] As Alexandra Stern notes, the practice was viewed "not as a punishment but as a prophylactic measure that could simultaneously defend the public health, preserve precious fiscal resources, and mitigate the menace of the "unfit" and "feeble minded" ("Sterilized in the Name," 1130).

to sterilize patients suffering from "'mental disease which may have been inherited' and was 'likely to be transmitted to descendants'" to be sterilized (Stern et al. 50; California Statute of 1909, Chapter 720). In the California Prison System, women were coercively and/or forcibly sterilized in a wide variety of cases where other solutions would have been more appropriate (Roth and Ainsworth 29). These practices in the California Prison System continued even after the state outlawed them, with cases being reported as recently as 2010 (Roth and Ainsworth 32). As the Madrigal Ten case made clear, hospitals also participated in the coerced and forced sterilization of female patients in the state until at least the 1970s (*No más bebés*). As we look at the different cases of sterilization in the state, certain patterns emerge. For example, the state utilized publicly funded facilities (prisons, county hospitals, etc.), to carry out their eugenic practices. The explicit juxtaposition of state-funded sites with these procedures underscored medicine's role as a technology of power. Tajima-Peña's film directly addresses these patterns of eugenics by sharing clips of multiple news reportings that discuss cases of forced sterilization throughout the state. The director also interviews a historian who discusses how concerns about overpopulation—particularly among racialized populations—led the United States government to explore an array of eugenics-related solutions to contain population growth.

Those California residents who favored eugenics continuously pushed in favor of legislation that would facilitate eugenics practices. Eugenicists often felt that their projects failed to deliver the results that they hoped for, but the state of California continued to lead the country in sterilizations, accounting for nearly one third of all of the nation's 60,000 sterilizations from 1909 through the 1960s (Stern, *Eugenic Nation,* 73). Eugenics in California were supported based on three factors:

> First, for many of the European American settlers who streamed into the Pacific West starting in the late 1800s, the act of civilizing what they saw as fertile yet underutilized terrain meant applying modern science, above all, the maxims of heredity and biology, to graft a new polis onto the Spanish and Mexican past...Second, there was a strong affinity between the doctrines of Manifest Destiny and nativism that seized California during and after the Gold Rush and eugenic racism. Sinophobia and discrimination against Latin Americans and American Indians, which permeated California from the 1860s to the 1880s, offered propitious ground for scientific racism, targeted principally at Mexicans and Filipinos, to materialize in the 1920s and 1930s. Third, California possessed a dense and multilayered matrix of educational organizations, civic groups, business associations, medical societies, and philanthropies that subscribed to eugenic philosophies. (Stern, *Eugenic Nation,* 74)

The longstanding support of eugenics legislation and movements beginning in the 19th century laid the framework for practices of forced sterilization that occurred at the USC Medical Center. As the state entertained anti-immigrant policies—particularly against Mexicans—eugenicists in California turned to an array of arguments to justify the exclusion of Mexicans from society. For example, they argued that Mexican immigrants were bringing diseases like typhoid to the state and endangering the lives of Californians (Andrés 102-103). Medical professionals during this time presented a significant interest in aiding in population control, as some "believed their

professional status and resources granted them the authority and responsibility to protect the public welfare by taking deliberate actions to reduce high rates of population growth" (Gutíerrez 20). Clearly, many medical professionals believed that they needed to decrease the Mexican population in order to ensure public health. These ideas survived in many ways well into the twentieth century, a fact that Tajima-Peña explores in great depth in *No más bebés*.

Although the film does not provide much detail as to how the eugenics movement in California differs from that of other states following similar practices, the film does present the viewer with the idea that individual states were able to function and dictate their own laws regarding eugenics. The decision to focus on one case from a state that supported eugenics demonstrates the freedom that the state of California had to forward its desired eugenics projects. In many cases, state officials used medicine as a technology of power towards these ends. It is perhaps because of this state-sanctioned power that California was able to manipulate different aspects of a patient's needs that would ultimately result in forced sterilization. In the case of the USC Medical Center, workers took advantage of linguistic and cultural differences to coerce and trick Mexican and Chicana women into accepting operations that they likely would have otherwise rejected.

Another component that Tajima-Peña is able to capture through her film is the United States' concern with population control. During the mid-twentieth century, the United States experienced an overwhelming increase in population that led to some concern about what would happen if reproductive policies were left unchecked for a generation or more. Paul R. Ehrlich's 1968 book, *The Population Bomb,* issued a call to action regarding population control. As a result of his book, family planning became a key component in tackling the growing population. Because his book focused most on curtailing low-income, particularly African American and

Latino(a) communities, his brand of family planning also aimed to curtail minority and other supposedly undesirable populations. His thought played a significant role in laying the groundwork for the policies of forced sterilization that took place at USC Medical Center and at other facilities throughout the nation. Indeed, the USC Medical Center proudly worked to curtail the birthrates of minority communities. The documentary includes the words Dr. Karen Benker, who worked at the county clinic as a medical student during those years, who claims that "Dr. Quilligan . . . said in a very proud way we've just gotten this big grant to see how low they could cut the birth rate of Negro and Mexican population" (*No más bebés*). This recollection from Dr. Benker demonstrates how thinkers like Ehrlich helped to drive medical policies that blatantly targeted and harmed Chicana and Mexican women as well as women from other marginalized groups.

As Tajima-Peña shows, the healthcare obstacles that Latinas and Chicanas faced during the 1960s and 1970s led to their right to obstetric care to be ignored as those in power used it as a technology of power against them. In the interviews of the women in the documentary, there are questions relating to family planning and their experiences with the services California's public healthcare system offered. Tajima-Peña's questions regarding family planning continue to build towards the narrative that Chicana women were actively targeted in the public healthcare system. Maria Hurtado and Consuelo Hermosillo both mention in their interviews the persistence of family planning centers that pressured them to hold off on having children. Hermosillo goes into further detail as she mentions the trend that if a woman already had multiple children, healthcare professionals would pressure them even more to use contraception (*No más bebés*). The highly racialized nature of these experiences suggests that a major goal of these early family planning agencies was to lower the birthrates of minority populations specifically. One of the aspects that

Tajima-Peña is able to bring forward in these women's cases are the small ways that the California public healthcare system attempted to control Mexican and Chicana/o reproduction. Viewed in this light, the film casts pushy medical professionals as the new front line in those attempts to control the population. If the state could no longer impose blatant eugenics on racialized communities, then it would seek other methods to contain that population. Viewed in this light, the state weaponized and abused family planning, and coerced sterilizations by aiming them at minority populations not to improve an individual's life and agency but to reduce undesirable populations. Tajima-Peña depicts the struggle of Chicana women as they lose autonomy over their bodies. Viewed in this light, she casts the forced sterilizations as a form of punishment for not succumbing to the demands of the state.

I begin this chapter with a discussion of the documentary's treatment of how inadequate access to obstetric care marginalized Chicana patients at the USC-LA County Medical Center. From there, I will discuss how healthcare literacy and linguistic barriers contributed to a context from which the state could sterilize these women. I finish by exploring the intersectional nature of the Chicana victims by highlighting how neither the feminists nor the Chicano activists of the day were willing to advocate for them. The discussion of healthcare for Latino(a)(x) communities will serve as a base into understanding the depiction of healthcare in Tajima-Peña's documentary. This approach will allow us to use the documentary mode to analyze the errors physicians made regarding care for Chicana patients.

Documentary and Social Critique in *No más bebés*

No más bebés deals specifically with the stories of the plaintiffs of the case Madrigal v. Quilligan. The documentary critiques California's use of the medical system to carry out eugenic

practices against Chicanas. Tajima-Peña centers her film around four of the ten women involved in the lawsuit against USC Medical Center: Consuelo Hermosillo, Maria Hurtado, Dolores Madrigal, and Maria Figueroa. These four women share their stories through interviews conducted by Tajima-Peña, who uses editing as a tool to accentuate the repetitive, almost formulaic nature of their cases. Beyond telling these women's stories, the film also includes interviews of the whistleblowers, attorneys, and expert witnesses who fought to hold the clinic accountable. Indeed, the film asserts that the USC Medical Center exploited language barriers to facilitate eugenicist practices by capitalizing on their patients' ignorance both of the language and of certain aspects of healthcare more generally. That said, Tajima-Peña avoids getting lost in theoretical arguments by keeping her representations grounded in the traumatized humanity of the victims. Beyond discussing the obvious physical damages that the women underwent, she also highlights the psychological trauma that accompanied these women who lost the bodily autonomy to decide for themselves whether or not they would have children. For some of the women in Tajima-Peña's film, sharing their stories and the abuse of power that took place sprouted immense fear; others were too embarrassed or ashamed to speak on the matter (*No más bebés).*

An analysis of the case through the lens of documentary film allows for a more contextualized discussion that pushes further than the actions of the physicians and brings into the conversation a sociopolitical discussion of what other factors allowed for these procedures to continue. Indeed, David S. Dalton argues that Tajima-Peña's production underscores the "advantage of the documentary mode to engage questions—and evidence—that may not be admissible in court. In this way, [the director] seeks a form of societal justice that the legal system failed to deliver" (Dalton, "Eugenics and Doubly" 131). One key point that he addresses

refers to what he calls “double marginalization,” which alludes to how racist and sexist ideas came together to create the conditions that allowed for these particular cases of violence against Chicana and Mexican bodies in the 1960s and 1970s Los Angeles (134). In Dalton’s telling, Mexican and Chicana women were marginalized by the State of California due to both their race and gender. For example, these women were marginalized along gender lines by the Chicano Movement while also being ignored along racial/ethnic lines by the Feminist Movement of the 1970s, which favored the interests of white women. That being said, I will now discuss the gendered implications of these forced sterilizations on women within the Chicano(a)(x) community.

The so-called Chicana Movement is generally said to have begun during the 1980s with the writings of Chicana feminists like Gloria Anzaldúa and Cherríe Moraga. These women played a key role in identifying and calling out the sexism that undergirded much of the Chicano Movement of the 1960s. In situating the Chicana Movement in the 1980s, historians and cultural critics are not suggesting that Chicanas were not a political force prior to those years. Indeed, beyond the clear contributions of women like Dolores Huerta to the Chicano Movement from its inception, several scholars have asserted that a distinctive, Chicana agenda had emerged in the Southwestern United States as early as 1962 (see Blackwell 14; see also Hurtado 3). Aída Hurtado and Maylei Blackwell argue that the institutional—and even intellectual—marginalization of Chicana thinkers has led to a sustained erasure of Chicana thinkers prior to the 1980s. This has, in turn, cast Chicana thinkers as secondary actors in the greater Chicano Movement. Chicana activists during the 1960s and 1970s clearly lacked the cultural validation that subsequent generations would receive, and this reflected, in no small part, the fact that it was

not until the 1980s that Chicana feminists like Anzaldúa would explicitly criticize their Chicano counterparts for their role in the continued marginalization of Chicana women.

This history proves key to understanding the political and cultural backdrop against which Tajima-Peña sets her documentary. As the film asserts, Chicano activists knew about the atrocities that the county clinic had carried out against urban Chicanas in the Los Angeles area, but they failed to wade in on the issue. In one particularly pointed interview, Gloria Molina, president of Comisión Femenil, explains that "the Chicano Movement was unfortunately all led by men, and very much, a very sexist kind of approach so when we raised these issues to many of our brothers in the Chicano Movement it was always considered a secondary issue" (*No más bebés*). It is for this reason that Dalton argues that "Chicano activists believed that the guarantee of female reproductive rights would not ensure gains in other spheres that they deemed more important" ("Eugenics and Doubly" 135). The point of this chapter is not to determine whether or not Chicano activists were justified in their findings; indeed, they had to deal with serious healthcare-related issues in rural parts of the state.[8] Rather, it is to point out that, ultimately, Chicanas were unable to seek refuge in a movement that they had helped to mobilize and that they strongly believed in. The leadership of the Chicano Movement chose not to support the needs of their urban, female counterparts because they did not view them as equal partners in the quest for social justice. Such a decision evinced a degree of machismo that permeated Chicano thought throughout the 1960s and 1970s.

Tajima-Peña highlights the fact that this machista underpinning existed among Chicano and Mexican men throughout the country. In her interviews with different women from the

[8] For a discussion of the United Farm Workers' work against carcinogenic agricultural practices, see Chapter 1 from David Dalton's forthcoming book, *Robo Sacer: Necroliberalism and Cyborg Resistance in Mexican and Chicanx Dystopias*.

Madrigal Ten case, she shows that the victims of forced sterilization came to face ridicule in their own community and even from their husbands and romantic partners because their inability to have any new children led people to characterize them as barren. Dolores Madrigal even tells of her personal experience, in which her husband not only blamed her for the forced sterilization but upheld the machista belief that her sterilization would allow her to sleep with other men without any consequences. This led him to become abusive with her. As she explains, in an interview during the film, "Él se refugiaba en el alcohol. Dice que a veces muchas mujeres se hacen eso para andar con otros hombres y el marido no se da cuenta. Así es de que yo no soy culpable, pero él no entendía eso y el de la nada me golpeaba, de la nada." Not only was she a victim of a violent forced sterilization, but she faced further violence within her home as her husband blamed her for an act of violence that the clinic doctors had carried out on her. One of the most poignant critiques of the film is that, due to the deep machismo within the community, these women struggled to obtain complete validation as victims from their own community, and, in many cases, their own families. It is for this precise reason that the film is so important: it gives these victims a voice, allowing them to speak out against the abuses that they underwent, both in the hospital and among their own communities. As these women share their stories, they testify of the traumatic results of the culmination of years of work in which California utilized obstetric care to carry out eugenics practices and curtail the reproduction of the Mexican and Chicano populations. While much of the fallout played out in the private sphere, it is clear that the state-sponsored clinic was the causal agent as it embarked on a eugenicist project to keep California whiter.

Furthermore, Tajima-Peña also highlights the cultural differences between the Chicana patients and clinical staff at USC Medical Center. In their interviews, Hermosillo, Hurtado,

Dolores, Madrigal, and Figueroa explain how their cultural upbringing had made them desire large families. Throughout their interviews, these four women express a commitment to their roles as mothers, and, more importantly, the unfulfilled wish of having larger families. We see this especially clearly in the case of Hermosillo, who was fairly proficient in English. However, her racialized status, which stemmed from the cultural beliefs and practices that she shares with the Chicano community, led directly to her forced sterilization. Cultural differences between the patients and their doctors played a major role in the care that they received. All of the women wanted at least three children, if not more. Nevertheless, they had the misfortune of belonging to a community that public health advocates—and even some professionals—felt were driving overpopulation. While the physicians in these interviews did not admit to administering forced sterilizations, their words seemed to favor increased numbers of sterilizations. Given their desire to do this, it seems quite likely that they would cut corners in order to sterilize larger numbers of women. Throughout the film, Tajima-Peña employs emotional, first-person accounts in order to achieve what Dalton calls "surrogate justice" (Dalton “Eugenics and Doubly,” 138). Dalton argues that this technique by Tajima-Peña "served to mobilize viewers and ensure that similar abuses do not happen in the future. In this way, the film's verdict, while not legally, binding, attempts to leave a mark that will last well into the future” (Dalton “Eugenics and Doubly,” 138). Tajima-Peña's editorial techniques are thus intended to leave a lasting impact on the viewer that provides them with information about the case as well as detailed, personalized, and emotional interviews with the women themselves. There is also control over whose story is represented and who is allowed the opportunity to provide their narrative.

Healthcare Disparities in the Latino(a)(x) Community

As I have shown throughout this chapter, one of the issues highlighted in Tajima-Peña's documentary is that of language barriers. Despite the US Supreme Court's ruling that Title VI of the Civil Rights Act of 1964 also protects non-English speaking citizens,[9] cases such as Madrigal v. Quilligan demonstrate that linguistic differences continued to impact medical care years after laws had been passed to protect linguistic minorities. Linguistic differences continue to present significant barriers for non-English-speaking patients. The stories of the women presented in *No más bebés* further demonstrate how clinics can exploit linguistic divisions to bring about eugenicist ends. Tajima-Peña elaborates on a key component in this case: all of the women involved in the lawsuit were coerced into signing documents in English—which was not their dominant language—rather than translated documents. As such, it was all the more difficult for them to understand what they were consenting to. Aware of their patients' low proficiency in English, doctors seized their opportunity to carry out coerced sterilizations; seeing the complications in proceeding with a natural birth, they informed their patients that the safest option for both the mother and child was through a Cesarean section. However, they insinuated that they would not carry out the procedure unless they agreed to a tubal ligation surgery. Even more so, the women were not mentally and physically well enough to make such a decision at the time the news was being delivered to them. The mothers were required to sign documents in English, after being consulted in English, without being given the time to consult with anyone in Spanish. Through interviews, Tajima-Peña highlights the duress under which these women found themselves. They were bombarded with news that they were experiencing labor complications

[9] The text states that "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied benefits of or be subjected to discrimination under any program or activity receiving federal assistance (Civil Rights Act Title VI–Nondiscrimination in Federally Assisted Programs). For an in-depth discussion of the legal framework surrounding access to language services, see Mellinger (121).

that would require an emergency procedure; they feared that they would lose their child. The hospital took advantage of this duress to then take advantage of the language barrier to coerce their patients into consenting to tubal ligation without understanding what they were agreeing to.

A statement made by Maria Hurtado during her interview for *No más bebés* elaborates further on the perception that doctors had of Latinas in their care: "Pues si oí yo que dijeron allí que 'no porque las mujeres mexicanas están teniendo muchos muchachos' y que ellos están viendo modo de que paren un poco" (*No más bebés*). Hurtado also goes on to mention doctors' complete disregard for communication. There was no common language between the doctor and patient, and they resorted to hand gestures. The absurdity is compounded by the fact that this communication happened with women in advanced labor. At one point, Hurtado reports that her doctor said "Mama" as he motioned for her to sign the documents pertaining to her tubal ligation without so much as a "sign here" or an attempt to explain the situation at hand. The film continuously mentions the USC Medical Center's disregard for the linguistic needs of these women to emphasize the fact that these women at no point received care in their native language. The ramifications of this fact are especially frightening: not only does low proficiency in English hinder a woman's ability to communicate in the case of emergency, but in the case of this clinic, it also dictated whether or not they had autonomy over their own bodies. The film charges that the physicians at the county clinic viewed their patients' linguistic differences as an opportunity to curb the explosive growth of the Mexican and Chicano communities in the area during those years.[10] Of course, the differences between patients and medical providers at the county clinic were not just linguistic; they were also cultural. This cultural disconnect may have led to a

[10] The story of Consuelo Hermosillo serves as an interesting counterpoint to a certain extent. She is one of the only women who shares her story in English. However, despite Hermosillo's higher proficiency in English, she is also forcibly sterilized at the USC Medical Center. Of course, as Mellinger notes, conversational competency in a second language does not necessarily mean that she had a medical competency in the language (119).

further lack of understanding about what many Spanish-speaking female patients may have wanted.

It should be noted that many of the issues that these women faced regarding linguistic differences are issues that continue to impact the care of non-English speaking patients into the present. Christopher D. Mellinger discusses linguistic differences and the disparities that the Latino(a)(x) community continues to face in the present day. Mellinger notes that the need for competent interpretation services is about more than just a question of legality; it also speaks to achieving optimal health results: patients will likely interact more with their doctor if they feel that they can communicate effectively (121). Of course, the film also shows that even a person who speaks English conversationally may not be able to communicate effectively with their doctor about medical subjects. Mellinger, for example, notes serious problems that can emerge when people use an ad-hoc interpreter or when a person who is bilingual but lacks the specialized medical terminology attempts to communicate with medical professionals. [11] This seems to be what happened in the case of Hermosillo; while she spoke English, she certainly lacked the specialized language to truly understand what she was consenting to. If she had received interpreting services, she could have better understood the ramifications of the procedure to which she was consenting. Viewed in this light, even people who seem to be

[11] In instances where translations or interpreters may not be offered to a non-English-speaking patient, the patient may resort to bringing their own aid. Unfortunately, when patients have to resort to bringing their family members, friends, etc., to interpret for them, there are further limitations set into place. Mellinger categorizes these interpreters as ad hoc interpreters: "These bilinguals are often referred to as ad hoc interpreters or language brokers, since they are performing the job of mediating between two languages without preparation or education to do so" (Mellinger 120). In lacking the adequate training or education, the ad hoc interpreter may not be well-versed in the specialized medical terminology they need to interpret. A study conducted by Glenn Flores, in a sample size of two hundred and sixty-one patients, found that "LEP patients with ad hoc interpreters less likely than EP patients to report medication side effects explained" (Flores "The Impact of Medical," 259). While this only presents one example of ad hoc interpreters, the study demonstrates that ad hoc interpreters are unreliable, as their inexperience can impact the quality of care that the patient receives.

competent speakers of the language face potential discrimination as a result of their linguistic abilities.

The women interviewed in Tajima-Peña's film emphasize that they were not provided with any interpreting services or translations for the documents they signed. Having been denied the opportunity to consult with a doctor in their dominant language—even if they spoke conversational English—robbed them of their ability to fully consent to the procedure they were scheduled to undergo. Certainly, it could be argued that, even if they had received interpretation services, the patients' health literacy could have impacted their decision to agree to the procedure. Howard Blanchette notes that even "if the patient spoke English, you would say 'well what we can do is tie your tubes, you're not going to say we're going to cut and tie your tubes– it was tie your tubes, and so some people believe that well if they're tying my tubes, they can come untied" (*No más bebés*). Blanchette thus shows that, even though a patient can be fluent in English (or receive competent interpretational services), there remains a possibility that a person may simply lack the health literacy to make an informed decision. In this case, Blanchett alludes to a common misconception at the time regarding what the procedure for tubal ligation entailed, particularly the fact that the decision would be irreversible. There is an unspoken expectation that this should be common knowledge to the patient, but if a patient does not know this for whatever reason, then she cannot truly consent. If it is possible that even English speakers could struggle to effectively communicate with their doctors, then non-English-speaking patients would face even more difficult circumstances. Based on the abuse that Tajima-Peña explores in her documentary, it appears that these Chicanas were punished for not speaking the dominant language and for not assimilating to the dominant culture—particularly regarding health literacy—of the United States.

One of the concerns that Blanchette's remarks raises is the issue of ethics in medicine, more importantly, the issue of informed consent. While the women in the film all signed the documents they were provided with, consenting to the tubal ligation, the women could not have provided informed consent, as the Tajima-Peña's film critiques. Andrew Clifford, discussing informed consent and the intervention of interpreters, stresses the fact that "for the physician, behaving ethically is largely a question of respecting the principles of autonomy and veracity, something that also explains the importance placed on obtaining informed consent from patients" (234). Clifford's point on informed consent highlights the unethical practices through which the physician's at USC Medical Center operated. Further discussing ethics in healthcare and healthcare interpreting, Robyn Dean provides further insight as to how having access to an interpreter provides non-English speaking patients with an advocate of their rights. One example that Dean provides discusses informed consent where a patient is provided with a document "which explains a treatment procedure to a patient who relies on interpreters for access and is told to review it in time for the provider to return for any questions" (208). Dean argues that in this scenario, an interpreter would advocate for the patient and express their inability to review the document, understand it, and pose any questions as the document is not in a language the patient understands (208). While Dean proposes this as a fictitious scenario, the women in Tajima-Peña's film demonstrate the real consequences that can occur when there advocate for a non-English speaking patient. As Clifford and Dean discuss informed consent and the ethical interjections of interpreters, their arguments serve as examples to the services that should have been offered to the women in Tajima-Peña's film. Not only were these women's linguistic needs ultimately ignored by the physicians at USC Medical Center, but so was their right to provide informed consent.

Furthermore, as this chapter continues to discuss the role of and access to interpreters for non-English speaking patients, there are also questions remaining regarding ad-hoc interpreters. While current research demonstrates the negative impact that ad-hoc interpreters can have given their lack of training (Mellinger 119-120), the question remains as to whether having an ad-hoc interpreter available could have prevented some of these women's forced sterilizations. Blanchette's claim that many English-speaking patients lack an understanding of tubal ligation, the interjection of an ad-hoc interpreter likely would have done very little to ensure that the patients make informed decisions. That said, a trained interpreter with knowledge of the language, medical terms, and general health literacy likely would have been able to explain the costs and benefits of undergoing this particular procedure more effectively. Viewed in this light, the lack of such services made it all the easier for the clinic to exploit its patients' poor English and health literacy to increase the number of sterilizations of Mexican and Chicana women. Viewed against this backdrop, it is clear that, deliberately or not, physicians and medical professionals utilized their Mexican and Chicana patients' low levels of English and their relatively low health literacy to assert their power over their right to obstetric care. The doctors could also use the patients' poor English in their own defense: if they were to be questioned about the procedures they carried out, physicians could easily assign the blame to the patient's lack of health literacy.

Although language barriers and health literacy are two separate factors, the interviews in Tajima-Peña's film demonstrate that in the two issues frequently overlap. The documentary suggests that the rushed, informal presentations of the procedure—made in English to native-Spanish speakers in advanced labor—implied to the women that tied tubes could eventually be untied at a later date (*No más bebés*). In a 2007 study on Limited English Proficiency (LEP) and

health literacy conducted in California, Latinos were the second-largest ethnic group of the study, and their health literacy rate of 45.3% was the lowest of all groups (Sentell and Braun 86). While the study analyzes LEP, health literacy, and the interviewees' health status separately, it finds a correlation between the patient's LEP and health literacy in reflecting the individuals' health status (Sentell and Braun 95). The case studies surrounding non-English speaking patients, as well as the Madrigal v. Quilligan case, demonstrate the prevailing issues hindering the care of Latino(a)(x) patients in the US healthcare system. The problems in these cases cannot be validated and acknowledged if the narrative itself is not given the opportunity to be heard by the system perpetuating them. Through Tajima-Peña's depiction of the case, there is a much more intimate and personalized discussion that speaks to the findings from studies similar to the one detailed previously. The film is able to demonstrate the possible situation in which a patient with limited English proficiency, low health literacy, and a lack of language services can find themselves in.

Having outlined healthcare disparities that continue to impact the quality of care of the Latino(a)(x) community, as well as the historical practices of eugenics that shaped the medical system in California, this chapter aims to tie in the multiple facets of this case into the discussion of Tajima-Peña's documentary.

Conclusion

Renee Tajima-Peña's documentary, *No más bebés*, depicts the trauma of ten women who were forcibly sterilized by their doctors following labor. These women, placing their trust in a facility that they believed was there to care for them during a medical emergency, were ultimately abused and ridiculed. While the case Madrigal v. Quilligan can be analyzed and

dissected on its own, the discussion of this case through Tajima-Peña's documentary brings the case to a wider spectrum. Through a film adaptation, viewers are not only presented with a personal and emotional understanding of the pain that these women were succumbed to, but they are also provided with a discussion as to how this abuse of power was possible. As Dalton has argued, the use of documentary film allows Tajima-Peña the liberty to edit and arrange the film to depict her intended message– a form of surrogate justice. As he argues, while the women involved in the class action lawsuit may have lost in court, Tajima-Peña's documentary allows them an opportunity to seek justice elsewhere. Through this lens there is an in-depth analysis of the political agenda of the time and a discussion of Civil Rights Movements, all of which fail the women in this documentary, resulting in the telling of their story. The documentary provides the viewer with an understanding that eugenics, population control, obstetric care as a technology of power, and inadequate healthcare practices led to the forced sterilization of the women in this case.

Given the scope of California's century-long practices of sterilization, we cannot simply argue that the cases of the women in this documentary were rare occurrences. The discussion of the case through documentary film allows the director to show the effects of California’s dubious history of sterilization on its population. More importantly, it opens the discussion to further analysis from other academics, filmmakers, historians, and so forth, to discuss and analyze the practice of eugenics outside of what the film depicts. The limited scholarship that exists of Tajima-Peña's documentary suggests that there is still plenty of room for further analysis of the implementation of medicine as a means of controlling the bodies of Latinas and Chicanas in California. The stigmatized perception of the community during the 1970s when this case took place, to the continued stigmatization that the community faces in the present day, demonstrates

the continued relevance of the issue at hand. The perception of racialized women in the United States continuously impacts the quality of care, as well as access to care, that racialized women have. The discussion around racialized women's bodies is one that continuously strips them of their autonomy and humanity. A current event in which this point can be further analyzed is through the current baby formula shortage in the United States.

On May 11th, 2022, congresswoman Kat Cammack, representative of Florida's third congressional district, uploaded a video through Facebook Live to discuss with her supporters President Joe Biden's tendency to put America last. Cammack made these claims after receiving a tip from a border patrol agent at the McAllen Processing Center, stating that, pallets of baby formula were being delivered for the children at the processing center. Throughout the roughly fifteen-minute video, Cammack claims a call to action from her supporters, a step to protect the American citizen first. A prominent point in Cammack's video is the repetition of the phrase "America last," a claim that Cammack states was further accentuated by the government's decision to feed illegal immigrants over American citizens. As the baby formula shortage continues, the sentiment expressed by Cammack is one that will persist; the ideology that racialized bodies, undocumented individuals, should be placed at the bottom of the societal hierarchy in times of shortages or distress is not new. In sum, through the argument presented by Cammack, the inability of undocumented mothers to lactate, while unfortunate and devastating for the child, are not equal to, or as necessary, to the needs of American mothers and children. Ultimately, Cammack's call to action holds a similar sentiment to the attitudes of the medical staff at the USC Medical center carrying out forced sterilizations that Renee Tajima-Peña highlights throughout their film. Tajima-Peña addresses a pattern in the United States, that

arguments such as the one made by Cammack support further, in which obstetric care can used as a technology of power over the bodies of racialized women.

There continues to be a push to use racialized women's medical needs against them. Such attempts are implemented through statist agendas, such as Cammack's call to action to favor Americans over immigrants, and the USC Medical Center's targeted eugenicist practices of Chicanas in California. It is important for people to continue to draw attention to the injustice that such policies represent for the most marginalized people in the country. Literature can provide one valuable medium through which writers can challenge such practices. Nevertheless, cinema provides one of the most powerful media from which to call out injustice due to its accessibility and its ability to reach wide audiences. Viewed in this light, *No más bebés* is an especially valuable film. It is critical of the forced sterilizations that took place in California from the 1960s to the 1970s, and it tells the story in a way—and through a medium—that is accessible to people from across the political spectrum. In bringing attention to the United States' repetitive and continuous, targeted practices, against racialized women and their right to obstetric care, the film implicitly calls on its viewers to do what they can to impede such projects in the future.

Conclusion

Ever since the beginning of the coronavirus pandemic in late 2019, most discussions pertaining to healthcare relate to the ongoing pandemic. Questions regarding access to adequate care and the availability of medical resources continue to be hotly contested in both Mexico and the United States. With the increased focus on health, it is also during this time that I became interested in researching the Latino (a) (x) community's access to healthcare, with a focus on language barriers and its impact in the quality of care that patients receive. This interest led to the decision to analyze cultural production from two different countries that discuss access to healthcare, and the quality of care, given to Maya women in Chiapas and Mexican and Chicana women in California. To this end, this thesis utilized Rosario Castellanos's, "La rueda del hambriento" and "El don rechazado" and Renee Tajima-Peña's, *No más bebés*, to discuss how people with racial privilege in both contexts use medicine as a technology of power to control and maintain political agendas that allow them to further control racialized communities. Both works discuss a history of eugenic practices, intersectionality between gender and race, and, most importantly, a comparative connection of these issues.

This thesis began by addressing the historical context of these cultural productions and by defining the terminology that would be used throughout the thesis itself. In laying out the historical context of the eugenics movements of both Mexico and the United States, this thesis was able to facilitate a clear discussion of the eugenic practices in each country. The study outlined the similarities and differences regarding how both countries had implemented these projects, and then it provided examples of how literary and cultural productions from both contexts engaged with and critiqued these movements. The United States blatantly implemented eugenicist laws and movements to curtail the growth of racialized communities. Mexico

undertook eugenics projects as well, though its history—and particularly its affinity for racial mixing—led it to employ a different methodology that rejected U.S. doctrines of racial purity (Stepan 148-152). Mexican eugenics focused specifically on modernization through official mestizaje, an ideal that reified racial mixing to overcome Indigenous primitivity (Swarthout 64-67**;** *The Eagle and the Virgin* 10-11**)**. In the United States, of course, the objective of eugenics was to protect the privilege of white communities throughout the country. This led to initiatives to forcefully curtail the growth of Black and Brown communities, particularly in the South and the Southwest. No state sterilized more people than did California (Silliman et al. 8); this reflected, at least in part, the state's massive size, but the fact remains that California was one of the central sights of US eugenics during the twentieth century. The desire to police and maintain a racial division was less common in Mexico, but a version of racial segregation occurred in states like Chiapas that sat far from the nation's center in Mexico City. As this study has indicated, white Ladinos in the state of Chiapas took advantage of the great distance between their state and the capital to continue to exercise control over the Maya, a demographic that provided the cheap labor necessary to maintain their style of life. Racial divisions remained more fluid than in the United States in the sense that mixed-race children could be considered Ladino if their Ladino fathers recognized them, but these hierarchies remained very rigid once a person was marked as Ladino or Indigenous. It is for this reason that local Chiapanecans in Castellanos's stories so strongly oppose attempts from Mexico City to incorporate Indigenous actors into modern society.

Castellanos's short stories, "La rueda del hambriento" and "El don rechazado," both critique the societal power dynamics that exist between the Ladinos and Maya of Chiapas. More importantly, Castellanos presents medicine and obstetric care as a technology of power that

Ladinos use to maintain their dominance over the Maya. In making medicine and obstetric care central to both stories, Castellanos speaks to the various attempts that Mexico made throughout the twentieth century to achieve official mestizaje by modernizing indigenous bodies through medicine and education (Dalton, *Mestizo Modernity* 4-5). However, with the history of conflict over racial power dynamics in Chiapas, Castellanos also critiques the state's manipulation of federally funded medical campaigns that are overrun with corruption. As both stories charge, far too often, state-sponsored *indigenismo* reinscribes the very structures of power that have marginalized Indigenous populations ever since the Contact Period into the national fabric once again.

While the treatment of Chicana and Mexican women in southern California differs significantly from that of Indigenous women in Chiapas on multiple fronts, women from each of these marginalized communities have faced similar difficulties regarding obstetric treatment during pregnancy and childbirth. As this thesis has tried to show, these women's struggles in accessing adequate healthcare have reflected eugenicist drives in both contexts to keep them—and any potential offspring—racially marginalized in society. Renee Tajima-Peña's discussion of Madrigal v. Quilligan, which addressed the forced sterilization of Mexican and Chicana women in the USC-LA County Clinic, provides a powerful denunciation of the eugenics movement that undergirded initiatives of population control in the 1960s and 1970s United States (Dalton, "Eugenics and Doubly" 137). Tajima-Peña's inclusion of personalized interviews provides a deeper contextual understanding both about the procedures that county clinic doctors carried out on these racialized women and, crucially, the trauma that these actions inflicted on them. In addressing the United States' troubled history with forced sterilization and eugenics, the director criticizes the actions of not only those workers at the county clinic, but also the endorsement of

eugenics throughout much of the twentieth century at both the state and federal level in the United States.

This thesis aimed to discuss medicine, specifically obstetric care, as a technology of power through which statist agendas further marginalize racialized women. Although Castellanos's stories are set in Chiapas, Mexico, and Tajima-Peña's film discusses a case that took place in Los Angeles, California, the patterns, and similarities that exist between these stories demonstrate the central role that medicine has held (and continues to hold) with regard to eugenics in both countries. What is more, the selected works speak to events and practices that took place in the mid-twentieth century: Castellanos's texts were published in 1960 and likely take place either in the 1950s or the 1960s; the forced sterilization of the Madrigal Ten occurred during the 1960s and 1970s. As such, both works speak to concrete examples of obstetric care being used to promote racial formation during roughly the same years. While I have focused on the mid-twentieth century throughout my thesis, the intersection of women's health with racial formation has played out in different ways throughout the history of both Mexico and the United States. In many ways, medicine interfaces with race formation into the present day in both contexts.

That women's access to healthcare would be fluid and change across time should come as no surprise. That said, recent developments in both countries have shown just how abruptly different hard-fought medical rights can be reversed. As I finish this thesis, women's rights to reproductive health have undergone radical change in both the United States and Mexico. In April 2007, the Mexico City legislature passed a law "decriminalizing elective abortion in the first 12 weeks of pregnancy," while allowing states to dictate their own laws regarding abortion (Becker and Díaz Olavarrieta 590). More recently, the Supreme Court of Mexico decriminalized

abortion in all of Mexico (Morán Breña and Barragán). This does not *legalize* abortions in all of Mexico, but it provides important protections for women who choose to terminate their pregnancies (Morán Breña and Barragán). The legal landscape of abortions in the country varies significantly by state, with the most conservative allowing for it only in the case of rape and the most progressive allowing for abortions up to nine months for an array of reasons (Becker and Díaz Olavarrieta 592; Morán Breña and Barragán). While this patchwork of laws is a bit difficult to navigate, the country now ensures women's rights to abortion more completely than does the United States. On June 24, 2022, the Supreme Court of the United States voted to overturn Roe v. Wade, the ruling that had determined that the right to an abortion was enshrined in the Constitution through an implicit right to privacy (Sherman). This ruling sent the issue of abortion back to the states, many of which passed draconian laws criminalizing abortion even in cases of rape or incest. The ramifications of this ruling may prove life threatening for women of color throughout the nation. As both of these decisions show, women's health remains a highly politicized issue in both countries; changes are likely to occur in the coming years as women make their access to healthcare a central issue in the politics of Mexico and the United States.

This thesis has emphasized that access to abortion is only one of many examples of the politicization of women's rights. Erika Cohn's 2020 documentary, *Belly of the Beast,* discusses the forced sterilization of racialized women in the California prison system well into the twenty-first century. Once again, the state intervened and blocked women's rights to reproductive autonomy, this time by stopping them from having children. The history of eugenicist movements in controlling the bodies of racialized women has left deep scars on marginalized populations in both the United States and Mexico. Even so, casual observers in both countries may be shocked upon learning about these practices; neither the Mexican nor the U.S. state make

a point to broadcast their abuses of the racialized women living within their borders. It is precisely for this reason that we have an ethical duty to share the stories of the traumas that racialized women have faced in the name of eugenics. Only through this means can we attempt to learn from these atrocities and not repeat them; indeed, a general ignorance about how the state has hindered women from corporeal autonomy almost certainly contributed to the conditions leading up to the overturning of Roe v. Wade in the United States. Beyond just an intellectual theorization of the role of medicine in assigning people their societal roles, then, this thesis is also ethically committed to tell the stories of racialized women and their struggles to receive the care necessary to be able to exercise autonomy over their own bodies.

At the same time, this thesis has remained modest in its objectives; I have discussed only a handful of examples of literary and cultural production from both Mexico and the United States that discusses the role of medicine in projects of eugenics and racial formation. This study has highlighted how similar concerns exist across national borders as they regard to racialized women's access to healthcare. Nevertheless, many more stories, films, and performances speak to these precise questions in both national contexts, and they, too, deserve greater attention from the academic community and from the public at large. Tajima-Peña's film reminds us that solidarity must be the goal of activists of all stripes; one of the film's greatest criticisms is that both the Chicano Movement and the Feminist Movement generally ignored the plight of the Madrigal Ten because they were not interested in incorporating these women's needs into their respective platforms. As such, these activist organizations unwittingly furthered the power of the white patriarchy that they were trying to contest. A similar critique arises in the work of Castellanos, who characterizes many mission workers as racists themselves whose actions ultimately support local constructs of Ladinaje while failing to better incorporate Indigenous

populations. As both Tajima-Peña and Castellanos implicitly assert, then, dialogue is key to achieving liberation. This lesson holds true into the present, especially given the state of women's rights and women's health in both countries. In Mexico, women will need to build on the momentum of recent political and legal decisions to further enshrine their corporeal autonomy into the national culture. In the United States, women will depend on as many mediums as possible to make their voices heard as they contest draconian laws against abortion in an array of states across the nation. In any event, just as Castellanos and Tajima-Peña assert, an open national dialogue will be key to securing future gains.

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